Inside Out over the past few months has been involved with the Bowel Disease Foundation at the Royal College of Surgeons in central London. I was invited by Azmina Verjee to be a representative for patients.

I attended the patient's forum in March of this year, there was representatives from Crohn's and Colitis and the IA as well as eminent surgeons from around the country. We looked the final questions that had been selected, (see below), these 25 were reduced from the five hundred that were put forwarded.

The surgeons that attended by the end of the day's consultation were to say the Consultants were in shock as what they had put in order of priority were completely reversed after the patients had participated in the days event and made their selections electronically at the end of the day.

I was asked if I could be part of the Delphi Games, this is where a few of the questions out of the 25 selected, at a time, were gone into more detail with selected surgeons who wished to research it deeper and see if there were ways of improving the ways of doing things and taking on board the patients point of views, so that it was not all medically driven, a better balance, patient and medical.

What is pleasing to see is that it is not lip service, our contributions are for the first time being listen to and taken on board and I for one am delighted.

We will be meeting up again in September of this year to see how much progress the research projects are coming along and see if there is anything else we can inject to help the process.

Meanwhile Inside Out has also been involved with the CCG pan London; looking at how the 111 services can be improved and better recognised within the community. As at the moment it is not fit for purpose, the suggestions we have put forward are that it holds a list of services that are open when others are shut down after hours, dentists, pharmacists, GP's etc. and a list of support groups as sometimes all they need is someone to talk to. Again it seemed to be that we were going over and over the same issues, for the sake of it and going nowhere fast and resolving nothing.

Finally, I have been looking in to the possibility of moving Inside Out, out of the hospital and in to the community, (see attached), it would work on the premise of a not for profit coffee shop and one stop shop for all stoma patients and jo public.

We would have to become a registered charity in our own rights, the work that Andy has already done on this has not been wasted, which would allow us to reclaim 80% of the rates.

On the ground floor we would be open to the public and this in turn would provide us with the means to be self-sufficient after a short while, I have already been talking to Dansac to see if they would be sole sponsor in the beginning or if they would prefer us to have a number of sponsors.

On the floor above we would run the other services for the community, i.e. yoga classes, aroma therapy, massages, counselling, information centre for pan London,

IBD, all stomas, running workshops for careers on behalf of the CCG, printing our own newsletters etc.

We would be able to move into 21st century as this government is moving us through enhance recovery back into the community and we would be part of the infrastructure where we can be of more use and helping the new stoma patient on their road of recovery by being out of the hospital and in the high street where they can start to be included back in society.

Just over 30 years ago British Colostomy Association as it was known then, had a similar idea in central London, but after a couple of years they had to shut it down as they could not keep it going.

This I personally feel is the step we should be taking for the future and at the same time showing the UK wide IA, CA and UA how all stomas are the same except in name only. I see us as the new pioneers of the future and can see these popping up all over the country and I want us to be part of it.

Bowel Disease Research Foundation

Delphi Oracle

Setting the Research Agenda

The Modified Delphi Exercise is a ground-breaking attempt to democratically identify the highest-priority areas in colorectal research, weaving together input from across the profession in order to prioritise key challenges facing researchers.

Drawing on as wide a range of expert knowledge and specialist experience as possible, along with significant patient input, the project hopes to establish the research agenda for coming years in the study of colorectal disease in the UK. The work is being funded by BDRF and led by ACPGBI with input from the Royal College of Surgeons of England (RCSE).

The story so far

Delphi Champions at work

Through extensive surveying of the ACP membership, over 500 research questions were submitted and whittled down over 2 rounds of voting to the 25 considered to be of absolute highest priority. This list is available in full here.

The next step was to recruit a 45-strong team of "Delphi Champions", who have committed to taking on the questions either individually or as part of a team alongside their fellow Champions.

Patient consultation

Patients briefed surgeons at our consultation

On March 26th 2015 we held an event at the RCSE which brought patients and surgeons together to discuss the 25 priority research questions. This ensured patient voices were heard from the outset, and the conclusions from this exercise are to form an integral part of the professionals' approach to each of the 25 topics. We were joined on the day by representatives from the Ileostomy Association, Bowel Cancer UK, the British Society for Gastroenterology and the Inside Out Stoma Support Group, as well as current patients.

Delphi Games

The Delphi Games have now kicked off, with the first two events being held on 28th and 29th of April 2015. Further workshops will run in May and September, to develop strategies for each question.

Bowel Disease Research Foundation

Research Priorities Identified

Now that the ACPGBI's Modified Delphi Exercise has been successfully concluded, BDRF is in a much better position to identify areas of research which are considered the highest priority by the wider colorectal research community.

During this ground breaking process, ACPGBI members submitted over 500 questions, and subsequently cast more than 400 votes in the second and third rounds to define their top 25 research questions. Of these, 15 relate to the treatment of bowel cancer while 10 relate to diverse topics including benign disease, surgical technique and clinical governance.

Full results will be published in the December issue of Colorectal Disease and are currently available electronically ahead of publication, citation Tiernan et al, Colorectal Dis. Oct 5. doi: 10.1111/codi.12790. We are most grateful to the Editor for allowing us to include the results tabled below.

What next?

The ACPGBI, BDRF and RCS, together with patient groups, wish to develop a co-ordinated strategy to evolve and implement the Delphi research agenda. In the first instance we would like to hear from individuals or groups who wish to participate in answering any of these questions. We are now seeking **Delphi Champions.** These Champions will be invited to attend the Delphi Games in spring 2015, a series of themed meetings that will bring together clinicians, methodologists, patients and funders to develop our trials strategy.

The ACPGBI has agreed to provide a start-up fund to help groups grow. Additional resources are available through the RCS .

If you are interested in becoming a Delphi Champion, or simply want to support work on a specific research question, then please do apply **before December 15th** providing:

- *your name, position and place of work*
- *contact details*
- *which research question(s) (maximum of 3) you would like to help develop*
- *paragraph of less than half a side of A4 explaining your interest*

Applications and queries should be sent by email to gsaffery@bdrf.org.uk

A full list of the ACPGBI's established priority questions is available below, reproduced by kind permission of the Editor of Colorectal Disease

Cancer-related research questions in order of priority:

1	What is the optimal treatment for early rectal cancer? What are the relative roles of endoscopic mucosal resection (EMR), transanal endoscopic microsurgery (TEMS), radiotherapy, chemotherapy and resectional surgery? In cases of early rectal cancer amenable to local excision techniques, are there benefits from additional treatment modalities?
2	What is the best method to predict complete pathological response to chemoradiotherapy in rectal cancer treated with neoadjuvant chemoradiotherapy prior to surgery? Do these patients require immediate resectional surgery? If not, what is the best strategy for surveillance?
3	What is the optimal treatment for endoscopically removed polyp cancers? When is surgical resection necessary? What is the long-term outcome of polyp cancers treated with polypectomy alone?
4	What are the short and long-term outcomes after extralevator abdominoperineal excision of rectum (ELAPE)? Is there an oncological gain and is it justified?
5	What biomarkers (including genetic profiling) affect response to chemoradiotherapy for rectal cancer?
6	Why do some patients develop colorectal cancer metastases? Can early markers of metastatic disease be developed?
7	What is the optimal timing of resection of liver and/or lung metastases from colorectal cancer – before, during or after primary surgery?
8	What is the optimal method of wound closure after abdominoperineal excision of rectum (APER)? In which situations are mesh or plastic reconstruction indicated, and is there a benefit from these techniques?
9	Is there a benefit to preoperative (chemo)radiotherapy in T3 rectal cancer with non-threatened margins? If so, does it justify any potential additional toxicity?
10	Is chemotherapy better given before or after surgery for locally advanced colon cancer? Or both before and after?
11	Is there a price to cancer survivorship after treatment for colon, rectal and anal cancer? What is the impact of treatment on quality of life? What level of poor function is justified to avoid a permanent stoma?
12	What is the role of delayed resection of the primary tumour in chemoresponsive metastatic colorectal cancer?
13	What are the optimal methods and intervals for population screening for colorectal cancer? How can uptake of screening be improved? Are there subgroups of the population who are at higher risk and should be screened earlier or at different intervals?
14	Which colorectal adenomas indicate significantly increased risk of future colorectal cancer? What is the optimal screening strategy for these patients?
15	What is the optimal surveillance strategy for patients who have undergone transanal local excision of rectal cancer?

Non-cancer research questions in order of priority:

1	How can early detection and outcome of anastomotic leakage be improved? Are there any new techniques or approaches that will reduce anastomotic leak rates in colorectal surgery?
2	What is the best method of i) preventing parastomal hernias ii) repairing parastomal hernias?
3	What are the indications for, and what is the optimal timing of, surgery for Crohn's disease in the era of biological therapy?
4	What are the short and long term outcomes of minimally invasive approaches (e.g. percutaneous radiological drainage, laparoscopic washout and drainage) to managing complicated diverticultis?
5	How can postoperative ileus be reduced?
6	What is the optimal multimodal strategy for managing fistulating perianal Crohn's disease?
7	How does reporting and sharing of surgeon specific outcomes affect clinical practice?
8	What are the short and long-term outcomes of laparoscopic ventral mesh rectopexy (VMR), and is the mesh material important?
9	What are the predictive factors for poor outcome in patients with severe intra-abdominal sepsis? How can outcomes be improved?
10	When should a colorectal anastomosis be defunctioned? Are there predictive factors which would aid decision-making about need for diversion?

Chamberlain
COMMERCIAL

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Particulars

Large Double Fronted Retail Unit Central Harrow
2,450 sq ft Arranged Over Two Floors
Restaurant, Bar & Retail Use
Large Walled Rear Garden Area

Available To Let
As a Whole or in Part
STATION ROAD

Station Road, Harrow

Chamberlain Commercial, The Clock House, 87 Paines Lane, Pinner, Middlesex, HA5 3BZ

- **2,450 sq ft**
- **Ancillary Outside Area**
- **A3/A4 Bar & Restaurant Use**
- **Office & Retail Use Available**
- **Town Centre Location**
- **Area of Regeneration**
- **Available in Part**
- **Freehold Option Possible**

LOCATION
The property occupies a great position in Central Harrow in the very heart of the regeneration area surrounding Station Road and College Road. The unit sits adjacent to Iceland and directly opposite McDonald's and Barclays Bank. Harrow is currently undergoing substantial change with over 1500 new apartments currently under construction. The Town Centre has an under supply of bars and seated restaurants and this property offers good scope to create a new business.

DESCRIPTION
A double width ground floor retail unit with ancillary first floor commercial space, which is currently accessed internally. To the rear is a wall yard which was previously used as a beer garden. The property also has rear access for loading which is accessed via a side footpath. The property previously traded as a public house but has subsequently been fitted out as offices.

ACCOMMODATION
Ground floor 1,776 sq ft
First Floor 861 sq ft
Total 2,637 sq ft
NB The walled garden area provides approximately 700 sq ft of outside area.

PLANNING
The property previously traded as a public house and has A3/A4 use. Prior to the pub, the property was a building society and A2 business and Professional use, together with A1 retail use would be acceptable. The upper parts could be converted to residential and there is scope to extend to the rear, subject to planning permission.

TERMS
The property is available to let either as a whole in it can be split into smaller units, by way of a new Full Repairing & Insuring Lease for a term to be agreed. Rental upon negotiation. A single shop unit of 600 sq ft and without the outside space will start at a rental of £25,000 per annum. The Freehold is available by negotiation.

ENERGY RATING

VIEWING
Strictly by prior appointment via sole agent Chamberlain Commercial.
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