



<b>Group</b>	Regional Colorectal Cancer Group
<b>Date and Time</b>	Tuesday 8 <sup>th</sup> December 2009, 2.00pm – 4.00pm
<b>Venue</b>	Lecture Room, Fern House

### Attendees

Mrs Cara Anderson	NICaN
Mr Victor Blease	NICaN
Ms Karen Boyd	Belfast Trust
Mr Manos Epanimeritakis	Southern Trust
Dr Robert Harte	Belfast Trust
Mr Geoff Hill	Belfast Trust
Dr Dermot Hughes	NICaN
Mr Kouros Khosraviani	Belfast Trust
Mr Roger Lawther	Western Trust
Dr Maurice Loughrey	Belfast Trust
Ms Caroline Lynas	SEHSCT
Ms Gail Malmø	NICaN
Mr Roy Maxwell (Chair)	Belfast Trust
Mr Michael Megaw	NICaN
Mr Kevin McCallion	South Eastern Trust
Mr David McCrory	NHSCT
Dr C. Ozo	NHSCT
Dr Richard Park	Belfast Trust
Ms Sarah Williamson	BHSCT
Dr Richard Wilson	Belfast Trust & QUB
Mr Chris Thomas	Belfast Trust

### Apologies

Ms Wilma Boyd Carson	SEHSCT
Dr Simon Johnston	Belfast Trust
Dr Kiran Kuar	Belfast Trust
Mrs Sarah Liddle	NICaN
Dr Paul Lynch	Northern Trust
Dr Myles Nelson	Northern Trust
Dr Tracy Owen	Public Health Agency

Dr Colin Rodgers	Northern Trust
Ms Mary Jo Thompson	Southern Trust

## 1.0 Welcome

- 1.1 Mr Roy Maxwell welcomed everyone to the meeting and a round of introductions took place.

## 2.0 Minutes of previous meeting

- 2.1 The minutes of the previous meeting were agreed as a true and accurate reflection.

## 3.0 Matters arising

- 3.1 **Regional Health and Social Care Board (RHSCB) representative** – Mrs Cara Anderson noted that a letter had been sent to Mr John Compton seeking commissioner representation on the group. Mr Compton has intimated that as there is a close link between the RHSCB and Public Health Agency (PHA) the commissioner representative may be drawn from the PHA or the HSCB. Cara indicated that it is possible that they will nominate Dr Tracy Owen who is already a member of the group.
- 3.2 **Outcome of NICaN Board meeting** – Dr Dermot Hughes outlined that the purpose of the NICaN board meeting was to discuss the future of the network post RPA. Mr John Compton attended the meeting in order to inform decisions yet to be taken regarding the future role and accountability of the Network. Dr Hughes noted that the majority view was that NICaN should network should move towards a commissioner-led governed partnership in order to strengthen its links with the commissioner. However, there was a strong view that to move too far down the continuum towards commissioning was to ignore the strength of the Network which lies with its clinician and provider engagement. To this end, it was felt to be important for the Board to continue to be chaired by a Trust Chief Executive but with a more direct line of accountability to the commissioner. Mr Compton is to consider this feedback and will inform the Network as to his decision. Cara Anderson will then establish a small working group to redraft the Network's constitution accordingly.
- 3.3 Mr Maxwell felt that there was no clear definition of roles or lines of communication, and felt that further work needed to be done to improve clinician engagement.
- 3.4 Dr Robert Harte outlined that the final outcome of the meeting was satisfactory from a clinical point of view and stated that the challenge lay in engaging those clinicians who did not participate in regional group meetings.
- 3.5 **Confirmed contacts for patients with metastatic disease** – Mr Maxwell outlined that Mr McGuigan (lung), Mr Diamond (hepatic) and Mr Fogarty (plastics) have

been identified as leads for patients with metastatic disease or requiring plastics input.

#### **4.0 Clinical Management Guidelines**

- 4.1 Mr Maxwell indicated that the CMGs would have to be signed off at today's meeting subject to amendments agreed during the meeting.
- 4.2 Mr Kevin McCallion outlined that the use of peri-anal throughout the document should be replaced with trans-anal.
- 4.3 Section 3.3 – 'The vast majority of early rectal cancers' should be replaced with 'selected early rectal cancers' and it will be the purpose of the MDT to decide who this applies to.
- 4.4 Mr Chris Thomas highlighted that note 8 should be removed.
- 4.5 Section 5.2 – The abbreviation DRTT should be clarified in the document. Mrs Anderson to clarify with Dr Myles Nelson.
- 4.6 Section 5.4 – Surveillance / follow – up – Mr Kevin McCallion outlined that available research shows a minimal difference between scheduled CT and aggressive follow up and CEA's. Mr McCallion felt it would be beneficial to leave this section more open as it will be difficult to establish mandatory surveillance. Dr Harte emphasised the need for agreement on a unified approach and a high standard of care. Mr Blease, agreed and stated that a variable standard of service would create anxiety for patients.
- 4.7 Dr Richard Wilson noted that if CT's are not used it is possible to miss something in patients that are potentially curable. Mr Epanimeritakis agreed and felt it essential to have a CT 15 month's post colorectal surgery.
- 4.8 It was agreed that while the evidence base is not clear that the group should agree a statement around a minimum standard of follow-up but would also allow for more intensive follow-up in those patients where a clinician identifies a clear need / benefit. This is likely to be informed by a number of considerations including: the stage and location of the tumour; risk of recurrence; co-morbidity; and patient wishes. It was agreed that the ACP guidelines should form the minimum standard with the Oncology Association guidelines providing stretch in those cases where more aggressive follow-up is deemed necessary or beneficial.
- 4.9 Section 6 – Pathology – Mr McCallion highlighted that there is no pathologist at the SE Trust MDT and this will result in a failing MDT. Dr Hughes outlined that this had been raised with commissioners following the first round of pre-visits but there are resource issues. Ms Sarah Williamson noted that the Belfast Trust have just reconfigured their MDT's so this may be a good time to raise the issue with them. It was agreed that the group should write formally to Dr Hughes to follow this up.

- 4.10 **Anal Cancer** – Mr Maxwell outlined that the peer review team were concerned about the large number of people in Northern Ireland performing small numbers of anal cancer surgery, and suggested a need to create a central anal cancer MDT with two named oncologists and two named surgeons.
- 4.11 It was suggested that, based on data of current practice, there could be local diagnostic and staging with input from the surgeon and oncologist. If there is a clear course of treatment this should be initiated and brought to the central MDT for approval. If there are any difficult issues the central MDT decide on an appropriate management plan. Mr David McCrory queried if a central MDT would meet once a week, as if not it would delay patient care. Dr Harte outlined that there would be rapid access referral to a central MDT through the oncologist who will then start preparation for treatment. Mr McCrory emphasised the need for clear pathways of responsibility to ensure that it works function effectively.
- 4.12 Dr Parke presented audit data which demonstrated that anal cancer outcomes overall in Northern Ireland (i.e. looking at all treatment modalities combined) compare well with those of ACT II data reports. This led to a debate about whether or not it was necessary to seek to reconfigure the current system. After some discussion it was agreed that there should be two named colorectal surgeons, one at RVH and one at the Ulster. After further discussion it was deemed reasonable that for reasons of cross-cover and succession planning two named surgeons would be identified in each trust, operating on a buddy system. A named plastic surgeon would also be identified at each site. It was also agreed that the number of oncologists should be reduced to three. It was agreed that the group should present their outcome data together with a proposed structure for the service to the next meeting of the NICaN Board so that commissioners could consider what was being proposed.
- 4.12 Stenting Policy – It was agreed that stenting should not be confined to the left side of the colon.
- 4.13 Involvement of interventional radiologist – It was agreed that this should be amended to 'interventional radiologist or colonoscopist'.
- 4.14 Exclusion criteria – It was agreed that this section should be changed to 'relative exclusion criteria' and caution should be exercised with closed loop or sharp angulations.
- 4.15 Mrs Anderson stated that once the amendments agreed at today's meetings had been made, the CMG document will be forwarded to each individual MDT who will be expected to hold a business meeting where they agree to sign up to implementation of the CMG.

## **5.0 Care Pathway for Colorectal Cancer**

- 5.1 Mr Maxwell highlighted that cases of colonic cancer should be discussed at MDT prior to treatment unless the situation dictates otherwise (e.g. emergency or informed patient choice). Mrs Anderson emphasised that pathway applies to

elective patients only and not to patients with urgent clinical need. It was agreed that the pathway should be amended accordingly. Mrs Anderson agreed to amend the document and re-circulate.

## **6.0 Clinical Trials Update**

- 6.1 Mr Maxwell confirmed that all MDTs had confirmed their nominated trials lead with the exception of SE Trust. Mr. McCallion confirmed the SE lead as Mr. Ian McAllister.
- 6.2 Dr Wilson, NSSG trials lead, presented the updated NSSG agreed list of open clinical trials dated December 2009). Dr. Wilson acknowledged that the portfolio was currently limited to non-surgical trails but stated that the trials unit hoped to extend and broaden the portfolio in the coming year.
- 6.3 Mrs Anderson presented slides clarifying how each MDT has to address the clinical trials peer review aspect at the end of the year.

## **7.0 Regional Audit**

- 7.1 There are two regional audits currently underway. Mr Maxwell outlined that Clare Jones has been in communication to say that the hepatic colorectal metastases study discussed at a previous meeting is now underway and to thank those MDTs who have already agreed to participate (Northern, Southern and Western). Mr Maxwell encouraged the remaining MDTs to make contact with Clare. While the audit will take up to two years to complete it was agreed that it would be useful to have Clare present initial findings at the group's next meeting in order to identify any early practice implications. Mrs. Anderson is to contact Clare to arrange.
- 7.2 Cara Anderson indicated that the results of the regional patient information audit would also be ready to present at the next meeting.
- 7.3 Dr Hughes highlighted that the Cancer Registry has produced a draft colorectal audit and stated that it might be useful to invite Dr Gavin along to present the initial findings and to see if there is any additional analysis that the group would like to see included. He also felt it might provide an opportunity to discuss how we can make best use of CaPPs data on an ongoing basis. It was agreed that Dr Gavin should be invited to present at the next meeting. Mrs Anderson to write to Mrs Gavin.

## **8.0 Peer Review**

- 8.1 Ms Gail Malmo gave a presentation outlining key areas of feedback from the peer review pre visits. Ms Malmo outlined that the operational policy should clarify local detail, include achievements and challenges, and the annual report should be based on 2009 data. Ms Malmo added that the annual work plan should be based on key challenges and service/team development for 2010 and should include

things such as remedial actions in relation to trails accrual, planned audit activity etc.

- 8.2 Ms Malmo outlined the next steps for the peer review process. Revisions need to be made to evidence documents and practice changes such as key worker policy and patient survey need to be implemented. Mrs Anderson added that each MDT is required to review and approve the CMG's and this should be minuted in the evidence folder.
- 8.3 Ms Malmo highlighted that the final deadline for documents to be submitted to CQUINS is 12<sup>th</sup> February 2010. Formal peer review visits will start on 20<sup>th</sup> April 2010.