Northern Ireland Cancer Network (NICaN)  
Colorectal Cancer follow-up Workshop Report  

18th October 2013  
Antrim Enterprise Agency  

Report compiled November 2013
Contents
1. Summary of Key Messages .................................................................................................................. 2
2. Summary of Way forward .................................................................................................................... 2
3. Workshop Programme ......................................................................................................................... 3
4. Workshop Participants ........................................................................................................................ 3
5. Synopsis of Presentations .................................................................................................................... 4
   6.1 Mr Roy Maxwell: Opening Remarks .............................................................................................. 4
   6.2 Dr Helen Coleman: The Changing Picture of Colorectal Cancer in NI ........................................ 4
   6.3 Mrs Mary Jo Thompson and Mrs Martha Magee: Cancer Follow-up – Where are we now? .......... 5
   6.4 Sheila McQuaid: The Patient Perspective ...................................................................................... 6
   6.5 Mr Kevin McCallion - Evolvement of colorectal cancer follow-up at the South Eastern Health & Social Care Trust ........................................................................................................ 6
   6.6 Mr John Griffith – Risk Stratified approach to Colorectal Follow-up ........................................ 7
   6.7 Dr Jane Winter – Patient Triggered follow-up – The Southampton experience ............................. 10
7. Workshop: Discussions Sessions ......................................................................................................... 11
   Q1. What is good about the current follow up? – Key themes ............................................................ 11
   Q2. In moving this forward, what principles do we need to include? – Key themes ....................... 11
   Q3. How are we going to take this forward – what are the enablers? – Key themes ...................... 12
8. Workshop Close .................................................................................................................................. 13

Tables and Figures
Figure 1: Earlier stage of diagnosis shift seen in first three screening trusts (60-71yrs) ... 4
Figure 2: Marginal ‘knock-on’ effect in non-screen ages throughout NI?............................................. 5
Figure 3: Risk stratified model of care (NCSI) ...................................................................................... 6
Figure 4: Location of Recurrence: Colon vs. Rectal Primary ................................................................. 8
Figure 5: Criteria for Colorectal cancer risk stratification ..................................................................... 8
Table 1: South Eastern Trust Risk Stratification ..................................................................................... 7
Table 2: Specific follow-up procedures for Stages II + III .................................................................... 7
Table 3: Pathways for low, medium and high risk CRC follow up ....................................................... 9
1. Summary of Key Messages

I. The rising prevalence of colorectal cancer and the growing numbers of screen detected colorectal cancers means there is escalating pressure on hospital outpatient services.

II. Variation in practice exists across Northern Ireland in relation to follow up for patients treated for colorectal cancer.

III. There is a need to consider new pathways to adequately meet patients unmet needs and to begin to explore the potential for regionally agreed risk stratified approaches which are both clinically and cost effective.

IV. The risk stratified pathways currently being tested by the National Cancer Survivorship Initiative merit further consideration.

V. Remote monitoring via IT system with supported self management has the potential to provide real benefits for patients, clinicians and commissioners, however, careful implementation and management of the risks associated with its use should be considered.

VI. Delivering on sustainable change will require a collaborative, integrated approach between primary and secondary care.

2. Summary of Way forward

I. The Regional NiCaN Colorectal Network Site Specific Group has been re-established and comprises as a minimum colorectal surgeons, oncologists, clinical nurse specialists, GPs, and Cancer Registry. The group will work with the transforming cancer follow-up team and begin to develop risk stratified protocols and patient pathways beginning with the earlier lower risk patient group.

II. This work forms a key aspect of the Transforming Cancer Follow Up (TCFU) programme and as such will be incorporated into the work programme of the TCFU Steering Group, chaired by the Director of Commissioning.
3. Workshop Programme
The aim of the workshop is to provide a forum for regional exploration, debate & shared learning on local & national approaches to colorectal cancer follow-up in line with the National Cancer Survivorship Initiative.

<table>
<thead>
<tr>
<th>Time</th>
<th>Topic</th>
<th>Speaker</th>
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<tbody>
<tr>
<td>12.30pm</td>
<td>Sandwich Lunch</td>
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<tr>
<td>1pm</td>
<td>Opening Remarks</td>
<td>Mr Roy Maxwell&lt;br&gt;Consultant Colorectal Surgeon BHSCT NICaN&lt;br&gt;Clinical Lead Colorectal NSSG</td>
</tr>
<tr>
<td>1.10pm</td>
<td>The Changing Picture of Colorectal Cancer in NI</td>
<td>Dr Helen Coleman&lt;br&gt;NI Cancer Registry</td>
</tr>
<tr>
<td>1.30pm</td>
<td>Follow-up - Where are we now?</td>
<td>Mrs Mary Jo Thompson&lt;br&gt;Macmillan Survivorship Programme Manager&lt;br&gt;Mrs Martha Magee&lt;br&gt;Macmillan TCFU Project Manager</td>
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<tr>
<td>1.40pm</td>
<td>Patient experience</td>
<td>Mrs Sheila McQuaid&lt;br&gt;(Patient and Public Representative (NICaN Colorectal Group)</td>
</tr>
<tr>
<td>1.50pm</td>
<td>Evolvement of colorectal cancer follow-up at the South Eastern Health &amp; Social Care Trust.</td>
<td>Mr Kevin McCallion&lt;br&gt;Consultant Colorectal Surgeon SEHSCT</td>
</tr>
<tr>
<td>2.10pm</td>
<td>Risk Adjusted Follow-up for Colorectal Cancer – National Cancer Survivorship Initiative</td>
<td>Mr John Griffith&lt;br&gt;Consultant Colorectal Surgeon&lt;br&gt;Bradford NHS Improvement Lead – Colorectal</td>
</tr>
<tr>
<td>2.55pm</td>
<td>Tea / Coffee</td>
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<tr>
<td>3.10pm</td>
<td>Patient triggered colorectal cancer follow-up – The Southampton Experience</td>
<td>Dr Jane Winter&lt;br&gt;Consultant Colorectal Nurse&lt;br&gt;Southampton Hospital</td>
</tr>
<tr>
<td>3.50 – 4.45pm</td>
<td>Discussion, Feedback and Way Forward</td>
<td>Mrs Liz Henderson&lt;br&gt;Special Advisor, Macmillan Cancer Support</td>
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<tr>
<td>4.45- 4.55pm</td>
<td>Closing Remarks</td>
<td>Mr Roy Maxwell&lt;br&gt;Consultant Colorectal Surgeon BHSCT NICaN&lt;br&gt;Clinical Lead Colorectal NSSG</td>
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5. Workshop Participants
A wide range of stakeholders were invited to attend the workshop which included: Colorectal Surgeons, Oncologists, Clinical Nurse Specialists, GPs, Patient and Public representatives, Service Managers, Commissioners, TCFU team, Cancer Charities, NICaN Colorectal Network group members, (See Appendix 1 for the complete delegate list).
6. Synopsis of Presentations

6.1 Mr Roy Maxwell: Opening Remarks
Mr Roy Maxwell welcomed everyone to the NICaN Colorectal Cancer Follow-up workshop. He explained this workshop would provide an opportunity to explore colorectal cancer follow up and hear from local and national speakers about developments and patients’ needs. He welcomed Mr John Griffiths, Consultant Colorectal Surgeon, Bradford and National Improvement Lead for Colorectal Cancer and Dr Jane Winter, Colorectal Nurse Consultant from Southampton University Hospital to provide presentations on how their areas have adopted new models of review. Sheila McQuaid was welcomed in providing the very valuable patient perspective in colorectal cancer follow-up. It was indicated the format of the workshop was to hear a number of presentations which would then inform a discussion session. Progression of work arising from the discussions would be undertaken through the re-established NICaN Colorectal group and build on the current colorectal clinical management guidelines.

To view the full presentations follow the link below
http://www.cancerni.net/events/nicancolorectalcancerfollowupworkshop

6.2 Dr Helen Coleman: The Changing Picture of Colorectal Cancer in NI
Dr Coleman stated colorectal cancer is the 2nd most common cancer in NI and the 3rd most common cancer in UK. Age-standardised rates are relatively stable; however the actual number of colorectal cancer cases is rising due to ageing population
- 2011: 1,224 cases
- 2006:1,064 cases
- 2001: 967 cases

She indicated the colorectal cancer risk factors which cannot be changed are increasing age (median age of diagnosis 71 yrs in men; 73 years in women), being male and genetic syndromes (<5%). However the factors we can change are lifestyle factors (up to 70%!!). It was reported there have been limited improvements in survival rates over time in Northern Ireland with one year survival increasing from 72.0% (1993-1996) to 79.5% (2007-2011) and the five year survival from 47.2% (1993-1996) to 57.3% (2007 – 2011).

Figure 1: Earlier stage of diagnosis shift seen in first three screening trusts (60-71yrs)

Dr Coleman reported that following the introduction of bowel cancer screening an increase in the number of Dukes A staged bowel cancers is evident in the screening age group (Figure 1).
The NI Cancer Registry’s colorectal polyp register demonstrated >11,000 individuals had colorectal polyps removed between 2000 and 2005. She indicated these two factors will impact on follow up services into the future given many colorectal cancers arise from precancerous lesion (polyps). Dr Coleman concluded that the changing picture of colorectal cancer in Northern Ireland included more cases are being diagnosed, that bowel cancer screening IS WORKING, has led to earlier stage of diagnosis with more males being diagnosed earlier. The future picture presents a challenge for follow-up of more cases, hope that screening will translate to better survival, promotion of screening uptake and promotion of healthier lifestyle factors to reduce recurrence.

6.3 Mrs Mary Jo Thompson and Mrs Martha Magee: Cancer Follow-up – Where are we now?

Ms Thompson and Ms Magee provided an overview of progress to date within the transforming cancer follow-up programme. The HSCB/PHA have been working in partnership with Macmillan, facilitated by NICaN, to introduce a programme to transform cancer follow up and support survivorship which will:

- Improve the quality of patients after treatment experience and promote their health & well being
- Reduce inefficiencies in hospital follow up
- Enhance service coordination and integration

Ms Thompson reported issues with the current system with rising prevalence of 3.2 % per annum (NICR, 2013) and predictions that by 2030 there will be approximately 100,000 people living with and beyond cancer in NI. It was highlighted that we have an increasing ageing population with 15% of our population aged 65, estimated to rise by more than 25% by 2020. With busier clinics, long waiting list backlogs and many recurrences detected outside clinic, this may suggest follow-up is not being as effective as it could be. Patients are surviving cancer and many are living with late effects from cancer treatments. A recent UK study reported 500,000 people living with and beyond cancer have one or more physical or psychosocial consequences of their cancer or its treatment that affects their lives on a long-term basis (Macmillan Cancer Support, 2013*). The culmination of these issues mean we are suffering from major capacity issues resulting in our current system becoming ineffective.

*Macmillan Cancer Support (July 2013) Cured but at what cost - Long-term consequences of cancer and its treatment
National Cancer Survivorship Initiative (NCSI) have introduced a risk stratified model with three different pathways: supported self manager, shared care and complex care. Significant progress with the introduction of new models of follow-up with breast and prostate cancer has been achieved in NI through the transforming cancer follow-up programme in line with this risk stratified approach (see figure 5).

**Figure 3: Risk stratified model of care (NCSI)**

Some examples of these different pathways where highlighted such as supported self directed aftercare and shared care arrangements. Surveillance tests are used to detect recurrences of cancer – so mechanisms to ensure these are timely and effective are critical to the success. One example is automated mammography post breast cancer treatment and remote PSA IT tracking for patients with stable prostate cancer.

It was reported that equipping the patient through holistic needs assessment and information provision on how to access services can help people to live well and keep well. Providing clear end of treatment plans and rapid access points have been core within this new approach. Health and wellbeing events have supported patients to rethink and adopt healthier lifestyle choices and access services to support their recovery.

Ms Magee provided information on a recent audit of current follow-up practice, whereby patients diagnosed in 2008 were tracked for 5 years. The results indicated variation across the Trusts however duplication between surgical and oncological follow-up was not overly evident within Trusts.

Information obtained from NI Cancer Registry and Trusts CaPPs systems comparing 2011 and 2012 data, indicated a rise in patients with Dukes A staged colorectal tumour for 4 out of 5 Trusts.

### 6.4 Sheila McQuaid - The Patient Perspective

Sheila provided an insightful perspective of how a cancer diagnosis affected all aspects of both her life and the lives of her family. It highlighted the importance and need to embrace the many facets of survivorship such as benefits advice, family support and personal support to deal with the physical, emotional and psychosocial issues which a cancer diagnosis evokes.

### 6.5 Mr Kevin McCallion - Evolvement of colorectal cancer follow-up at the South Eastern Health & Social Care Trust

Mr Kevin McCallion presented how SET have developed new models of cancer follow up. He explained that seven years ago they introduced a new model of follow-up because it was recognized that there was variable follow up between consultants and a lack of equity of care. The new model of care stratified patients according to their staging at surgery. The following stratification was introduced:
Table 1: South Eastern Trust Risk Stratification

<table>
<thead>
<tr>
<th>Stage I</th>
<th>Endoscopy surveillance</th>
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<tbody>
<tr>
<td></td>
<td>Self-directed care</td>
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<tr>
<td>Stage II + III</td>
<td>Intensive follow-up (see below)</td>
</tr>
<tr>
<td>Palliative Stage IV</td>
<td>Palliative care (GP +/- Specialist)</td>
</tr>
<tr>
<td>“Curative” Stage IV</td>
<td>Personalised follow-up</td>
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All stages – access to colorectal nurse specialist, Macmillan Information and Support Manager, Counsellor, Social Worker, Other services

Table 2: Specific follow-up procedures for Stages II + III

<table>
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<tr>
<th>Procedure</th>
<th>Frequency</th>
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<tbody>
<tr>
<td>History &amp; physical examination</td>
<td>Every 4mths for first 2 years</td>
</tr>
<tr>
<td></td>
<td>Every 6 mths during years 3-5</td>
</tr>
<tr>
<td></td>
<td>None after 5 years</td>
</tr>
<tr>
<td>CEA</td>
<td>At each visit</td>
</tr>
<tr>
<td>CT chest / abdomen / pelvis</td>
<td>Initially – No</td>
</tr>
<tr>
<td></td>
<td>Now – annually for 3 years</td>
</tr>
<tr>
<td>Colonoscopy</td>
<td>Complete colonoscopy peri-operatively (ideally pre-op)</td>
</tr>
<tr>
<td></td>
<td>Repeat at 1-3 years, and if normal, every 5 years thereafter</td>
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</tbody>
</table>

Shared between surgeons and oncologists
No FBP, LFTs or CXR unless clinically indicated

In addition to this:

- Patients unfit for further intervention were not to be followed up
- Patients who are unlikely to benefit from follow-up were not to be followed up, this included Stage I – 93% FYS (Endoscopy only) and Stage IV - palliative care (GP or Specialist)
- Personalised follow-up for complex cases as introduced e.g. “curative” stage IV

However, a number of difficulties were identified with the new model. Firstly, there were problems ensuring the protocol was adhered to. Secondly, duplication was still occurring between surgeons and oncologists. In addition it was recognised that the clinics remained medically orientated and that generally psychological needs were not being addressed.

SET have thus made some recent changes to their model of care which align it with the principles of Transforming Cancer Follow-up. These include introduction of:

- Holistic needs assessment
- Nurse-led cancer follow-up clinics with dedicated cancer review slots to ensure the protocol is delivered and more time for patients to raise concerns. These have freed up surgical / oncology clinics allowing medical staff more time to spend with those with complex medical needs
- Annual CT scans for 3 years

6.6 Mr John Griffith – Risk Stratified approach

Mr John Griffith provided a presentation on the risk stratified approach to follow-up utilised in Bradford Hospital and within the Yorkshire Cancer Network. The principles within this approach were outlined as

- Risk stratified pathways of care
- Personalised care plan and treatment summary with a hand held record
• Information and education
• Remote monitoring
• Care coordination with open access

A detailed retrospective study was presented which examined colorectal cancer recurrence over a 4 year period (n=1000). Mortality and recurrence was found to be 40.9% mortality rate of which cancer related deaths was 51.3%. Recurrence rate was found to be 26.5% (n=232 recurrences). There was no significant difference between the centres (3) involved in the study.

The location of recurrence for colonic primary in 28.9% of patients was found to be isolated liver metastasis which demonstrated a statistical significance(p=0.09). Those with a rectal primary found the most common location of recurrence to be isolated lung metastasis (30.0%) again demonstrating a statistical significance (p=0.0004).

Figure 4: Location of Recurrence: Colon vs. Rectal Primary

The recurrence mode of identification for isolated anastomosis / pelvis recurrences was endoscopy 37.4% and CT 46.5%. For isolated liver recurrences: CT detected 69.4%. There was a significantly increased risk of recurrence if EMVI was present from primary (P=<0.001).

Mr Griffith reported that by 3 years, 84.5% of recurrences were detected.

Mr Griffith reported the risk stratification criteria used were disease, treatment or effects of treatment and the individual (see figure 8).

Figure 5: Criteria for Colorectal cancer risk stratification

<table>
<thead>
<tr>
<th>Disease</th>
<th>Treatment or effects of treatment</th>
<th>Individual</th>
</tr>
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<tbody>
<tr>
<td>Supported Self Management pathway (green)</td>
<td>O1. Dukes A, B, C 11-3 N0 2</td>
<td>Curative intent After closure of temporary stoma After completion of adjuvant therapy</td>
</tr>
<tr>
<td>Clinically Supervised Pathway (amber)</td>
<td>Unstable CEA T4 Trial Patients N1N2</td>
<td>Palliative intent Port op bowel or urological dysfunction Temporary stoma in place Poor symptom-control</td>
</tr>
<tr>
<td>Complex Care pathway (red)</td>
<td>Dukes D M1 Liver metastases High score EMVI patients</td>
<td>Poor hepatic surgery Severe side effects of treatment On active treatment</td>
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Mr Griffith reported Salford (38%), Bristol (96%) and Guys (72%) have introduced a risk stratified approach for colorectal cancer follow-up and the percentages shown represent those patients on the self management follow-up approach. Of these (20%) were deemed suitable at 12 months or before. 74% of patients reported satisfaction with the quality of their care and services they received, 83% were confident or fairly confident in managing their own health and only ¼ of patients received a care plan and ¾ of patients knew who to contact. Survivorship and education programmes are provided and include signs and symptoms to be aware of, benefits and finance, group care and well being, dietetics, exercise (local councils) and follow-up regime. This was estimated to save £187K across all three sites in year.
Mr Griffith reported that there is a lot of interest in the overall package of the care their patients receive and reiterated follow up regimes should be patient specific.
6.7 Dr Jane Winter – Patient Triggered follow-up – The Southampton experience

Dr Jane Winter outlined the patient triggered approach to colorectal cancer follow-up provided by the CNS team within Southampton. The principles of this approach involve:

- Rapid access
- Surveillance managed
- Survivorship programmes

Jane explained that implementing the NCSI Risk Stratified model has allowed Southampton to introduce the following key features:

1. **Assessment of patient suitability**
   Patients are reviewed by the CNS, a holistic needs assessment is completed, Patient-Triggered Follow-Up (PTFU) is introduced to the patient and tailored follow up planned with the patient.

2. **Patient preparation and education**
   Patients willing to move to PTFU are invited to a 4 hour workshop which prepares them for self-management. The workshops are delivered by the CNS and cancer survivors trained in motivational interviewing techniques.

3. **Treatment Summary & Follow-up Care Plan**
   New documentation has been introduced and those patients on PTFU receive a treatment summary and care plan, which is also sent to their GP and replaces the previous clinic letter.

4. **Surveillance**
   Continuation of all routine follow-up surveillance tests with appropriate evidence base to support use

5. **Introduction of an IT surveillance system**
   This allows tracking of all patients on PTFU, ensures investigations are conducted as planned, results checked and abnormal results actioned.

6. **Telephone advice from clinical nurse specialist if needed**
   All patients on PTFU can contact the CNS for advice/support, additional resources, referral to other services or to re-access clinical review if required.

7. **Rapid access back for assessment by clinical team if needed**
   If disease recurrence is suspected or the patient has ongoing or new treatment side-effects the CNS can arrange an urgent clinic appointment.

Progress to date includes that since 2012 328 patients have moved to PTFU in Southampton which equates to 40% of all new colorectal patients. Jane acknowledged that implementation has not been without its’ challenges, however through time and effort key outcomes have been achieved:

- A whole system change has allowed a sustainable service to be established
- Patients in existing follow-up are now risk stratified and migrated according to need
- There has been a dramatic reduction in outpatient attendance and those who do attend have a negotiated pathway according to the nature of their ongoing need. More time is available for those with complex health problems – keeping patients at the heart of service change.
- A robust evaluation project is in place including ongoing evaluation of quality of life.
- Patients are being successfully supported to self manage their condition whilst their surveillance is ensured to be
7. Workshop: Discussions Sessions
Delegates were divided into groups with equal representation of surgeons, oncologists, CNS’s, commissioners, AHPS and other interested parties. Five groups were formed and the following topics were allocated for discussion.

Q1. What is good about the current follow up? – Key themes

- Surgeons are accessible to patients
- Macmillan specialist nurse role is invaluable: sees a span of patients: ‘well’ and ‘unwell’ – important for collection of data / results
- Provision of feedback / educational value to surgeons
- Equality of treatment and access
- There tends to be a standardised follow-up pathway within Trusts
- Treatment is individualised based on discussion with patients
- Evidence based and effective
- Follows NICE guidelines
- CNS Perspective: more involved in patient care, confidence in system, happy to be point of contact
- Other issues are picked up through clinical follow-up
- Referral onto other specialties if needed
- Continuity of care – someone takes responsibility for looking after them
- Multi-disciplinary teamwork
- Effective at picking up recurrence – manages public expectations
- There is minimal duplication of appointments between surgery / onc
- Patient’s perspective – likes to see the Consultant, puts faith in the system, know how to get back into system
- Cancer Manager’s perspective: already using risk stratified nurse-led protocol

Summary of good practice to be included in any pathway changes
- Treatment and surveillance based on evidence
- Safe and dependable clinical processes
- Access to specialist team
- Effective multi-professional teamwork
- Holistic assessment of patient needs and data collection
- Care coordination

Q2. In moving this forward, what principles do we need to include? – Key themes

- The service must be patient centred – designed to address patients needs
- There needs to be a clear definition of the goals of the programme
- Active patient involvement in any new development
- Regionally agreed risk stratification to new pathways which are applied consistently across NI – non postcode lottery
- Robust systems and processes to ensure patients are not lost in the system – safety is paramount
- Evidence based surveillance which adheres to NICE guidelines
- CEA /CT scans are timely, documented and communicated to relevant staff / across sectors
- Robust evaluation structure
- Holistic approach with collaboration across sectors
- Buy-in from primary care
- Incorporates all disciplines – AHPs as well as medical and nursing, to look at pre-rehabilitation, transition and recovery as well as late effects of treatment
- Patients have access to timely information to meet their individual needs
Need to address current gaps in follow up e.g. long term consequences, look wider than medical / nursing teams  
New pathways need to be safe, clinically effective and cost efficient  
Adequate professional staffing levels which makes use of skills mix and multi-professional competencies

### Summary of principles to be included in risk stratified pathways

- Professionals working in partnership with informed patients
- Clear programme goals
- Regionally agreed risk stratified pathways which include a process to monitor late effects
- Evidence based timely surveillance which is communicated effectively
- New pathways need to be safe, clinically effective and cost efficient
- Maximum use of multi-professional team members (in terms of skills and competencies)
- Robust evaluation of new pathways

### Q3. How are we going to take this forward – what are the enablers? – Key themes

- Mirror what’s happening in UK with patient triggered pathways
- Regional agreement of protocols for colorectal follow up and how often surveillance is done
- Clear about target group ‘patients with curative intent’ – what types of patients go into each, referral pathways
- Identify clinical champions to take forward
- Transforming cancer follow-up Project Managers are in place within each trust to support the change
- Utilise the Cancer Charities Collaborative – already aligned and working together
- CNS’s are key - More CNS's needed along with an economic analysis of the service change – should help to make the case for sustainable funding
- Holistic approach – better referral pathways needed for self-management programmes. Look at models in others areas e.g. cardiac rehabilitation & pulmonary rehabilitation
- CaPPs system – common software for colorectal patients across the region
- Re-establishment of the NICaN Colorectal regional group – consistency for province and will ensure joint working between medical / nursing / patient along with engagement of commissioners
- Decide what we need to do and create structures to support
- Joint nursing / medical with patient support e.g. establishment of IBD nurse to engage with commissioning and enable change Resurrect the NICaN Patient & Public Involvement group to ensure patient involvement and participation
- Recommendations carried forward and enable change – engagement and dialogue
- Learn from the change programme for Breast and Prostate – look at pathways, at ‘how?’
- Research and evaluation incorporated into model
Those present at the workshop agreed that the output of the workshop should go to the NICaN colorectal group to determine the appropriate course of action to drive forward this initiative.

**Summary of Process enablers:**
- Be clear about purpose
- Learn from others
- Harness available evidence
- Be inclusive and negotiate agreements
- Make maximum use of current (time limited) project infrastructure
- Evaluate change process and impact

8. Workshop Close
Mr Roy Maxwell thanked all the speakers and participants for their invaluable contribution to the day, and expressed thanks to those who had organised the event. He advised a summary report from the event would be circulated and be made available for download via the NICaN website [www.cancerni.net](http://www.cancerni.net). Alternatively telephone the NICaN Office on 028 9056 5860
### Northern Ireland Cancer Network Colorectal Cancer Follow-up Workshop Antrim Enterprise Agency 18\textsuperscript{th} Oct 2013 List of Delegates

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<th>Forename</th>
<th>Surname</th>
<th>Occupation</th>
<th>Organisation</th>
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<tbody>
<tr>
<td>Ms Edel</td>
<td>Aughey</td>
<td>Macmillan TCFU Project Manager</td>
<td>Belfast HSC Trust</td>
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<td>Ms Lynn</td>
<td>Berry</td>
<td>Colorectal Nurse Specialist</td>
<td>Southern HSC Trust</td>
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<td>Ms Wilma</td>
<td>Boyd-Carson</td>
<td>Clinical Service Manager for Cancer Services</td>
<td>SE HSC Trust</td>
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<tr>
<td>Ms Emma</td>
<td>Christie</td>
<td>Macmillan Specialist Palliative Care Physiotherapist</td>
<td>Belfast HSC Trust</td>
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<td>Dr Helen</td>
<td>Coleman</td>
<td>Research Postdoctoral Fellow</td>
<td>NI Cancer Registry</td>
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<td>Ms Deirdre</td>
<td>Conlon</td>
<td>Care Services Manager</td>
<td>Cancer Focus NI</td>
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<tr>
<td>Dr Graeme</td>
<td>Crawford</td>
<td>Macmillan GP Facilitator</td>
<td>Douglas GP Practice, Bangor</td>
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<td>Dr John</td>
<td>Griffiths</td>
<td>Consultant Colorectal Surgeon</td>
<td>SE HSC Trust</td>
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<tr>
<td>Ms Sara</td>
<td>Groogan</td>
<td>Assistant Director of Unscheduled Care &amp; Co-Chair Cancer Commissioning Team</td>
<td>Action Cancer</td>
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<td>Ms Enda</td>
<td>Hanna</td>
<td>Macmillan Oncology Nurse Practitioner</td>
<td>Western HSC Trust</td>
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<td>Dr Robert</td>
<td>Harte</td>
<td>Clinical Oncology, Belfast City Hospital Cancer Centre</td>
<td>Western HSC Trust</td>
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<td>Ms Mary</td>
<td>Haughey</td>
<td>Network Clinical Coordinator</td>
<td>Macmillan Cancer Support</td>
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<td>Belfast HSC Trust</td>
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<tr>
<td>Ms Mary</td>
<td>Kane</td>
<td>Clinical Nurse Specialist - Stoma Care &amp; IBD</td>
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<td>Ms Madeline</td>
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<tr>
<td>Ms Paula</td>
<td>Kealey</td>
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<td>Macmillan Cancer Support</td>
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<td>Ms Caroline</td>
<td>Lynas</td>
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<td>Ms Martha Magee</td>
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<td>Ms Annette Mawhinney</td>
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<tr>
<td>Mr Roy Maxwell</td>
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<td>Ms Pat McClelland</td>
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<td>Mr Damian McKay</td>
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<tr>
<td>Ms Sheila McQuaid</td>
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<tr>
<td>Ms Lisa McWilliams</td>
<td>Senior Network Manager</td>
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<td>Dr Moyra Mills</td>
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<tr>
<td>Ms Heather Monteverde</td>
<td>General Manager NI, Macmillan Cancer Support</td>
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<tr>
<td>Mr Keith Mulholland</td>
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<td>Mr Adrian Neill</td>
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<tr>
<td>Mr Jaroslav Novak</td>
<td>Consultant General &amp; Colorectal Surgeon, Causeway Hospital</td>
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<tr>
<td>Ms Gloria O'Connor</td>
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<tr>
<td>Ms Jane Rankin</td>
<td>Lead Physiotherapist Cancer Centre/Lead Lymphoedema Network</td>
<td>Belfast HSC Trust</td>
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<tr>
<td>Ms Fiona Reddick</td>
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<tr>
<td>Ms Mary Jo Thompson</td>
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<td>Mr William Wallace</td>
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<tr>
<td>Dr Jane Winter</td>
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<tr>
<td>Ms Claire Young</td>
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