NICaN Colorectal Clinical Reference Group (CRG): Terms of Reference

Date Agreed by CRG	Version	Comments/changes
Dec 2006	1.0	Agreed at regional meeting.
August 2013	2.0	Prepared for and agreed by NICaN Colorectal Clinical Reference Group in adherence with Manual for Cancer Services Colorectal Measures. Updated to reflect change in membership
May 2017	3.0	Updated to reflect the minimum membership set out in the Manual for Cancer Services Colorectal Measures (Version 1.0, January 2014,14-IC-104d) and revised membership.

NICaN Colorectal Clinical Reference Group: Terms of Reference

1. <u>Purpose</u>

All NICaN Clinical Reference Groups (CRG) are multi-disciplinary with representation of professionals from across the care pathway. The clinical reference groups aim to ensure that mechanisms are in place to involve service users in the planning and review of Cancer services and ensure active engagement of all relevant professionals across the Network.

The NICaN Colorectal Clinical Reference Group (CRG) will bring together those interested in the planning, development and delivery of colorectal cancer services in Northern Ireland for those with, or suspected of having a colorectal tumour. It will give leadership to, and continuously develop, colorectal cancer care in Northern Ireland.

In order to ensure high quality person centred care, the Group will:

- be the authoritative source of expertise and guidance to planners, commissioners and providers of services;
- indicate service reconfiguration, and resource implications required to achieve the highest quality care;
- review existing standards and guidelines and develop regionally agreed standards of care which are periodically monitored/audited; and
- Prioritise resources within colorectal cancer service developments.

2. <u>Objectives</u>

The NICaN Colorectal CRG should work collaboratively to deliver the following key core objectives:

a) Service Planning

The CRG should ensure that service planning:

- Is in line with national guidelines and standards.
- Considers the full patient pathway.
- Promotes high quality care and reduces inequality.
- Takes account of patient and carers views.
- Recognises opportunities for service and workforce redesign.
- Establishes common guidelines.

b) Service Improvement/Redesign

The CRG should commit to service improvement and redesign by ensuring:

- Responsiveness to pathway issues highlighted at regional cancer operational meetings / Trust performance meetings.

- Regular participation in service improvement/redesign and ensuring that evidence of such is readily available to support resource applications etc

c) Service Quality Monitoring and Evaluation

- Agree on priorities for data collection and support the development of regionally agreed clinical data sets.
- Review the quality and completeness of data, recommending corrective action where necessary.
- Facilitate processes which allow for service users/carers to evaluate services.
- Produce audit data and participate in open review.
- Monitor progress on meeting national cancer measures and ensure action plans are agreed.

d) Service delivery

- Assist in the delivery of Trust priority areas (e.g. access, Cancer Service Indicator Framework) through the development of appropriate guidelines and protocols that support delivery.

e) Education & workforce

- Participate in relevant training and development events to facilitate sharing of best practice and service development.
- Undertake regular sharing of audit information.

f) Research and Development

- The CRG should agree a common approach to research and development and ensure participation in nationally recognised studies whenever possible.

3. Core Membership

Membership will be open to all those interested in the planning, development and delivery of colorectal cancer services in Northern Ireland and should be representative of all key stakeholder communities relevant to the disease area. The representation on the Colorectal CRG should be such that the NICaN Board agree to authorise it as the source of the Network's clinical opinion on matters relating to colorectal cancer.

The Manual for Cancer Services Colorectal Measures sets out the agreed membership for the Colorectal Clinical Reference Group:[1]

- Representation from each of the associated MDTs;
- At least one nurse core member of an associated MDT;

[1] http://www.cquins.nhs.uk/?menu=resources

- A colorectal surgeon;
- Representation covering both clinical and medical oncology;
- An imaging specialist;
- A histopathologist;
- A colonoscopist;
- Two user representatives;
- There should be a named chair who should be a core member of one of the associated MDTs;
- One of the HSC employed members of the network group should be nominated as having specific responsibility for users' issues and information for patients and carers;
- A member of the network group nominated as responsible for ensuring that recruitment into clinical trials and other well designed studies is integrated into the function of the network group;
- Named secretarial/administrative support.

Trust Cancer Executive Directors provided details of their nominations to the Colorectal Group in August 2013. The table below sets out the confirmed nominations and was updated in May 2017 to reflect changes in staffing/membership.

Named Individual	**Role**	**Trust/ Other**
Nominations received April 2017: Dr Maurice Loughrey Dr Caroline Coghlin Dr Robert Harte Mr Tim McAdam Dr Victoria Coyle Ms Sarah Henderson Dr Scott Gillespie	 Consultant Histopathologist Deputy Consultant Histopathologist Consultant Clinical Oncologist Consultant Surgeon Consultant Medical Oncologist Colorectal Nurse Specialist Consultant Radiologist	Belfast
Confirm following meeting on 18.5.17 Mr James Patterson Dr Myles Nelson Ms Shelagh Fleming	 Consultant Surgeon Consultant Radiologist Specialist dietician	Northern
Nominations received May 2017 Dr Niall Mackenzie Mr Roger Lawther Ms Gloria O'Connor	 Consultant Radiologist Consultant Surgeon Colorectal CNS	Western
Nominations received April 2017: Mr Ian McAllister Mr Keith Mulholland Ms Martina Finn	 Consultant Surgeon Consultant Surgeon Colorectal CNS	South Eastern

Named Individual	Role	Trust/ Other
Mr Brendan Byrne Dr Grant Caddy	Nurse Endoscopist Consultant Medical Gastroenterologist	
Confirmed following meeting on 18.5.17: Mr Damian McKay Mr Michael Gibbons Mr Manos Epanomeritakis Ms Lynn Berry	 Consultant Surgeon (Chair of CRG) Consultant Gastroenterologist Consultant Surgeon Colorectal CNS	Southern
Mr Fergal McAlinden	Patient/Public Representative	PPI Rep
Dr Gerry Millar		GP
Ms Paula Treanor	Clinical Network Co-ordinator	NICaN
Extended Membership		
Ms Loretta Gribben	Nurse Consultant	PHA
Ms Clodagh O'Brien	Network Manager	NICaN
Ms Davinia Lee Ms Edel Aughey	Cancer Manager Macmillan Service Improvement Lead	Belfast Trust
Ms Pat McClelland Ms Moyra Mill Dr Ciaran O'Neill	Cancer Manager/lead nurse Macmillan Service Improvement Lead Consultant Cellular Pathologist	Northern Trust
Ms Mary Jo Thompson Ms Caroline Lyness Mr Robert McCormac	Clinical Cancer Manager Macmillan Service Improvement Lead Operations Manager, Cancer	South Eastern Trust
Ms Fiona Reddick Ms Mary Haughey	Cancer Manager/lead nurse Macmillan Service Improvement Lead	Southern Trust
Ms Elizabeth England Ms Bridget Tourish	Cancer manager/lead nurse Macmillan Service Improvement Lead	Western Trust
Ms Sinead Lardner	Clinical Advisor	NICR
Dr Helen Coleman	Senior Lecturer in Cancer Epidemiology	QUB

It is the responsibility of Core Members to report back within their own professional group and to ensure adequate consultation and involvement in key areas of the regional group work plan.

4. Frequency of Meetings

The CRG should meet regularly with meetings agreed in advance by Clinical Lead. All attendance should be recorded.

5. Accountability and reporting arrangements

The Groups authority will come from its credibility. This credibility will be evidenced by the application of the Group and its member's knowledge and expertise. It will be the principal source of advice to indicate the service reconfiguration, and resource implications required to achieve the highest quality care.

Individual members will be accountable to their own profession and are responsible for reporting back to their own multi-disciplinary teams. The Lead/Chair of the group will be held accountable to the NICaN Board, via a member of the NICaN management team, for the delivery of the agreed work plan. The Lead/Chair will be responsible for reporting to the NICaN Board annually.

6. Attendance at CRG Meetings

In order to keep up to date with progression of the CRG plan, it is crucial that members attend regularly. If a nominated member fails to attend three consecutive meetings, a new nomination will be sought. Contact will be made with the member following non-attendance at two consecutive meetings to establish reasons for non-attendance.