

## YCRN Strategy Group meeting

Minutes of the Meeting Wednesday 11<sup>th</sup> March 2009  
2.00 pm in Room 6.047 (level 6)  
Bexley Wing,  
St James University Hospital, Leeds

**Present:** David Jackson (DJ) Chair  
Michael Crawford (MC)  
John Todd (JT)  
Caroline Mozley (CM)  
Sally Lane (SL)  
Barry Tinkler (BT)  
Anita Hill (AH)  
Angela Darby (AD)  
Petra Newbound (PN)  
Carole Paley (CP)  
Debbie Burns (DB)  
Carol Sleigh (CS)  
Alan Anthoney (AA)  
Linda Bamford (LB)  
Annabel Johnston (AJ)  
Chris Twelves (CT)  
Subramanian Kanaga-Sundaram (SKS)  
Fiona Halstead (FH) Vice Chair  
Lynda Hickey (LH) Minute taker

Meeting open at 2.10pm

### 1. Apologies

Kim Last  
Jo Dent  
Jane Shewan  
Matt Walsh

### 2. Welcome

DJ opened inaugural meeting of the YCRN strategy group. Thanked everyone for attending and particularly thanked everyone for the high level of attendance.

### 3. Terms of reference

The new YCRN Strategy Group will replace the previous Management Executive. The membership and terms of reference of the YCRN Strategy Group has been agreed and approved by the YCN management board.

DJ reviewed the terms of reference.

BT commented that the two main challenges would be to get clinical engagement with a Yorkshire focus on the portfolio, influencing upward to the national clinical study groups. A further challenge of involving the Commissioners in issues surrounding excess treatment costs.

#### **4. Work programmes**

2007/08 progress report - DJ reviewed the progress report for the 2007/08 annual programmes report.

Highlighted achievements include;

- Infrastructure
  - YCRN website re-launch
  - Procurement and implementation of the EDGE database.
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- YCRN Profile raising
  - Regular attendance of the Network Site Specific Group meetings.
  - Regular meeting with the Portfolio Development Officer and local teams.
  - Implementation of Letters of Agreement between coordinating centre and individual organisations
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- Training and Education
  - The YCRN co-ordinating centre will continue to provide a comprehensive training and education curriculum.

#### Work programme 2009/10

DJ guided the group through the document highlighting particular areas within the 7 work streams

##### 1. Governance and Finance

- Development and continuation of the Cancer Unit Meetings
- Working with service network to support peer review process
- New source of funding from DH.
- Ongoing work with commissioners to understand funding for excess treatment costs. AJ commented that this early work has been very helpful from a commissioner prospective.
- Corporate Services -The YCRN has received a 8% uplift to distribute to organisations to support corporate functions.

##### 2. Portfolio Development

DJ outline the current funded staff distributed between the co-ordinating centre and the local teams with in the member organisation.

DJ outlined the new research management and governance structure developed by The West Yorkshire Comprehensive Local Research Networks (WYCRLN) and the North and East Yorkshire and Northern Lincolnshire Comprehensive Local Research Networks (NEYNLCLRN). JD pointed out some functional inaccuracies in the document which will be amended.

A Band 5 Rotational Post has been proposed as a training post for general nurses to experience research nursing activities. CM asked that it was ensured that this post is placed in a well established team and closely supervised. This proposal was supported by the group.

The piloting of a Nurse Educator role was proposed. This role would advise, support and mentor other research nurses in a clinical setting. This proposal was supported by the group.

The YCRN now has a standing agenda item on the Network Site Specific Group (NSSG) meetings. AA pointed out that some NSSG do not have representation from oncologists, and that there were informal oncology forums. DJ commented that appropriate route was through the formal network mechanisms and hoped that this would strengthen the informal groups that had come together.

In shaping the network portfolio it was recognised that conflicting pressures between aspirations for a fully comprehensive portfolio and the efficiency and effectiveness of the research teams on the ground. It was agreed that a better awareness of the portfolio and the need to cross refer their patients between the sites was appropriate. This was recognised that this would require increased awareness for commissioner colleagues.

The group acknowledged the success of the portfolio development officer role, and the portfolio development meeting were extremely helpful. It was also recognised that the need to identify research representative within each of the eighty MDT's with in the network. It was recognised that this was a peer review measure.

The group was informed of the NCRN suggestion that we employ local recruitment targets for local teams, in line with the national targets set by the NCRN coordinating centre. This was agreed in principle.

The strategies for increasing recruitment, as outlined in the annual work program were discussed. CM suggested that when assigning portfolio priority should be given to studies that stood the highest chance of recruiting. DB pointed out the need to have a balance between the types of studies leaving complexity in the portfolio. It was recognised that a national funding system that acknowledges the complexity of studies was being developed through NIHR.

The strategies for increasing patient awareness regarding clinical studies were discussed, including a poster and leaflet campaign, and also at the inclusion of a description of clinical research on outpatient letters.

With regard to increasing professional awareness and the role of the YCRN, AJ suggested considering the launch of the NHS medicines handbook on the 23rd March.

CS outlined the steps for the development of the Service User partnership group, including the collaboration between YRCN, ECMC and the CRUK cancer centre. A launch event is being held on the 25th April.

With training and education we recognised that the contribution of Paul Maher who recently has left his post. The YCRN coordinating centre is committed to continuing the comprehensive training program in association with Phlex global.

CM would like to congratulate YCRN on the clarity of the Work Programmes.

#### **Actions**

- **Re-write the paragraph pertaining to the WYCLRN hubs reflecting the corrected sub division of those hubs**
- **The YCRN CC will seek CLRN funds to undertake the nurse educator project.**
- **Collect information on research representative for all MDT groups.**
- **Access to the NCRN numbers for industry trials and improving access to these industry adopted trials**

## **5. Recruitment**

The tabled recruitment report was discussed. This demonstrated that the recruitment has been stable over the last three years. The group recognised the increasing burden of follow-up over the past few years.

The group recognised that YCRN was reaching its overall accrual targets, but not accrual targets regarding randomised control trials.

The group reviewed the proposed local targets table. But there was a robust discussion regarding the figures within the table, which remained undecided as to the best denominator to use for setting local targets. However the concept of trying to develop a framework for local targets was approved by the group.

The group also approved a more strategic approach to developing and maintaining the portfolio across the network.

## **6. Resource Allocation**

The proposed resource allocation for 2009/10 was discussed, including those funded from YCRN core budget, CLRN funding and FSF funding. The proposed allocation was approved.

## **7. Feedback from Trusts**

Calderdale - JD- will be opening a raft of trials (7 in the next few weeks) with the employment of two new haematology consultants. Accommodation for research nurses is very limited. With the opening of the above mentioned trials pharmacy, haematology and pathology will be under pressure. Portfolio is looking good with a return of a lot of enthusiasm.

York - CM -The team is in good heart with the recent addition of an enthusiastic CTA but badly need to move to a new bigger office, (which they have been trying to arrange for a year now) latest promise is a move in April. A continuing issue is the large open portfolio with very few patients who are able to be recruited into these studies. This is both justified and increasingly a concern.. (AD) A lack of aseptic on site for pharmacy has been a real block

Harrogate - AD - notes that no in-patient unit setup (to open later in the year) has limited patients especially those trials involving biological agents not part of standard treatment and the consequences they may entail.

Pathology - SL- still have a problem seeing where they fit into the system as pathology doesn't have enough resources especially with the increase in studies requiring pathology review over the last few years. Adding to this is the fact while money is set aside in the trial budget it does not appear to reach the correct place. This problem is compounded due to HTA changes restricting the access for peripatetic staff retrieving the blocks.

DB is setting up a process in Leeds to flag studies requiring pathology as is done with other departments.

Airedale MC - Major restructuring in the oncology service and exceedingly long delays in setting up of trials. FH for CP- Capacity has been reached in radiology with 1 CT scanner

Bradford LB - Blocks in R&D, and staffing levels. AH- a recent increase in haematology recruitment. Blocks faced include R&D approval times, lack of a haematology trials radiologist.

Leeds - DB follow-up burden is significant 500+ patients in breast alone. Office space is at capacity with no more room to grow into. Pharmacy and radiology (even basic CTing). Pharmacy set up and

management of studies, resulting in having to prioritise which studies are opened due to pharmacy restraints even when approved.

Mid Yorks - SKS- Follow up burden is high, staffing levels with some studies are not being open due to lack of resources and space especially for storage of documentation. SKS would also like recognition that some centrally based trials that gain recruitment from referring Trusts.

Commissioner AJ - linking with individual request, Specialist Commissioning and knowledge base around portfolio studies is key, what can commissioners do to resolve blocks to recruitment. As well as working towards knowing excess treatment cost as early as possible to smooth the opening of trials.

BT - was concerned about tension from cancer waiting times and the timing required for a patient to decide to join a trial. DB has recently had to change plans of an academic study to fit into the 31 days target.

Service Support costs- PN-CLRN has funding to unblock these block and there is a real need to develop the processes to achieve this. BT suggests that the development of service level agreements for support service to deliver this otherwise it could be lost in the transition between CLRN and the correct departmental budget. DJ - CLRN distribution model are in their infancy and these will be looked at in light of the 2009/10 distribution with different organisations receiving different levels of intervention. AJ suggests that with the commissioner expertise in this area they would be able to 'bring quiet a lot to the table' to help in this area

#### **8. AOB**

No Other Business

**Next meeting will be scheduled for Wednesday 9th September at 2pm level6 Bexley wing SJUH but any feedback and discussion is welcome between meetings.**

DJ closes meeting at 4.40 pm