YCRN Strategy Group meeting

Minutes of the Meeting Wednesday 09th September 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)	
	Caroline Mozley (CM)	
	Deborah Burns (DB)	
	Carol Sleigh (CS)	
	Linda Bamford (LB)	
	Denise Hancock (DH)	
	John Hancock (JH)	
	Angela Norton (AN)	
	Neville Young (NY)	
	Jane Shewan (JS)	
	Subramanian Kanaga-Sundaram (SKS)	
	Fiona Halstead (FH)	Vice Chair
	Lynda Hickey (LH)	Minute taker

1. Apologies

Chris Twelves
Jon Todd
Matt Walsh
Barry Tinkler
Anita Hill
Petra Newbound
Carole Paley
Angela Darby
Alan Anthoney
Sally Lane

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## 2. Governance and Finance

2008/09 Annual Report - DJ presented the report to the strategy group. This has been submitted to the NIHR CC, and the formal feedback session is scheduled for 13th October 2009. DJ highlighted the increasing recruitment to 13% of cancer incidence, compared to the 10% target. Strategies to further increase recruitment were discussed including the used of the portfolio development managers to look at local portfolio and identify block to recruitment, as well as working closely with the NSSG to increase ownership of the portfolio. YCRN has worked closely with the two comprehensive local research networks to obtain transitional funding to increase capacity for recruitment. The report is due to be presented to the YCN management board on 7th October 2009.
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CM Congratulated the YCRN Coordinating team on the report and the increase in recruitment that has been demonstrated.

JS noted that the Yorkshire ambulance service should be mentioned in the report.

Cancer Unit Meetings - is an annual review face to face meeting which are taking place in October, November and December (as listed below) at each trust to further expand on the work on the PDO meetings and allow for the face to face working through of blocks to recruitment and to allow the YCRN to feedback the information and feedback from the NIHR to each trust

Airedale - 25th November 2.30pm
Bradford - 26th November 2pm
Calderdale and Huddersfield 10th November 2pm
Harrogate - 2nd November 2pm
Leeds 15th December 2pm
MidYorks - 3rd November 2pm
York - 20th October 2pm

JH suggest that the local commissioners could be included about the cancer unit meeting.
JS - Suggest that the local primary care providers meeting could be used for the local commissioners

Funding - DJ highlighted the roles of the two local CLRNs, and the different strategies for making further funding available. For WYCLRN this included activity based funding that had already been distrusted to the organisations, and also a rolling program of responsive funding, and it was noted the meeting that a number of the trust had already put bids into this funding stream.

3. Portfolio development and recruitment

In years recruitment was discussed (see appendix 1). This projects an overall further increase in recruitment of 09/10. Key strategies for increasing recruitment are the portfolio development manager meetings with each of the research teams, and the YCRN reports at the NSSG meetings. Examples of the NSSG and PDM reports were circulated and discussed.

JH - concerned that due to the nature of system that simple high recruitment will be focused on.
DJ - The balance of the portfolio could in theory be affected by this but in practise this has not been the case
CS - have taking the type of trial into account when discussing the trials to be opened, e.g. Harrogate was having a lower number of the non randomised trials but due to a recent placement of a new CTA this balance has been corrected.

The YCRN wants to engage the clinician in to this process so they have an awareness and ownership of portfolio; this is done both by copying them into the PDO minutes and bringing these reports into the MDT feedback loop (which will help with peer review responsible).

4. Information and Communication

Peer review - YCRN has worked with the YCN management team to help the network and individual MDTs meet the peer review research measures. MDT handbooks have been distributed to each MDT giving details of the local portfolio, and also studies available across the network.

JH asked about referral pathways for clinical trials, and discussed that these are usually along normal service referral lines.

5. Service user partnership Group

As reported in March there is a collaborative service users group planed for; YCRN ECMC, and CRUK centres. This group is in the process of recruiting with session in Bexley wing on weekends and weekdays a stand at race for life, and other flyers at other events. There will be a half on 3rd October where those who expressed interest will be invited to hear a little more about the organisation and projects they can get involved in.

6. Training and education

A Curriculum has been developed in conjunction with Phlex global last year (this can be found in the annual report appendix pg19) which as received very good feedback (with the exception of a recent GCP session which is being investigated). There are plans to expand this curriculum when the quality issues have been resolved.

Action
Link in With LTHT courses to cross advertise course

7. Information Systems

Edge has been used to great advantage since implementation, not least in the areas of challenging the accrual discrepancies with the NIHR CRN CC which this year was over 100 recruits missing. Which with activity based funding has been very effective.

AN - commented that the target recruitment function is not being well utilised and wanted these targets updated, as would like to have a uniform look for when using edge to produce reports. Group suggests that SSI and NXD forms can be used to find out this information if it's not known at site.

As edge has been adopted by so many network there is now a national forum for looking at the modification and updates to the system

Action
Targets in the trial section need to formalised and uniformed

8. Cross referral

Leading on from JH question under item 4, this was discussed in more detail.

AN raised concerns about cross referral for specific trials with regard to giving information regarding a trial, also concerns about PCT commissioning of excess treatment coasts within trials.

The strategy group agreed that cross-referral within a network was essential for maximising availability of studies for patients. It is acceptable to tell patients about the existence of a trial in another organisation and refer to colleagues for consideration of the trials, although it was recognised that trial specific information could not be handed out.

With regards to commissioning issues the issue of PCT commissioning of excess treatment costs is much wider than just for cross-referrals, and current there is an ongoing piece of work within YCN to look at this. It was acknowledged at this point that the commissioners were probably unaware of some of these issues, it was understood that majority of such referrals occur within existing service pathways.

9. Feedback from Trusts

Leeds R&D - NY-Process is going well with portfolio studies are in pretty good condition and they are under the impression that turnaround times are good.

York- CM - Pharmacy is still a major block but they are employing additional staff and are building extra facilities to badly need a functioning aseptic's unit. There are on going issues with office spaces for the research nurses. R&D approval times are being slowed down due to the CLRN interaction with an increase in the efficiency as the CSP system becomes more familiar. Wants to mention the new implantation plan for (streamlining) research governance (NIHR document). R&D dept are for the first time mentioned and CM will be part of the DOH reference group.

Leeds - DB- Having a problem with CLRN funding, the funding doesn't come through until a person is appointed to the post and the trust will not advertise the position until they have received the money, this is an ongoing issue which has been circulated with Petra Newbound and David fox involved in discussions, but delays have been experienced.
Leeds is now setting up a streamline process with pathology for proposed trial applications and a means to track the applications.
A band 8 CLRN funded pharmacists to support portfolio studies is now in place. There are still issues surrounding complex CTIMPS studies due to the aspectics process, the requirements to prepare those drugs have to be done in a strict time line function and this does not fit with the standard way it passes through aseptic now.

Mid Yorks - JS- things have improved a lot over the last year, CLRN money and the staff it has provided have been a very helpful especially in the support dept. Radiology has a few problems but they seem to be affecting stroke trial more than NCRN ones. There is a shortage of space in the day chemotherapy units. But happy with the CLRN and the clear routes to discuss and resolve an specific issues.
SKS- in specific to urology, recruiting quiet well to open trials but would like to open more but due to work load it is not possible. There are approx 200-300 patients on the trial portfolio and extremely difficult as some trial are life long follow up. Archiving of notes is becoming an issue (JS is look at the commercial archiving issue) due to the move to electronic.

SKS wanted to know if we have an influence where we can stress our dislike of the large amount of amendments that are being put through with trials. A large amount of re-consenting is being done as a result. The group agrees that the there are a large amounts of amendments being pushed through. JS points out that what due to the limiting of what amendments R&D now look at major changes have been made to documents without R&D review. SKS uses an example of a trial that has had 32 amendments
Action
Group to bring back examples to the next meeting and when the network wide picture has been established the YCRN will bring it to particular trials units' attention

Commissioner JH - a new chemotherapy hot line coming into place and whether link between this group and the new chemotherapy group have been established?
Want to be advised about what to put in the York service specifications for non-surgical oncology about access to clinical trials.

Bradford - LB - Now has Funding for a trial pharmacist and radiology approvals (Sharon packer) had been given funding for a half day a fortnight for research work which should be increase efficiency. Meeting has been set with the Histology manager to discuss application for CLRN funding for a technician to help easy the burden on pathology. A bid is also being prepared for research non-surgical oncology Nurse funding via the CRLN.

Calderdale and Huddersfield - DH The trust has made no secret of the fact we have struggled with the lack of management, which has impacted on recruitment into studies. Have been successful in bids for extra staff but due to lack of management it has taken a year for the post to be advertised and interview. The trust has also been successful in bids to have a new person in the pathology and

in histopathology. Recently Interviewing has taken place; two new nurse this month and two new CTA's last month (which have been chosen and are awaiting references to appoint).

Airedale MC - Research nurse staffing changes. Irmer is still a blockage in place but as Bradford has brought Sharon packer's time and Airedale buys Bradford's time this should also help Airedales blockage. Have a decent range of trial either open or in setup but in haematological area there is one consultant and they don't have a strong research orientation. R&D approval time is an issue in Airedale, this has been put down largely to the R&D understanding of costing and the large turn over of staff in that department.

Harrogate- AN - Maggie Peat is back and has taken on the lead research nurse position; she has identified blocks and will be increasing staff in the following areas Labs, Pharmacy and IT. Major stumbling block at present is Gynaecology as no PI can be found for any gynaecology studies.

10. AOB

Anita Hill will be standing down from the group due to pregnancy but Chris Bradley is aware that a replacement needs to be found.

Next meeting will be scheduled for Wednesday 10th March at 2pm level6 Bexley wing SJUH but any feedback and discussion is welcome between meetings.

Appendix 1 - Accrual Year to Date handout

Counts Accrual	Airedale			Bradford			C&H			Harrogate			York			Mid Yorks			Leeds			TOTAL
Disease site	RCT	non RCT	**Total**	RCT	non RCT	**Total**	RCT	non RCT	**Total**	RCT	non RCT	**Total**	RCT	non RCT	**Total**	RCT	non RCT	**Total**	RCT	non RCT	**Total**	
Brain and Nervous System												**0**			**0**			**0**	2	12	**14**	**14**
Breast	1	39	**40**	0		**0**	1	0	**1**	2	30	**32**	8		**8**	0	62	**62**	23	41	**64**	**207**
Colorectal Cancer	3		**3**	1	0	**1**	3		**3**	4	8	**12**			**0**	5	21	**26**	17	10	**27**	**72**
Gynaecology		3	**3**				0		**0**			**0**			**0**				7	0	**7**	**10**
Haematology	0	0		4	20	**24**		1	**1**	1	0	**1**	4		**4**	3		**3**	16	17	**33**	**66**
Head & Neck				31		**31**			**0**			**0**			**0**				0	0	**0**	**31**
Lung	4	1	**5**	2		**2**	6	3	**9**	1	2	**3**	3		**3**	1	1	**2**	5	0	**5**	**29**
Melanoma		1	**1**		5	**5**		2	**2**		0	**0**			**0**		1	**1**	3	10	**13**	**22**
Paediatrics												**0**			**0**				17	25	**42**	**42**
Palliative Care												**0**			**0**				39		**39**	**39**
Psychosocial and Clinical Studies												**0**			**0**					147	**147**	**147**
Radiotherapy							0		**0**	1		**1**	1		**1**	0		**0**	1		**1**	**3**
Sarcoma												**0**			**0**				1		**1**	**1**
Soft Tissue												**0**			**0**				2	0	**2**	**2**
Thyroid												**0**			**0**				1		**1**	**1**
Upper Gastrointestinal		0	**0**	1	2	**3**	2	0	**2**			**0**	1		**1**	0		**0**	6	0	**6**	**12**
Urology	0		**0**	3		**3**	3		**3**		0	**0**	0		**0**	10	5	**15**	29	2	**31**	**52**
Total	8	44	**52**	42	27	**69**	15	6	**21**	9	40	**49**	17	0	**17**	19	90	**109**	169	264	**433**	**750**

Not Counts Accrual	Airedale			Bradford			C&H			Harrogate			York			Mid Yorks			Leeds			TOTAL
Disease site	RCT	non RCT	**Total**	RCT	non RCT	**Total**	RCT	non RCT	**Total**	RCT	non RCT	**Total**	RCT	non RCT	**Total**	RCT	non RCT	**Total**	RCT	non RCT	**Total**	
Brain and Nervous System																						**0**
Breast	4	0	**4**	3	0	**3**	0		**0**					0	**0**				6	3	**6**	**13**
Colorectal Cancer																	1	**1**				**1**
Gynaecology								0	**0**											22	**22**	**22**
Haematology																						**0**
Head & Neck																				0	**0**	**0**
Lung																			38		**38**	**38**
Melanoma																						**0**
Paediatrics																				3	**3**	**3**
Palliative Care																						**0**
Psychosocial and Clinical Studies					0	**0**														4	**4**	**4**
Radiotherapy																						**0**
Sarcoma																						**0**
Soft Tissue																						**0**
Thyroid																						**0**
Upper Gastrointestinal																				11	**11**	**11**
Urology																				4	**4**	**4**
Total	4	0	**4**	3	0	**3**	0	0	**0**	0	0	**0**	0	0	**0**	0	1	**1**	44	47	**88**	**96**