Brain & CNS CANCER PATHWAY BOARD MEETING

MINUTES

DATE: 01/07/2014

Member's attending:

Dr McBain (Chair)	**Christie**	**Dr Harrison**	**UHSM**
Julie Emerson	**AHP, Christie**	**Andrea Wadeson**	**Skull Base CNS, SRFT**
Alison Gilston-Hope	**SRFT**	**Elizabeth Molloy**	**Christie**
Dr Tran	**Christie**	**Dr Sein**	**East Cheshire**
Sarah Cundliffe	**SRFT**	**Dr Douglass**	**Tameside / SRFT**

Apologies

Dr Kallat	**Bolton**	**Prof Selby**	**CMFT**
Dr Kearney	**SRFT**	**Dr Ismail**	**WWL**
Dr Dizayee	**Stockport**	**Miss Karabatsou**	**SRFT**
Mr Rutherford	**SRFT**	**Sara Robson**	**Christie**

In attendance

J Leighton	**Manchester cancer**

- **Introductions and apologies**

Dr McBain (CMB) welcomed all to the meeting and noted the apologies received.

- **Minutes of the last meeting**

Dr Tran was added to the attendance and Dr Harrison was removed from the list of apologies as her attendance is shared with Dr Kay.

Some other typos were corrected and the minutes accepted as a record of the meeting.

- **Board roles**

CMB outlined the purpose of the board and how the Manchester cancer boards have been constituted.

Andrea Wadeson (AW) raised an issue with regard to peer review, and what appeared to be some confusion, on how the board and the previously established NDSG group relate. CMB confirmed that the board essentially replaces the NDSG as there were no plans to hold both the NDSG and pathway board meetings. This would be fed back to the relevant cancer manager.
Action - JL to discuss with the cancer manager at SRFT and send out the relevant Manchester cancer briefing note.

There was further discussion on GP and patient representation. CMB outlined the recent patient representative event and that Manchester cancer would lead on this. However some board members had identified certain GPs as potential board members. This will be followed up by CMB
Action – CMB to review nominated GP representatives.

CMB then went onto discuss the difficulty in scheduling of the pathway board to ensure nominated representation. After a recent poll there was no session identified as an ideal time for the group to meet.

- **Proposed clinical outcome measures**

CMB outlined the board outlined the objectives set for pathway boards by Manchester cancer. However she explained that the brain pathway is not comparable to other pathways as there is no structural change required and because of the work successfully undertaken by the previous network group.

One thing that the board did feel should be undertaken is the generation of outcome measures to demonstrate year on year improvement. CMB then tabled a list of proposed outcomes measures for the board to review. These were –

1. **Overall tumour numbers and % by grade**
    a) Important demographic but not a metric that reflects the quality of care.
2. **% of high grade tumours presenting as emergencies to A&E**
    a) This is complicated by the onset of symptoms (FAST test +ve and within 4 hrs) the pts would attend a recognised stroke centre (SRFT, SHH, Fairfield). Therefore pick up from these centres will increase.
    b) The complexities of managing cancer pts picked up on a stroke pathway across the primary/secondary care boundary and across greater Manchester.
    c) The fact that % of cases presenting to A&E does not reflect quality of care or early detection rates as it does for some other cancer types
3. **% of cases operated on as an emergency**
    a) Routinely collected by the neuroscience MDT (Miss Karabatsou (TK)). **CMB to discuss with TK**.
4. **% of cases operated on by a non neuro-oncology core surgeon**
    a) Should be measured for the board. **CMB to discuss with TK**.
5. **% of high grade gliomas operated on within 2 weeks of MDT**
    a) Current internal target **CMB to discuss with TK**.
6. **Survival – 2 year survival of GBM pts treated with chemo-RT**
    a) Difficult for neuro pts. In this category of GBM grade 4 pts with chemo/RT 2 year survival is accessible and reproducible and therefore more appropriate.
7. **1 year survival**
    a) See 6
8. **% of GBM pts who receive active treatment? Who are operated on? Who have complex resections?**
    a) See 6
9. **Patient satisfaction**
    a) Difficult because of small numbers and accessing suitable pts. Should use the last 100 pts with the information generated by the SRFT audit department. Agreed as an annual measure for the board and looking for a broad measure for pts diagnosed 6-9 months ago.
10. **% of patients who had research discussed with them?**
    a) Difficult to gather as it would be a retrospective measure which may prove difficult to confirm.
11. **Research recruitment figures**
    a) Agreed to report - but needs to be all trials and not just NCRN trials
12. **Treatment toxicity**

a) Hard to collect

13. **% discussed at network MDT/ reviewed by neuro AHP/ who had holistic needs assessment completed.**
    a) Looking for a measure for the more holistic aspects of the service. To review outside of the board meeting.
14. **30 day mortality – post-surgery and post-chemotherapy**
    a) Agreed to report
15. **% on gold standard framework**
    a) Not thought to be a measure of care as the GP puts the pt on the framework. To review alternative potential measures outside of the board meeting.
16. **1 year survival of brain mets pts treated with SRS**
    a) Agreed to measure
17. **Vestibular schwannoma outcomes?**
    a) AW to review alternative potential measures outside of the board meeting. (? Function)
18. **Pituitary measure**
    a) To review alternative potential measures outside of the board meeting.
19. **2 week wait referrals**
    a) Dr Douglass (CD) reported low pick up rates form GP requested CT scans
    b) Agreed to report

During discussion other possible measures proposed were

GP requested scanning rates and pick up rates.

This is currently provided in Macclesfield and Tameside. Not every area in GM has GP requesting scans. The board agreed that this is more likely to be an audit rather than an outcome measure.

- **Annual report**

CMB outlined the board annual report process and timescales. The report would be drawing from the peer review reports and assessments. CMB asked the relevant leads to send the most up to date documentation to JL.

Action – speciality leads to send peer review documentation to pathway manager.

- **Research and audit**

The board noted the paper form the NIHR on current clinical trials participation. The board noted that there was no national ranking as expressed in previous reports. JL to discuss this with NIHR.

Action – JL to obtain a national ranking for clinical trial recruitment.

- **Data**

CMB outlined the data input system currently used with the Christie and the potential usefulness this could have for future analysis of activity. She also outlined the existing databases in base of skull and within the neurosciences group.

- **Educational event**

This is to remain a standing item on the agenda and kept under review by the board.

- **Any other business**

Dr Sein confirmed that there was now remote electronic access for referrals to the MDT. Dr Douglass to check if this was also available at Tameside.

Dr Harrison raised the issue of UHSM having visibility that their patients have been discussed at the relevant MDT. This will be kept under review by both organisations.
CMB informed the board that the Radiology support at the MDT has been reduced as a participating Radiologist has left the Trust. This may have an impact on the quality of Radiology input at the MDT and will be kept under review.

- **Date & Venues for Future Meetings**

The next meeting of the board is scheduled to be on the 7th October; however Tuesday afternoon remains a difficult session for all to attend. CMB asked that the board is polled about re-arranging this date to one of the following dates –

- 30th September 13.30 – 15.30
- 3rd October 13.00 - 15.00
- 3rd October 14.00 – 16.00

Following a poll of Board members I can confirm that the next meeting of the pathway board will be held on **Friday 3rd October 13.00 – 15.00hrs**. The venue will remain at SRFT.