

**Meeting of the Peninsula Cancer Alliance Brain and CNS SSG**

Thursday 10<sup>th</sup> May 2018: 10:30-12:30

Future Inns, Plymouth

**FREEDOM OF INFORMATION**

*This group will observe the requirements of the Freedom of Information Act (2000) which allows a general right of access to recorded information including minutes of meetings, subject to specific exemptions. No one present today had any objections to their names being distributed in the minutes.*

**Draft Notes**

1.0	<b>Welcome and Introductions</b>
1.1	Please refer to separate record of attendance <a href="#">here</a> .
2.0	<b>MDT</b>
2.1	There were a number of concerns arising from peer review last year;
2.2	(i) Dr Bliss (Oncologist) had been unable to attend the Brain/CNS MDT due to a clash with the timing of the Breast MDT; this has now been resolved.
2.3	(ii) Video conferencing (VC) facilities were not fit for purpose: VC facilities have now been updated and the MDT functions well.
2.4	Exeter clinicians have advised that the MDT meeting room is too small and they struggle to attend on site. PF has requested that the MDT be moved to the meeting room on level 9 (Derriford Hospital) if this becomes available; for now it is hoped that 1 or 2 members of the team from Exeter will attend.
2.5	CNS workload is also a concern-there is currently 3 WTEs, admin support has improved but more support is required to reduce CNS time spent on activities that could be delegated to support staff.
2.6	<b>MDT Submissions</b>
2.7	Dr Gutowski raised concerns about the cut off time for MDT submissions being incompatible with the neurology ward round and the ability to add cases on to the list at short notice (due to a lack of time for neurology to then review imaging).
2.8	PF advised that patient care must not be delayed by the cut of time and urgent cases must be added to the list; James (MDT Coordinator) is aware of this.
2.9	<b>Action:</b> PF will write to the radiologists to advise them of the above.
3.0	<b>Histology</b>
3.1	LD explained that the new tumour classification often requires bloods to be done, and patients are getting pulled back which subsequently delays their oncology

	appointment. Posters have been circulated to the wards, however, delays are still being noted.
3.2	PF advised that the solution to this would be to add this to the ward round proforma.
3.3	<b>Action:</b> LD to action amendment to the proforma.
4.0	<b>SRS Cover</b>
4.1	Concern was raised about the lack of SRS Oncology cover when Liz Lim is on annual leave. The current position is that there are no suitable candidates, however it is anticipated that this is a short term issue and that new trainees will be coming through in the next 1-2 years.
4.5	<b>Action:</b> PF to ensure that a statement regarding SRS cover is added to the Operational Policy.
5.0	<b>MDT Quoracy</b>
5.1	LD has requested an updated as to the quoracy of the Brain and CNS MDT-it is thought that the requirements are being met; however the skull base MDT is not currently quorate.
5.2	PF discussed the generic nature of the QST MDT attendee requirements; this has been discussed at length and agreed that AHPs and a neuropsychologist do not need to be present as the purpose of the MDT is to make clinical treatment decisions.
5.3	A trial attendance of Physiotherapists was carried out, the results supported that their input at point of MDT was not required.
5.4	It is important to establish a balance of efficiency and purpose of the MDT; Close working relationships with AHPs/Psychology means that such services can be called upon on an as and when required basis.
5.5	RW from Brain Tumour Support added that a trial of pre-op physio assessment has been undertaken in Bristol and it has been found that such input is not particularly helpful at that point in the patient's pathway.
5.6	Brain and CNS MDT accept that they will be criticised for their approach to meeting attendance, however the group is happy that they have a clear, evidence based rationale for this decision.
5.7	<b>Presentation</b> (Nina Kamalarajan): Streamlining MDTs to maximise efficiency (CRUK).
5.8	Please follow these links for further information:  <a href="#">MDT Effectiveness Presentation</a>  <a href="#">CRUK Executive Summary</a>

5.9	Summary of discussion following the presentation:
5.10	LD queried if it would be helpful to have a protocol for benign acoustic tumours-PF thought that this would probably not make much difference as the decisions tend to be black and white, however it is helpful to continue to discuss these patients at MDT.
5.11	In relation to an MDT specific Morbidity and Mortality (M&M) review it was felt that patient outcomes do get translated to the MDT and that there was no need to hold a separate M&M.
5.12	It was thought that generic outcome measure for GBMs may not work as these cases can be particularly complex.
6.0	<b>Clinical Guidelines/Patient Pathways</b>
6.1	Once finalised, the agreed algorithms will be available via University Hospitals Plymouth NHS Trust cancer services webpage (Derriford) and the Brain and CNS SSG webpage ( <a href="#">SWCN</a> ).
6.2	An emergency surgery protocol for patients requiring intervention before MDT discussion has also been created.
6.3	<b>Action:</b> PF suggested that he will look again at the issue of GPs not being informed of the MDT outcome.
7.0	<b>Guest Speakers:</b>
7.1	<b>John McGrath and Jocelyn Watson: “100,000 Genomes” Update</b>
7.2	Genomic sequencing is becoming relatively affordable and there are many benefits of this, including personalised medicine using genome sequencing to guide best treatment and trials.
7.3	In 2012 the government announced funding that was to be set aside to change the way teams work and since then, the UK has undertaken pioneering work to identify consent and test patients in order to build new pathways of care.
7.4	Funding for the project ceases in October; the NHS and Genomics England has created a test directory (however, from October this will be limited to sarcoma and childhood cancers).
7.5	The need to link genomic testing with existing SSGs and to build a multidisciplinary tumour advisory group to inform developments at a regional level is apparent.
7.6	Genomic testing will become part of the “core business” of each established specialist group, with test results informing improvements in patient care.
7.7	Currently tissue retrieval is undertaken at point of surgery, the frozen sample is then sent to the lab for sequencing.
7.8	Exeter is the host organisation for the South West and are on target to get 100,000 genomes sequenced; recruitment to the cancer arm has been a challenge.

7.9	From March 2019, more funding will be available for cancer patient genomic sequencing. The timing from testing to feedback on the fast track pathway is 17 days, it is hoped that this will be further reduced to 7 days.
7.10	A network event has been organised for 4 <sup>th</sup> June; NK to will liaise with JM/JW to circulate event information to the SSGs. <b>Post Meeting Update</b> -this event has been postponed and rescheduled for 11 <sup>th</sup> September 2018-information to follow when available.
8.0	<b>Service Development</b>
8.1	A Physiotherapist at PHT has been looking out improving the discharge process for patient with a brain tumour. The PT is looking at obtaining support for a 12 month study to look at increase length of patient stay arising from a lack of available support services in the community.
9.0	<b>Low Grade Glioma Nurse</b>
9.1	The Brain Trust Charity is looking at funding one 3 year band 6 position to support patients with low grade glioma. LD has mentioned this to the directorate lead as the trust would need to take over funding of the post at the end of the 3 year time period. LD will further explore this opportunity.
10.0	<b>Neuropsychology Capacity</b>
10.1	The service is managing but there is a lack of cover in RNs absence, particularly for awake craniotomies (approximately 2 procedures/ month are undertaken). Expert input for these procedures is essential.
11.0	<b>Brain Tumour Support Charity</b>
11.1	Rosemary and David provided feedback to the group; key concerns currently are waiting times for CTs, and the length of time that patients are waiting for results-this is particularly in respect of surveillance scans. It was suggested that this could be audited.
12.0	<b>Audit</b>
12.1	There are currently 3 audits on-going-one of which has almost been completed-looking at best supportive care (BSC) decisions and date of patient death, to determine if BSC was the right decision.
13.0	<b>AOB</b>
13.1	A new Skull Base CNS is due to start in post at Derriford on 4 <sup>th</sup> June.
14.0	<b>Date of Next Meeting</b>
14.1	Thursday 22 <sup>nd</sup> November 2018 (10:30-12:30) at Future Inns Hotel, Plymouth (please send agenda item requests to <a href="mailto:nina.kamalarajan@nhs.net">nina.kamalarajan@nhs.net</a> ).