GMCA GREATER MANCHESTER COMBINED AUTHORITY

NHS in Greater Manchester

Greater Manchester Cancer

HPB Pathway Board

Date of Meeting **24th January 2017**
Time of meeting **14.00hrs – 16.00hrs**
Venue **Education Centre, Wigan Royal Infirmary**

Attendance	**Representation**
Derek O'Reilly	Pathway Director
Steve Sawyer	Patient representative
Lucie Francis	Macmillan User Involvement
Harry Kaltsidis	UHSM rep
Rafik Filobbos	PAT/CMFT
Claire Newton	CNS, CMFT
Aileen Aherne	CNS, CMFT
Nicola De'Liguori Carino	CMFT
Juan Valle	Christie rep/research lead
Steph Gooder	Stockport rep
Gurvinder Banait	WWL rep
Vicki Stephenson-Hornby	WWL deputy rep
Rebecca Price	Greater Manchester Cancer
Apologies	
Hans-Ulrich Laasch	Christie
Melanie Dadkhah-Taeidy	Tameside
Vinod Patel	Tameside
John Moore	CMFT
Saurabh Jamdar	CMFT
Claus Jorgensen	Cancer Research UK Manchester Institute
Ramasamy Saravanan	Macclesfield

1. Welcome and introductions

Welcome, introductions and apologies
DOR welcome all to the meeting and noted the apologies received.

i) Minutes of last meeting

The minutes of the last meeting were reviewed and approved.

2. Matters arising

Discussion summary	LF provided feedback through from the User Involvement Steering Group on the NSQIP Patient Consent and Risk Predication tools. Mr Ahmed Mirza (surgical SpR) had presented the tool to the group on 19th January 2017:

	• The Steering group generally approved of the use of such a tool to assess patient's risk. • In particular they agreed that it would provide a consistent approach for all patients and this is a good thing. • Members liked the use of statistics but highlighted that these would need to be put into context by the surgeon when a discussion takes place. • The group were clear that for this tool to be useful and effective it needs to be completed with the patient an appropriate way and at the right time to allow information to be considered before consenting to surgery. It was accepted that the first appointment in clinic for example would be a suitable time to do this. • Despite this being a legal requirement there still needs to be an element of patient choice - not all patients will want to see the results of such a test.
Conclusion	To proceed with the introduction of this individualised risk calculator into clinical practice for HPB patients undergoing surgery at CMFT. To monitor patient response to this tool.
Actions & responsibility	**Ahmed Mirza, DOR, LF**

3. Jaundice Pathway in Stockport

Discussion summary	SG presented progress to date in establishing a one-stop jaundice clinic at Stepping Hill Hospital (SHH), Stockport. Progress has included: a Stockport HPB Service established in 2016; full time CNS hours; recruitment to Gastro Consultant team and HPB lead – Dr Aujla. Advice from other centres providing a one-stop service was obtained and a decision made to base the SHH model on that existing at Macclesfield, i.e. a once-weekly clinic, with ultrasound for all and access to MRCP or CT for those indicated. Regrettably, launch did not take place as anticipated due to: Radiology pressures/ No Consultant cross-cover; sonographer unable to request the additional appropriate modality to progress the patient through the pathway; and no Gastroenterology Consultant cross-cover
Conclusion	To request further support for the establishment of a one-stop jaundice clinic at SHH through the Greater Manchester Cancer Vanguard radiology lead.
Actions & responsibility	**DOR, SG**

4. Jaundice Pathway: CMFT

Discussion summary	AA outlined that there had been 47 Referrals for Fast-Track Pancreatic Surgery between 1 Jan 2016-present, of which 21 were suitable to proceed to fast-track surgery. Median time from CT to surgery for these patients now stands at 10 days, compared with 33 days pre-pathway. Feedback from patient surveys has been very positive. Funding has been obtained from commissioners for pathway to continue for a further year.
Conclusion	Further development of one-stop jaundice clinics throughout the region and expansion of those offered fast-track surgery in 2017.
Actions & responsibility	**AA, DOR, All**

5. GP HPB & Vague Symptoms TWW referral forms

Discussion summary	DOR explained the Two-week wait referral forms for urgent cancer referrals, in use throughout Greater Manchester, are due for re-evaluation and revision. In light of the presentation given at the last pathway board meeting by Dr Ellena Badrick, Farr Institute, Manchester, which showed the very low positive predictive value of patients with diabetes mellitus developing pancreatic cancer, the board agreed that the following be removed as an indication for HPB cancer referral: "Age >60 and new onset diabetes (with no predisposing features or family history)". Moreover, it is an indication over and above that recommended by NICE.
Conclusion	To recommend removal of this indication from the HPB two-week wait referral form
Actions & responsibility	**DOR, Dr Sarah Taylor (GP Cancer Early Diagnosis Lead for Greater Manchester)**

6. 'Taking Charge in GM 2016-21' document and response

Discussion summary	DOR discussed the document 'Achieving world-class cancer outcomes: Taking charge in Greater Manchester 2017-2021', which represents the plan of the Greater Manchester Cancer Board. The draft document had been distributed to all HPB Pathway Board members and comments/corrections sought. DOR outlined the contributions that he had forwarded, in response to this document: • A regional jaundice pathway for pancreatic cancer, with one-stop diagnostic clinics in every hospital and fast-track referral for surgery at the specialist centre. What and when? Regional jaundice pathway for pancreatic cancer in place by January 2018 • Include reference to a single regional stage 4 colorectal cancer MDT by September 2017, to include all those involved in the treatment of metastatic colorectal cancer: colon, liver & lung surgeons, medical and clinical oncologists. The purpose will be to have a single-MDT discussion for patients presenting with synchronous metastatic colorectal cancer, avoiding the current 'death by MDT', currently typically a trip to at least 3 different MDTs for that patient's single presentation. • Prehabilitation programme securely established for HPB patients, following successful pilot project, by April 2017
Conclusion	To circulate final document once ratified by the Greater Manchester Cancer Board
Actions & responsibility	**DOR, RP**

7. Improving Effectiveness of MDTs (CRUK report)

Discussion summary	DOR presented the findings of a CRUK report 'Improving the effectiveness of multidisciplinary team meetings in cancer services'. These were: • There is not enough time to discuss the more complex patients • Current MDT meeting attendance is not optimal • The right information is often not used to inform in discussions • MDTs are unable to fulfil their secondary roles: in data validation, audit and education
Conclusion	There was broad agreement that the recommendations of this report should be

	taken forward for examination by a Pathway Board and HPB MDT sub-group, to examine their applicability to the HPB sMDT at CMFT, namely: • Recommendation 1: Identify where a protocolised treatment pathway could be applied and develop a set of treatment recommendations for each of these. Every Cancer network should develop their own approach based on these central recommendations. These treatment protocols should be reviewed regularly. • Recommendation 2: MDTs for tumour types for which a protocolised approach has been developed should agree and document their approach to administering protocols. This could include a 'pre-MDT triage meeting'. • Recommendation 3: National requirements for individual minimum attendance should be reviewed and amended where necessary, with an emphasis on ensuring all required specialties are present at a meeting. • Recommendation 4: MDTs should require incoming cases and referrals to have a completed proforma with all information ready before discussion at a meeting. • Recommendation 5: MDTs should use a database or proforma to enable documentation of recommendations in real time. Ideally this should be projected so that it is visible to team members • Recommendation 6: each MDT should ensure that they have a mortality and morbidity process to ensure all adverse outcomes can be discussed by the whole MDT and learned from, rather than discussed in silos.
Actions & responsibility	**DOR, JV, Ajith Siriwardena (Clinical Lead, HPB service, CMFT).**

8. Irreversible electroporation

Discussion summary	NDLC gave a presentation on Irreversible electroporation (IRE) a form of non-thermal tumour ablation, suitable for locally advanced (stage 3) pancreatic cancer. NDLC outlined the current standard of care for stage 3 pancreatic cancer; the principles of electroporation; the tissue effects of IRE; it's use in medicine; evidence of its efficacy in pancreatic cancer, largely based on its use in open surgery; the Nanoknife system; and the proposed introduction of an IRE service at CMFT.
Conclusion	Monitoring of results should occur, including participation on a national registry.
Actions & responsibility	**NDLC, DOR**

9. Research Report

Discussion summary	JV presented a Hepato-Pancreato Cancer Trials Report FY 2016/17 Q1-Q3 Recruitment activity window: 1st April 2016 – 31st December 2016 Data source: NIHR CRN CPMS (Central Portfolio Management System). The Greater Manchester LCRN has recruited well to interventional and observational trials. National and Greater Manchester (by Trust) recruitment and given in appendices 1 & 2, respectively.
Conclusion	Clarification about accuracy of the data was requested. Note: the data presented in the appendices is updated and verified as correct.
Actions & responsibility	**JV, DOR**

10. AOB

Discussion summary	HK requested that an agreed network-wide approach for biliary drainage be established.
Conclusion	A broad-based and multidisciplinary sub-group to be established to write a document on the preferred approaches to biliary drainage in a variety of circumstances.
Actions & responsibility	**DOR**

9. Date and time of next meetings:

- **28 February 2017 18.00. Irreversible electroporation educational event & dinner, Nowgen Centre, CMFT**
- **22 March 2017 14.00 – 16.00. HPB Pathway Board meeting. Holt Major, Patterson Building, Christie Hospital**
- **3rd May 2017** 10.00- 12.00 **HPB Pathway Board meeting Tameside Hospital**
- **26th September 2017. 14:00 – 16:00 HPB Pathway Board meeting Stepping Hill Hospital, Stockport**
- **November HPB Pathway Board meeting Macclesfield**

Appendix 1

National (England) analysis by LCRN's

NHS National Institute for Health Research

Design	Short Name	East Midlands	Eastern	Greater Manchester	Kent, Surrey & Sussex	North East & North Cumbria	North Thames	North West Coast	North West London	South London	South West Peninsula	TValley & South Midlands	Wessex	West Midlands	West of England	Yorkshire & Humber	Grand Total
	CRN Population source ONS (millions)	**4.4**	**3.7**	**2.9**	**4.5**	**3.1**	**5.5**	**3.7**	**2**	**3.1**	**2.2**	**2.3**	**2.7**	**5.7**	**2.4**	**5.4**	
Interventional	ABC-06: ASC alone or with mFOLFOX for advanced biliary tract cancer	1		4			3	2		2		2		4	2	4	**24**
	ABC-07								2								**2**
	ABC08: Ph Ib Acelarin + cisplatin in advanced billiliary tract cancer			6													**6**
	ACELARATE	1	1					11	6	2		2				1	**24**
	ACTICCA--1	1	1				4	2	3								**11**
	CANC - 3716 POLO1 Olaparib in gBRCA Mutated Metastatic Pancreatic Cancer		0	2			0	0		0							**2**
	CANC - 4032 Ramucirumab plus BSC vs placebo plus BSC as 2nd line treatment in HCC (JVDE)			2			1	1	0	1				2			**7**
	CANC - 4950			1			0	2	2	17				2			**24**
	CANC 4188			1			4	4		2				2			**13**
	CHR2845 in HCC						2										**2**
	ESPAC-4		4	5	1	2	1	2	2	1		2	1	1	1	3	**26**
	ESPAC-5F: European Study Group for Pancreatic Cancer - Trial 5F			2				2					1			2	**7**
	NCRN - 3137: STOP-HCC TheraSphere in Unresectable Hepatocellular Carcinoma (HCC) TS103		0	2	4	0	5	1	0	4						0	**16**
	NCRN640 Cabozantinib vs. Placebo in Subjects with HCC			1			1	1		2				1			**6**
	ORANGE II PLUS					1				8	5		12	12			**38**
	PANasta	14		6				55				32				10	**117**
	PRICKLE		2														**2**
Interventional Total		**17**	**8**	**32**	**5**	**3**	**21**	**83**	**15**	**39**	**5**	**38**	**14**	**24**	**3**	**20**	**327**
Observational	CTC in pancreatic cancer			21		30	3									93	**147**
	Evaluation of [18F]-FET-áAG-TOCA for the imaging of NETs								2								**2**
	Investigation of the molecular and genetic mechanisms promoting pancreatic cancer progression												31				**31**
	Molecular and cytogenetic characterisation of peritoneal surface malignancies												59				**59**
	Paired Biopsies in Lung Cancer									3							**3**
Observational Total				**21**		**30**	**3**		**2**	**3**			**90**			**93**	**242**
Grand Total		**17**	**8**	**53**	**5**	**33**	**24**	**83**	**17**	**42**	**5**	**38**	**104**	**24**	**3**	**113**	**569**

Appendix 2

CRN:GM analysis by Trust

NHS National Institute for Health Research

Design	Short Name	CMFT	EAST LANCS	THE CHRISTIE	Grand Total
Interventional	ABC-06: ASC alone or with mFOLFOX for advanced biliary tract cancer			4	4
	ABC08: Ph Ib Acelarin + cisplatin in advanced bililiary tract cancer			6	6
	CANC - 3716 POLO1 Olaparib in gBRCA Mutated Metastatic Pancreatic Cancer			2	2
	CANC - 4032 Ramucirumab plus BSC vs placebo plus BSC as 2nd line treatment in HCC (JVDE)			2	2
	CANC - 4950			1	1
	CANC 4188			1	1
	ESPAC-4			5	5
	ESPAC-5F: European Study Group for Pancreatic Cancer - Trial 5F	1		1	2
	NCRN - 3137: STOP-HCC TheraSphere in Unresectable Hepatocellular Carcinoma (HCC) TS103			2	2
	NCRN640 Cabozantinib vs. Placebo in Subjects with HCC			1	1
	PANasta	6			6
Interventional Total		**7**		**25**	**32**
Observational	CTC in pancreatic cancer		21		**21**
Observational Total			**21**		**21**
Grand Total		**7**	**21**	**25**	**53**

Clinical Research Network