GMCA GREATER MANCHESTER COMBINED AUTHORITY

NHS in Greater Manchester

Greater Manchester Cancer

HPB Pathway Board

HPB Pathway Board Meeting at Macclesfield General Hospital
Date of Meeting: **24 January 2018**
Chair: **Mr Derek O'Reilly**

Attendance	Representation
Derek O'Reilly	GMC HPB Pathway clinical director
Rebecca Price	GMC Pathway Manager
Vicki Stephenson Hornby	Wigan HPB CNS
Konrad Koss	ECHT Gastro Consultant
Anna Lewis	ECHT HPB CNS
Zahid Mahmood	SHH Consultant
Ramsay Saravanan	ECHT Consultant
Adrian Trang	ECHT Radiologist
Hatim Mudawi	ECHT Gastro Consultant
Mel Atack	User Involvement Manager
Steve Sawyer	User Involvement
Graham Wardies	User Involvement
Mairead McNamara	The Christie, Consultant
Apologies	Hans-Ulrich Laasch, Joe Geraghty, Mahesh Bhalme, Debbie Clark, Claire Newton, Saurabh Jamdar, Luke Williams, Lucy Foster, Claus Jorgensen, Rafik Filobbos, Angela Lamarca, Juan Valle, Amanda Corfield-Halliwell, Melanie Dadkha-Taeidy, Gurviner Banait, Sue Sykes.

1. Welcome and introductions

Welcome, introductions and apologies

DOR welcomed all to the meeting and noted the apologies received.

i) Minutes of last meeting

The minutes of the last meeting were reviewed and approved without amendment. These will be uploaded to the Greater Manchester website

2. Matters arising

Discussion summary	Items for future pathway board discussion: Consensus report from the Biliary Drainage sub-group; Implementing the Recovery Package in Greater Manchester; Improving Time from referral to treatment

3. MDT referral process- changes to proforma

Discussion summary	DOR presented changes to the HPB referral form used to list patients for discussion at the HPB sMDT at MRI. These are an option to list patient preferences; a clear "What is the question for the MDT" box; and new options for pancreatic cystic neoplasms and acute pancreatitis referrals. These were broadly welcomed. The need to provide a succinct patient history/brief summary was emphasised to facilitate a focused discussion at the MDT, which is time constrained.
Conclusion	RS suggested that improvements could be made so that less time is spent entering patient demographics.
Actions & responsibility	DOR.

4. Jaundice Pathway at Macclesfield

Discussion summary	RS presented the 'ONE STOP' JAUNDICE PATHWAY IN A DISTRICT GENERAL HOSPITAL: EVALUATION OF A PILOT PATHWAY-THE "MACC WAY" on behalf of the Macclesfield team. He noted previous guidelines for the management of jaundice from the BSG, NICE and UEG all recommended urgent access to speedy assessment and diagnosis. The Macclesfield Pathway consists of electronic referrals from primary care or within the hospital to a one-stop clinic with US/CT/MR availability, once a week on Mondays, followed by: Wed ERCP/MDT. Additional clinics slots are also freely available. The full East Cheshire Trust (ECT) Jaundice Referral Pathway can be found as Appendix 1. Their outcomes demonstrate that jaundice can be managed as OP with rapid access to investigations/specialist/clinics. This will reduce health costs/improve access to service /patient satisfaction
Conclusion	The jaundice pathway at MDGH has proven to be an effective pathway for patients to undergo investigations for jaundice. The majority of patients with jaundice can be managed as outpatients and this delineates a clear line of responsibility between primary and secondary/tertiary care. Adequate resource management is needed to facilitate this dedicated pathway. This has now been adopted as a GOLD STANDARD PATHWAY by the Central Manchester Cancer Network. A Jaundice interactive electronic and paper leaflet is in development. DOR congratulated the Macclesfield for continuing to lead and develop the one-stop jaundice clinic concept in Greater Manchester and Cheshire.
Actions & responsibility	Continued commitment to one-stop jaundice clinic and integration with the tertiary centre for management of detected cancers, as per the Manchester Jaundice Pathway. (All).

5. Fast-track pathway at MRI -DOR

Discussion summary	DOR presented a brief summary of Greater Manchester re-organisation and plan and how our jaundice pathway fits within the fundamental goal (domain) of 'Earlier and better diagnosis". He described the one-stop jaundice clinic at MRI, led by Aileen Aherne (HPB CNS) and the regional jaundice pathway (Appendix 2). Please note that there is no longer an arbitrary cut-off value for bilirubin; patients will be considered for fast-track surgery depending on a global assessment of their fitness. This is always assessed by cardio-respiratory exercise testing when indicated. Referrals to date via the fast-track jaundice pathway vary by Trust as follows:

	<table><tr><th>Bolton</th><th>CMFT</th><th>Macc</th><th>Salford</th><th>Tames</th><th>PAT</th><th>Wigan</th><th>Wyth</th><th>Stockport</th></tr><tr><td>9</td><td>4</td><td>11</td><td>7</td><td>14</td><td>23</td><td>13</td><td>3</td><td>9</td></tr></table> Results from 2017, comparing fast-track Whipple's operation with that after pre-operative biliary drainage shows comparable demographics, less complication (not significant), low mortality in both groups, longer length of stay in fast-track group (not significant)and a highly improved time from referral to treatment of 8 versus 41 days, favouring fast-track (Appendix 3). The Manchester Jaundice Pathway has been highlighted in the recent All-Party Parliamentary Group report on early diagnosis in pancreatic cancer, 'The Need for Speed' available at: http://www.pancanappg.org.uk/wp-content/uploads/2017/11/5934_PCUK_APPG_Report_HR4.pdf NICE guidance due to be released 31 Jan 2018 also recommends this approach: "Offer resectional surgery rather than preoperative biliary drainage to people who have resectable pancreatic cancer and obstructive jaundice and are well enough for the procedure and are not enrolled in a clinical trial that requires preoperative biliary drainage." He further outlined that future research by PRECISION-Panc will involve trials of neoadjuvant therapy and the need to obtain research specimens at multiple points of the patient pathway for genomic analysis and cancer model development.
Conclusion	The MRI unit remains committed to delivering fast-track surgery to those who are eligible.
Actions & responsibility	All-referring trusts to contact the regional jaundice nurse when they have a patient with a potentially operable pancreatic cancer. i.e. do not proceed to ERCP and stenting without prior discussion with the specialist MDT/ regional jaundice nurse/ or HPB consultant on call (24/7 service).

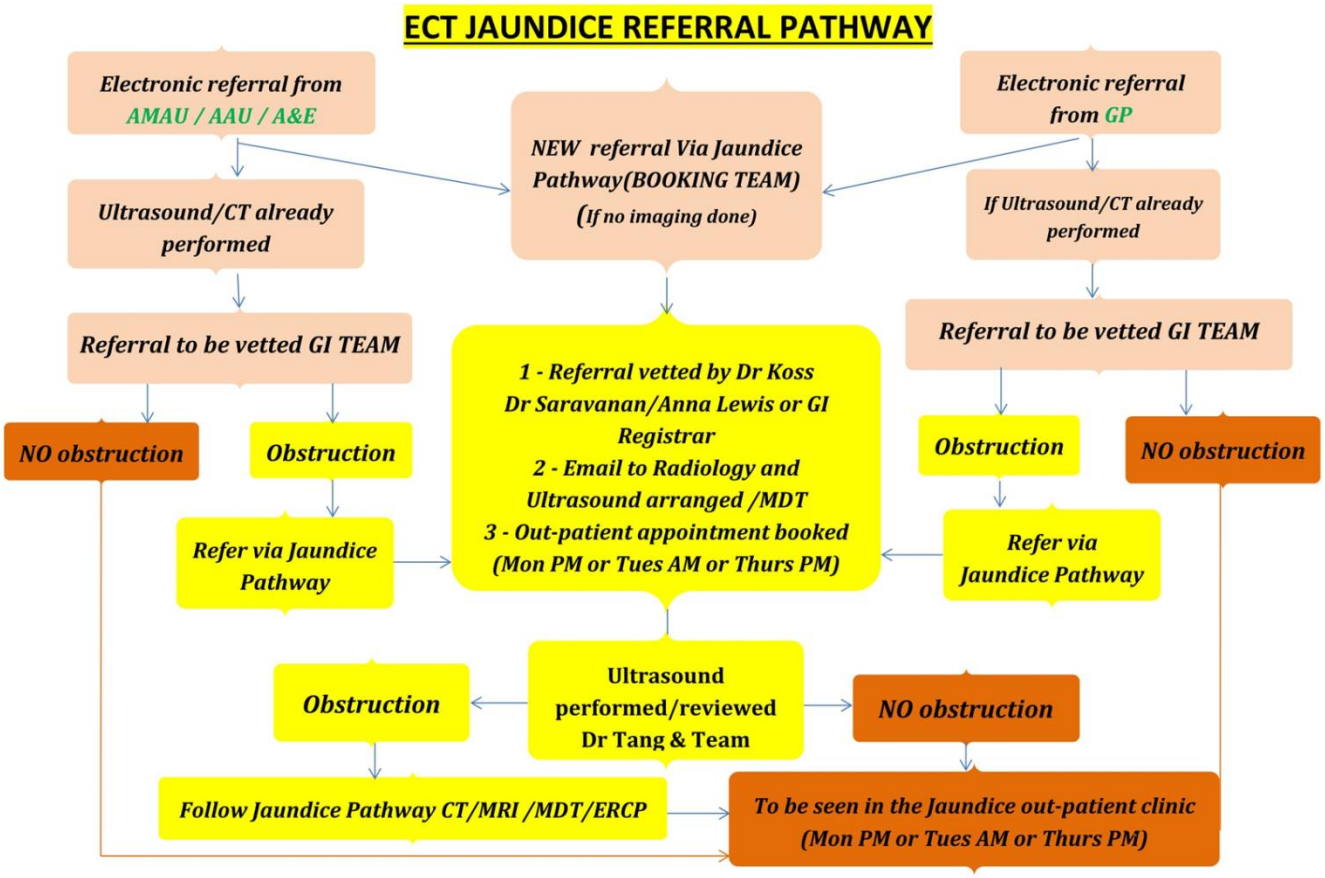
6. Jaundice Pathway progress at other referring hospitals

Discussion summary	Wigan: VSH reported 50% of patients referred via this one-stop jaundice clinic have been referred on for surgery and cancer pick up rate overall is 62% SHH: ZM outlined his plans for establishing a one-stop jaundice clinic at Stockport. PAT: DC undertakes the one-stop jaundice clinic at PAT. Bolton; No information. Tameside- Previous attempts have been made at establishing a jaundice clinic seems to be stalled. No updated information. SRI – possibility of establishing a one-stop clinic in 2018 Wythenshawe- no information. Lowest number of referrals to fast-track pancreatic cancer surgery (3).
Conclusion	Support and further development of one-stop jaundice clinics is vital to deliver earlier and better diagnosis to people with pancreatic cancer presenting with jaundice.
Actions & responsibility	To establish one-stop jaundice clinics at each referring hospital (All).

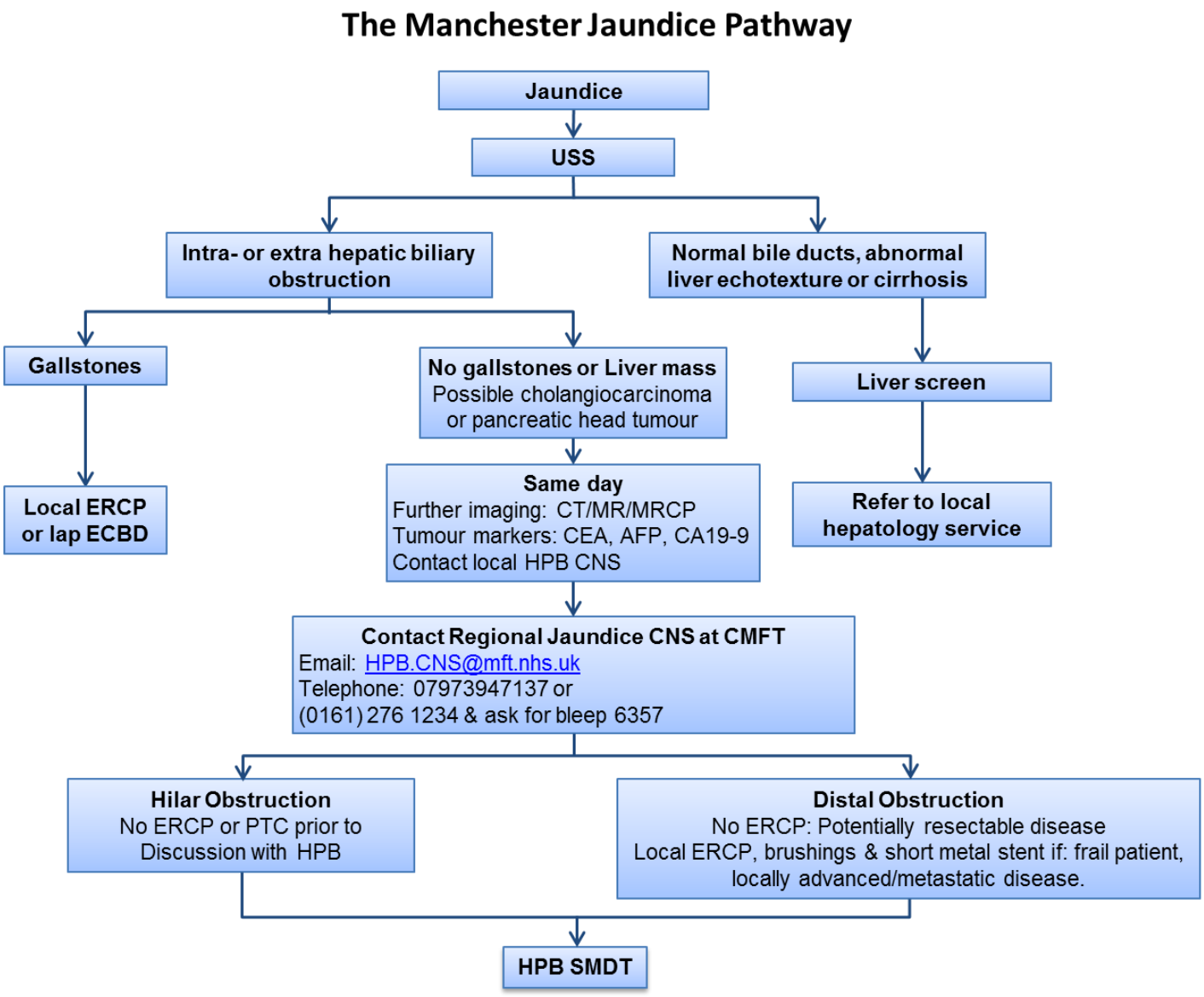
7. AOB & dates of future meetings:

Discussion summary	There was discussion about the recent poor attendance at pathway board meetings. It was agreed however, to continue with the policy of rotating meeting between sites; rotating days and times (but avoiding Weds am due to HPB sMDT, which prevented many from attending today). Consideration to be given to how to making the Pathway Board meetings more relevant to all. 6 March 14.00-16.00, Salford Royal Infirmary, 14 May, 10.00-12.00 Christie Hospital 13th September 2018, 14.00-16.00 MRI 13 November 2018 14.00-16.00 North Manchester General Hospital Jan 2019 Christie Hospital TBC
Conclusion	Agreed.
Actions & responsibility	Local organisers for SRI (LW), Christie (RP), MRI (DOR), NMGH (DC). Improved attendance requested from all pathway board Trust representatives or deputies.

Appendix 1
The East Cheshire Trust (ECT) Jaundice Referral Pathway



Appendix 2
The Manchester Cancer Jaundice Pathway



Appendix 3
Preliminary Results of fast-track pancreatic surgery versus non-fast-track (i.e. with preoperative biliary drainage).

	Fast Track N=34	Non - Fast track N=74	p-value (test)
Median age (range)	63.5 (40 to 78)	67 (23 to 83)	0.21
Gender	F = 18 M = 16	F = 33 M = 41	0.53
PF	5	9	0.76
DGE	8	10	0.27
PPH	2	5	1.00
Comprehensive Complications Index (post-op)	28.2	36. 3	0.39
Mortality	0	2	1.00
Median post-op hospital stay (days)	16 (6 to 61)	12 (5 to 99)	0.057
Median referral to surgery (days)	8 (2 to 45)	41 (5 to 287)	0.00001