Manchester Cancer

HPB Cancer Pathway Board

Annual Report 2014/15

Pathway Clinical Director: Mr. Derek O'Reilly
Pathway Manager: Rebecca Price

Version 1.3

Executive summary: HPB Pathway Board

1. The Hepato-Pancreato-Biliary (HPB) Pathway Board has been successfully established. There is active representation for all ten trusts in Greater Manchester and Cheshire that comprise Manchester Cancer. There is also primary care representation.

2. From October 6, 2014, a single IOG compliant HPB Service has been located at the Manchester Royal Infirmary, Central Manchester NHS Foundation Trust (CMFT). This is the result of the merger of the two previous HPB Units at the MRI and North Manchester General Hospital, Pennine Acute Trust.

3. The HPB Board have embraced the principle of wider engagement and educational meetings. HPB Pathway Board meetings take place at two monthly intervals at each of the ten participating Trusts, with the additional feature of an educational event for the benefit of the local MDT.

4. We have delivered on our annual plan of 2014; making significant progress on implementing a regional jaundice pathway, addressing patient experience, succeeding in recruiting to clinical trials and delivering a wide range of educational events throughout the region.

5. We can demonstrate our current five year survival outcomes for pancreatic cancer and colorectal liver metastases and that these are commensurate with international outcomes.

6. The HPB Pathway Board has identified that there is an unequal provision of HPB Clinical Nurse Specialists across the region. This has been escalated to the Manchester Cancer Medical Director for discussion at Provider and Cancer Lead Boards.

7. Research and Innovation is strength of the HPB Pathway board with a strong track record of leadership in academic activities: exceeding trial recruitment targets; high impact peer-reviewed publications; and the introduction of innovative treatments.

8. We have successfully obtained funding for implementation of the regional Jaundice Pathway through the Acceleration, Coordination and Evaluation (ACE) program. This is co-funded by NHS England, Cancer Research UK and Macmillan Cancer Support. Total funding: £68,000.00

9. The HPB Pathway Board submitted a grant application to the Macmillan Living With and Beyond Cancer Innovation Fund in January 2015: “An Integrated program of Nutritional support; Exercise and improved general well-being; and Screening for anxiety and depression, right across the four phases of: Prehabilitation, Enhanced recovery, Recovery/reablement and Living with and beyond cancer”. Although unsuccessful, an invitation was extended to enter discussion with Macmillan with a view to a reapplication with a revised application.

10. A comprehensive set of clinical guidelines and chemotherapy algorithms for HPB has been created. Thus, the entirety of HPB patient management is protocol-based and

accords with the latest evidence and international guidance. This process has involved all members of the new sMDT, as well as representatives from the local referral/diagnostic teams.

11. The HPB Pathway Board has identified endoscopic ultrasound (EUS) as a diagnostic technique suitable for regional audit. The aim of this audit is to fulfil the governance requirement to evaluate the performance and quality of EUS provided by a number of practitioners across five different Trusts in Greater Manchester & Cheshire. (CMFT, UHSM, PAT, SRI and Wigan) under the independent auspices of the Manchester Cancer HPB Pathway Board.

1. Introduction – the Pathway Board and its vision

This is the annual report of the Manchester Cancer HPB Pathway Board for 2014/15. This annual report is designed to:

- Provide a summary of the work programme, outcomes and progress of the Board – alongside the minutes of its meetings, its action plan and it scorecard it is the key document for the Board.
- Provide an overview to the hospital trust CEOs and other interested parties about the current situation across Manchester Cancer in this particular cancer area
- Meet the requirements of the National Cancer Peer Review Programme
- Be openly published on the external facing website.

This annual report outlines how the Pathway Board has contributed in 2014/15 to the achievement of Manchester Cancer's four overarching objectives:

- Improving outcomes, with a focus on survival
- Improving patient experience
- Increasing research and clinical innovation
- Delivering compliant and high quality services

1.1. Vision

Our key aims and vision are:

- Better Patient Outcomes
- Better Patient Experience
- Research and Innovation

1.2. Membership

Table1.1 The membership of the Pathway Board and the trusts/specialties of all individuals.

Name	Role	Organisation	Rep or Deputy
Dr Mahesh Bhalme	Consultant Gastroenterologist/Hepatologist	Bolton	Rep
Amanda Corfield-Halliwell	Clinical Nurse Specialist	Bolton	Deputy
Professor Juan Valle	Consultant Medical Oncologist/Pathway Board Research Lead	Christie	Rep
Dr Mairead MacNamara	Consultant in Medical Oncology	Christie	Deputy
Professor Ajith Siriwardena	Consultant Hepato-Pancreato-Biliary Surgeon	CMFT	Rep
Dr Jo Puleston	Consultant Gastroenterologist	CMFT	Deputy
Dr Konrad Koss	Consultant Gastroenterologist	East Cheshire	Rep

Name	Role	Organisation	Rep or Deputy
Dr Adrian Tang	Consultant Radiologist	East Cheshire	Deputy
Dr Emma Donaldson	Consultant Gastroenterologist	SRFT	Rep
Sr Sharan Ingram	Clinical Nurse Specialist	SRFT	Deputy
Dr Mong-Yang Loh	Consultant Radiologist	Stockport	Rep
Kirsty Williams	Clinical Nurse Specialist	Stockport	Deputy
Dr Harry Kaltsidas	Consultant Gastroenterologist	UHSM	Rep
Dr Guvinder Banait	Consultant Gastroenterologist	WWL	Rep
Vicki Stevenson-Hornby	Clinical Nurse Specialist	WWL	Deputy
Dr Rafik Filobbos	Consultant Radiologist/Radiology Lead	Pennine	Rep
Dr Vinod Patel	Consultant Hepatologist	Tameside	Rep
Melanie Dakha-Taeidy	Clinical Nurse Specialist	Tameside	Deputy
Dr Kevin Finn	GP Representative	-	-
Dr Martin Prince	Consultant Hepatologist/ co-opted member	CMFT	-
Debbie Clark	Clinical Nurse Specialist/ co-opted member	CMFT	-
TBC	Patient Representative		

Table 1.2 Individuals who have been appointed as lead for research, education, early diagnosis, living with and beyond cancer, palliative care, etc.

Early diagnosis	Vicki Stevenson-Hornby
Pathology	TBC
Surgery	Prof. Ajith Siriwardena
Radiology	Dr. Rafik Filobbos
Oncology	Prof. Juan Valle
Specialist nursing	Sr. Debbie Clark
Patient Mentor	Melanie Dakha-Taeidy
Living with and beyond cancer ('survivorship')	TBC
Research	Prof Juan Valle

Data collection (clinical outcomes/experience and research input)	Mr Derek O'Reilly
Palliative Care	Sr. Sharan Ingram
Education	TBC

New GP Representative: Dr. Rebecca Leon.

Gaps in membership to be addressed at next HPB Pathway Board meeting: 04 September 2015.

In late 2014 Manchester Cancer and Macmillan Cancer Support agreed to work in partnership to develop genuine user involvement in cancer services in Greater Manchester. This partnership agreement saw the commitment of over £300,000 from Macmillan to fund a dedicated five-strong user involvement team for Manchester Cancer. This team will be responsible for, among many other things, for making sure that each Manchester Cancer Pathway Board has at least two user representatives within its membership. The first members of this team began in post in June 2015 and the whole team will be in place by the end of August. The HPB Pathway Board is supportive of the broader user involvement aims of Manchester Cancer. As such rather than recruiting its own patient representatives has been waiting for the support of the Macmillan User Involvement Team.

1.3. Meetings

Table 1.3 A list of the meetings that have taken place this year and the frequency of future meetings. A link to the minutes of meetings on the Manchester Cancer website is included.

Pathway Board meetings and papers

Date	Venue	Minutes
14th April 2014	Christie Hospital	HPB Pathway Board Meeting Minutes
24th June 2014	Christie Hospital	HPB Pathway Board Meeting Minutes
18th September 2014	Wigan Infirmary	HPB Pathway Board Meeting Minutes
13th November 2014	Manchester Royal Infirmary	HPB Pathway Board Meeting Minutes
23rd January 2015	Stockport	HPB Pathway Board Meeting Minutes
20th March 2015	UHSM	HPB Pathway Board Meeting Minutes
06th May 2015	Macclesfield	

Future Pathway Board meetings:

04th September 2015 Venue: Bolton
18th November 2015 Venue: Tameside

The record of the attendance at each meeting to-date is in Appendix 1.

The HPB Board have embraced the principle of wider engagement and educational meetings. HPB Pathway Board meetings take place at two monthly intervals at each of the ten participating Trusts, with the additional feature of a wider meeting/educational event for the benefit of the local MDT.

Table 1.4 Educational events organised by the HPB Pathway Board.

Date	Venue	Speakers & Lecture
18th September 2014	Royal Albert Edward Infirmary, Wigan	"Hepato-biliary & Pancreatic (HPB) services in the Manchester Cancer Region" Mr. Derek O'Reilly, HPB Pathway Clinical Director, Manchester Cancer "Improving Outcomes in Pancreatic Cancer" Prof. Juan Valle, Professor of Medical Oncology, Christie Hospital.
23rd Jan. 2015	Stepping Hill Hospital, Stockport	"Hepato-biliary & Pancreatic (HPB) Services in the Manchester Cancer region" Mr. Derek O'Reilly "Improving Outcomes in Pancreatic Disease" Dr. Joanne Puleston Consultant Gastroenterologist, Manchester Royal Infirmary
31st January 2015	UHSM	GI CANCER STUDY MORNING A Practical Guide Screening and prevention of hepatocellular carcinoma. Dr M Prince, Consultant Hepatologist, CMFT Bowel Cancer Screening and Flexiscope. Dr A Makin, Consultant Gastroenterologist, CMFT Barrett's oesophagus. Dr R Willert, Consultant Gastroenterologist, CMFT The Manchester Cancer Jaundice Pathway. Mr D O'Reilly, Consultant Hepatobiliary Surgeon, CMFT Early Diagnosis in Colorectal Cancer. Mrs S Duff,

		Consultant Colorectal Surgeon, UHSM Early diagnosis in oesophagogastric cancer – Mr K Akhtar, Consultant Oesophagogastric Surgeon, Salford Royal
20th March 2015	UHSM	"Hepato-biliary & Pancreatic (HPB) services in the Manchester Cancer Region" Mr. Derek O'Reilly, "The role of ERCP as primary and/or secondary ("rescue") intervention for biliary decompression in malignant perihilar strictures" Dr. Harry Kaltsidas, Consultant in Gastroenterology and Pancreatobiliary Medicine, UHSM.
06th May 2015	Macclesfield	"HPB Services and Strategy in the Manchester Cancer Region" Mr. Derek O'Reilly, "Improving Outcomes in Pancreatic Cancer" Prof. Juan Valle, Professor of Medical Oncology, Christie Hospital.

2. Summary of delivery against 2014/15 plan

No	Objective	Alignment with Provider Board objectives	Tasks	By	Status Green = achieved Amber = partially achieved Red = not achieved
1	Implement a regional jaundice pathway	1. 1-year SURVIVAL 2. Patient EXPERIENCE 3. RESEARCH and INNOVATION	To obtain funding for a jaundice co-ordinator	Jan 2015	
			To establish pilot pathways in some referring hospitals	April 2015	
			To establish the concept of fast-track pancreatic surgery as the default strategy in suitable patients in the new merged HPB service CMFT.	July 2015	
			Full implementation: by end of 3 year MC cycle	Dec 2016	
2	Improve Patient Experience	2. Patient EXPERIENCE	Presentation of CPES data at HPB Pathway Board	Sept 2014	
			To obtain separation of CPES data for HPB	Jan 2015	
			To have a patient representative on the HPB Pathway Board	April 2015	
			Discussion of survivorship at Pathway Board from Survivorship Pathway Director	July 2015	
3	Increase recruitment of HPB patients to clinical trials	1. 1-year SURVIVAL 3. RESEARCH and INNOVATION	Establish reliable system of data collection by HPB sMDT	Jan 2015	
			Presentation of recruitment by	April 2015	

			NCRN targets		
			Develop at least 1 Manchester lead NCRN HPB surgical study	July 2015	
			To increase the HPB data and research infrastructure	July 2015	
4	Improve education for public, patients and referrers to the service.	1. 1-year SURVIVAL 2. Patient EXPERIENCE	HPB Pathway Board Meeting & Educational Event at Wigan	18.09.2014	
			Pennine Acute Trust Educational Event	15.10.2014	
			HPB Pathway Board Meeting & Educational Event at Stockport	23.01.2015	
			HPB Pathway Board Meeting & Educational Event at Wythenshawe	March 2015	
			Joint Annual Event with Colorectal & Upper GI Pathway Boards	April 2015	
			HPB Pathway Board Meeting & Educational Event at Macclesfield	May 2015	

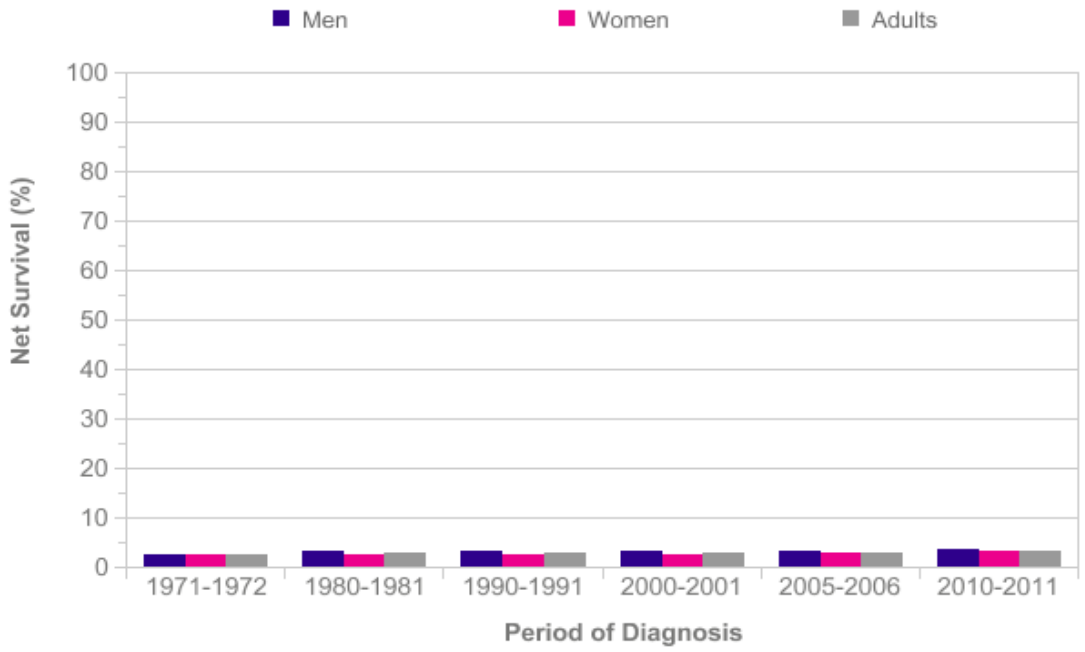
3. Improving outcomes, with a focus on survival

3.1. Information

National data on clinical outcomes is hampered by collection and presentation of results for HPB under the umbrella term “Upper Gastrointestinal Cancer”. This also includes oesophago-gastric cancer, an entirely different tumour group. Nonetheless, according to data from the *National Cancer Intelligence Network (NCIN)* data, age-standardised incidence, emergency presentation and mortality for “upper GI cancers” in the Greater Manchester Area exceed the national average. Prevention and survival are correspondingly lower. For further detail, see HPB Pathway board Annual Report 2014.
http://manchestercancer.org/services/hepato-pancreato-biliary/

The following incidence and survival data for pancreatic cancer has been obtained from Cancer Research UK:

Pancreatic Cancer (C25): 1971-2011
Age-Standardised Five-Year Net Survival, England and Wales



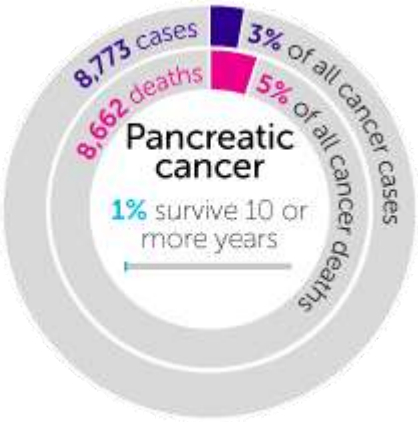
Prepared by Cancer Research UK

http://info.cancerresearchuk.org/cancerstats/faqs/#How

Original data sources:

Survival estimates were provided on request by the Cancer Research UK Cancer Survival Group at the London School of Hygiene and Tropical Medicine.
http://www.lshtm.ac.uk/eph/ncde/cancersurvival/http://www.lshtm.ac.uk/eph/ncde/cancersurvival/

Pancreatic cancer is currently the 5th leading cause of cancer deaths and by 2030 is predicted to overtake breast cancer as the 4th.



3.2. Progress

The Manchester Cancer HPB Pathway board is committed to measuring and monitoring what is important to both them and their patients. Previously, many cancer-related measures were related to service targets – we wish to change this emphasis.
We are also committed to openly publishing data to illustrate to the Manchester Cancer Provider Board and other stakeholders that we are making a difference. Data will be made publicly available via the website: www.manchestercancer.org
The HPB Pathway Board will agree a small number of meaningful measures that it will monitor closely. This set of measures will cover the whole cancer pathway, including where appropriate measures for early diagnosis, patient experience and survivorship as well as the treatment phase of the pathway.

Core measures include:

- Percentage of cancers diagnosed by stage
- Percentage of cancers diagnosed as emergencies
- Resection rates
- Operative morbidity and mortality
- Cancer survival (at 1, 3 and 5 years)

- measures of patient satisfaction
- the research involvement of patients

Data will be presented in the form of a scorecard so that easy assessment is possible.

CMFT HPB SMDT WORKLOAD

All new HPB cancer patients are reviewed by the HPB sMDT for discussion of initial treatment plan. Urgent cases can also be discussed outside of the MDT meeting, through the on-call HPB surgeon. The local referral/diagnostic teams are the local Upper GI and Colorectal Multidisciplinary teams at:

- Bolton NHS Foundation Trust
- Central Manchester University Hospitals NHS Foundation Trust
- East Cheshire NHS Trust
- Pennine Acute NHS Trust
- Salford Royal NHS Foundation Trust
- Stockport NHS Foundation Trust
- Tameside Hospital NHS Foundation Trust
- The Christie NHS Foundation Trust
- University Hospital of South Manchester NHS Foundation Trust;
- Wrightington, Wigan and Leigh NHS Foundation Trust

Urgent cases can be discussed outside of the formal MDT, however in this case the following protocol is to be followed:

- Telephone discussion between the relevant treating consultant or their deputy and another SMDT surgeon/clinical oncologist/medical oncologist. This discussion to include all available radiology and pathology evidence.
- Formal written letter to follow telephone discussion as a permanent record.
- The case will be discussed at the next scheduled SMDT meeting.

Table 3.1 CMFT HPB SMDT WORKLOAD 01.10.2014-31.03.2015

Indicator	October to December 2014	January to March 2015
MDT Workload		
Total patients discussed at HPB MDT	**732**	**633**
Total patients diagnosed with an HPB malignant neoplasm		
- Liver (C22)	59	51
- Gallbladder (C23)	14	11
- Other Biliary Tract (C24)	16	19
- Pancreas (C25)	76	70
- Other Digestive Organs (C26)	4	1

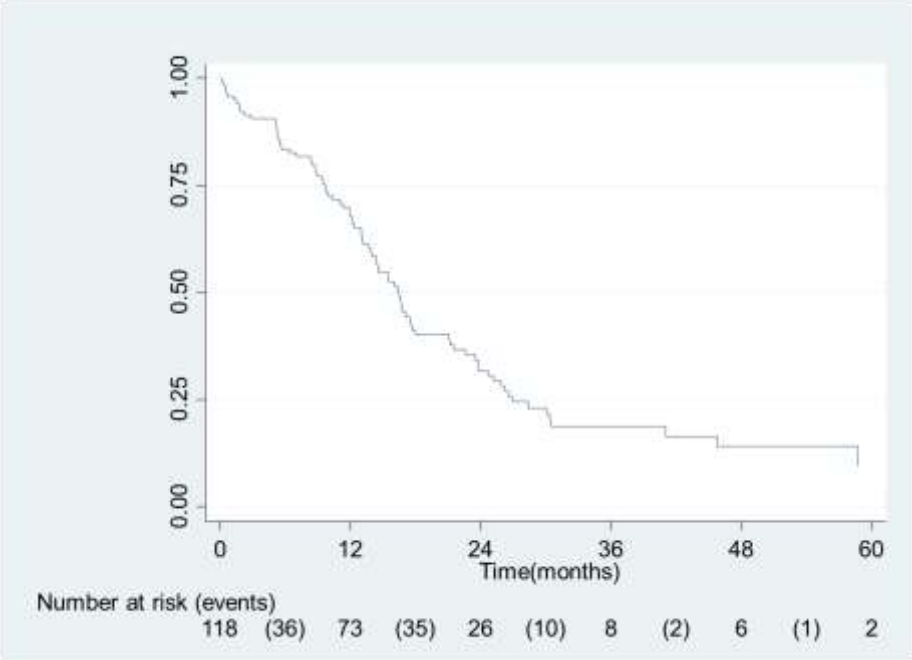
- Secondary Neoplasms (C78, C79)	52	40
Total patients with a benign diagnosis	11	2
Total patients with an "in-situ" diagnosis	0	0
Total patients with neoplasms of uncertain/unknown behaviour	3	2

Survival Outcomes

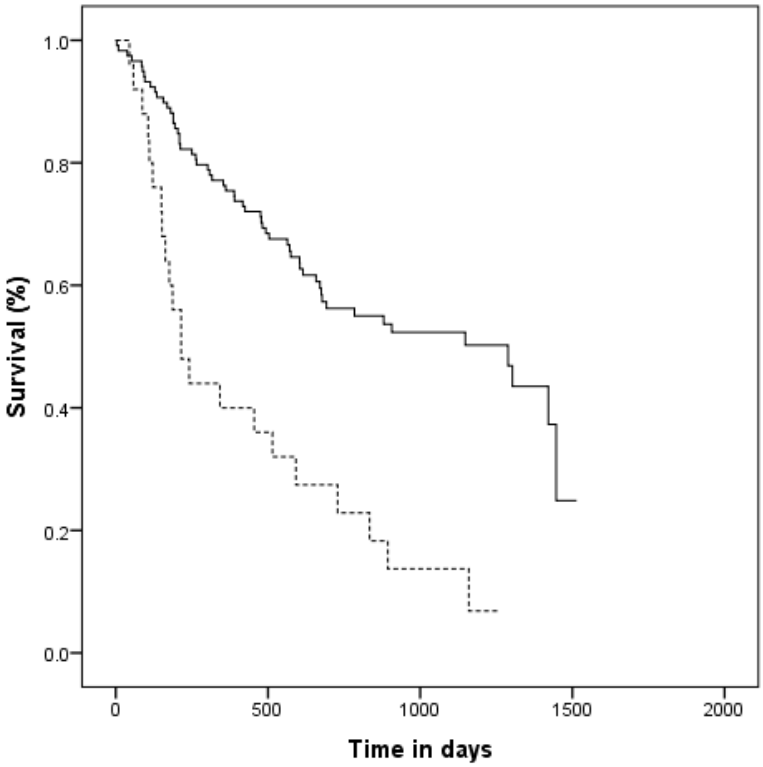
Survival data from the NMGH and CMFT units prior to the merger on 6 October 2014 can be found in the following graphs:

Pancreas Cancer

NMGH data: 283 patients underwent pancreatic resections over the six-year study period July 2007-13. One hundred and nineteen patients underwent intentionally curative operations for PDAC. One hundred and eleven patients had tumours of the pancreatic head, six of the tail and two of the body. Eighty-four patients received adjuvant chemotherapy (71%). Ninety-eight patients had available BMI data and were included in the final analysis. Overall median actuarial survival for patients was 16.4 months, with 1, 3 and 5-year survival of 67%, 18% and 10% respectively



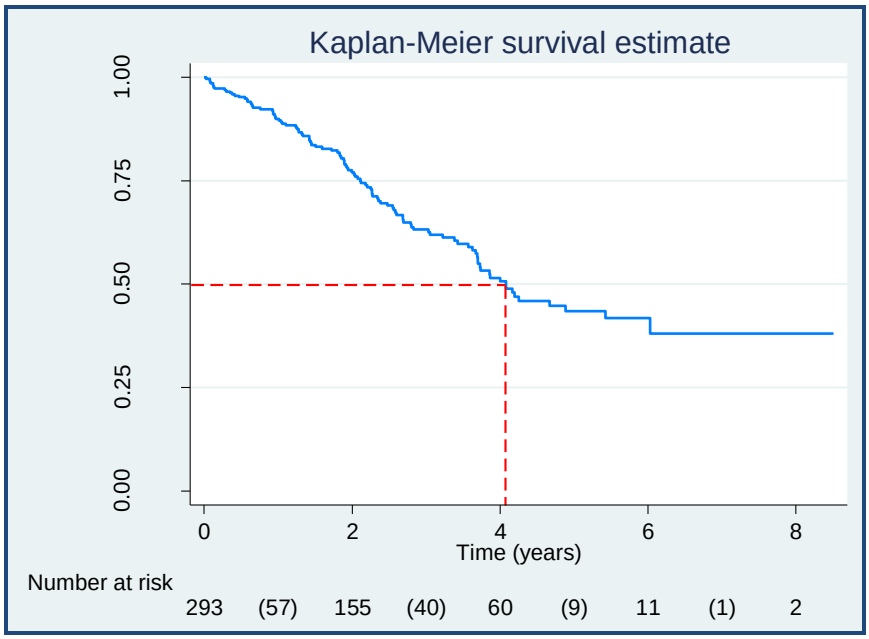
CMFT data: Kaplan Meier survival characteristics of 118 patients undergoing resection (—), with median survival of 3.53 years (95% CI 2.12 to 4.94). 25 patients were deemed inoperable (- - -) and had median survival of 0.58 years (95% CI 0.35 to 0.83) (log rank p<0.001).



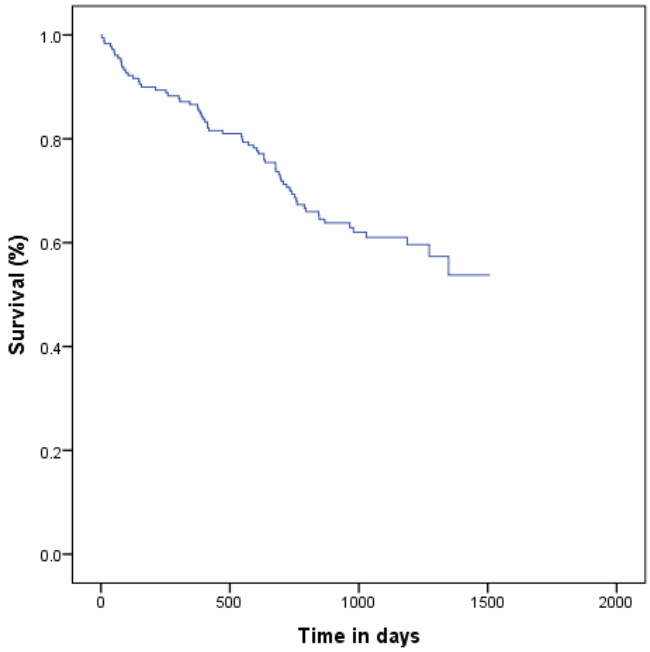
Number at risk	0 year	1 year	2 years	3 years	4 years
Operated	118	89	49	27	2
Inoperable	25	10	5	2	0

Colorectal Liver Metastases

NMGH data: A total of 293 resections for CLM were performed in 256 patients over the six-year study period July 2007-13. *Source: www.livermetsurvey database (NMGH data).*



CMFT data: Kaplan Meier survival for all operated cases of 179 hepatectomy patients during the time period September 2007 to December 2009. Mean survival 2.99 years (95% CI 2.77 to 3.21).



Number at risk	0 year	1 year	2 years	3 years	4 years
All operated	179	154	109	56	1

3.3. Challenges

The key challenge identified by the HPB Pathway Board is to obtain sufficient resources to implement clinical improvements that lead to better outcomes. The resources necessary include: additional personnel for better coordination of patient care, accurate data collection to measure progress.

4. Improving patient experience

4.1. Information

The data from the 2014 National Cancer Patient Experience Survey for Upper GI has now been split into oesophago-gastric and HPB components; which identified that Pennine had 19 HPB questionnaires returned and CMFT had 17. This data was discussed at the CMFT Trust NCPES event on 8 October 2014 and at the Manchester Cancer HPB Pathway Board meeting of 20.03.2015. The percentage returns for each question were as follows:

Table 4.1 HPB CPES RESULTS 2014

Q.	SEEING YOUR GP	PAT No.	%	CMFT No.	%	National
1.	Saw GP once / twice before being told had to go into hospital	11	64%	9	33%	75%
2.	Patient thought they were seen as soon as necessary	17	94%	16	81%	83%
3.	Patient's health got better or remained the same while waiting	13	87%	15	67%	80%
	DIAGNOSTIC TESTS	PAT No.	%	CMFT No.	%	National
4.	Staff gave complete explanation of purpose of test (s)	13	81%	13	54%	84%
5.	Staff explained completely what would be done during test	17	82%	14	64%	87%
6.	Given easy to understand written information about test	11	92%	9	56%	87%
7.	Given complete explanation of test results in understandable way	17	76%	14	43%	78%
	FINDING OUT WHAT WAS WRONG WITH YOU	PAT No.	%	CMFT No.	%	National
8.	Patient told they could bring a friend when first told they had cancer	13	93%	14	57%	75%
9.	Patient felt they were told sensitively that they had cancer	15	83%	17	71%	84%
10.	Patient completely understood the explanation of what was wrong	13	41%	17	68%	73%
11.	Patient given written information about the type of cancer they had	6	46%	13	23%	72%
	DECIDING ON THE BEST TREATMENT FOR YOU	PAT No.	%	CMFT No.	%	National
12.	Patient given a choice of	3	60%	4	100%	86%

	different types of treatment					
13.	Patient views definitely taken into account by doctors and nurses discussing treatment	13	72%	13	54%	68%
14.	Possible side effects explained in an understandable way	17	61%	13	62%	75%
15.	Patient given written information about side effects	13	72%	15	60%	82%
16.	Patient told about how side effects could affect then in the future	13	71%	16	23%	56%
17.	Patient definitely involved in decisions about care and treatment	13	68%	16	56%	72%
	CLINICAL NURSE SPECIALIST	PAT No.	%	CMFT No.	%	National
18.	Patient given the name of the CNS in charge of their care	15	79%	12	100%	89%
19.	Patient finds it easy to contact their CNS	9	69%	12	75%	73%
20.	CNS definitely listened carefully the last time spoke to	13	93%	14	79%	91%
21.	Get understandable answers to important questions all / most of the time	11	79%	12	83%	91%
	SUPPORT FOR PEOPLE WITH CANCER	PAT No.	%	CMFT No.	%	National
22.	Hospital staff gave information about support groups	10	77%	8	88%	83%
23.	Hospital staff discussed or gave information about impact cancer could have on work life or education	8	73%	6	50%	75%
24.	Hospital staff gave information on getting financial help	6	60%	15	33%	54%
25.	Hospital staff told patient they could get free prescriptions	4	80%	7	71%	78%
26.	Patient saw cancer research information in the hospital	17	89%	16	75%	86%
27.	Taking part in cancer research discussed with the patient	9	53%	16	75%	31%
28.	Patient went on to take part in cancer research	6	67%	11	82%	63%
	OPERATIONS	PAT No.	%	CMFT No.	%	National
29.	Hospital staff explained what would be done during the operation	7	88%	11	82%	88%
30.	Given written information about the operation beforehand	2	29%	11	55%	76%

31.	Got understandable explanation of how operation had gone	6	75%	12	58%	78%
	HOSPITAL DOCTORS	PAT No.	%	CMFT No.	%	National
32.	Got understandable answers to important questions all / most of the time	11	73%	14	71%	83%
33.	Patient had confidence and trust in all doctors treating them	15	94%	16	69%	85%
34.	Doctor's did not talk in front of patient as if they were not there	13	87%	16	75%	84%
35.	Patient's family definitely had the opportunity to talk to doctor	9	56%	14	50%	67%
	WARD NURSES	PAT No.	%	CMFT No.	%	National
36.	Got understandable answers to important questions all / most of the time	8	62%	16	44%	76%
37.	Patient had confidence and trust in all ward nurses	12	75%	16	63%	71%
38.	Nurses did not talk in front of them as if they were not there	14	88%	15	67%	85%
39.	Always / nearly enough nurses on duty	12	75%	16	50%	62%
	HOSPITAL CARE AND TREATMENT	PAT No.	%	CMFT No.	%	National
40.	Patient did not think hospital staff deliberately misinformed them	11	69%	16	75%	88%
41.	Patient never thought they were given conflicting information	11	69%	5	13%	79%
42.	All staff ask patient what name they preferred to be called by	7	44%	16	56%	60%
43.	Always given enough privacy when discussing treatment / condition	10	63%	15	0%	85%
44.	Always given enough privacy when examined or treated	16	100%	16	88%	95%
45.	Patient was able to discuss worries or fears with staff during visit as much as they wanted	5	38%	14	36%	65%
46.	Hospital staff did everything to help control pain all of the time	10	100%	14	64%	86%
47.	Always treated with respect and dignity by staff	14	88%	16	69%	84%

	INFORMATION GIVEN TO YOU BEFORE YOU LEFT HOSPITAL	PAT No.	%	CMFT No.	%	National
48.	Given clear written information about what should / should not do post discharge	8	62%	16	44%	85%
49.	Staff told patient who to contact if worried post discharge	13	93%	15	73%	94%
50.	Family definitely given all information needed to help care at home	6	40%	13	31%	60%
	ARRANGING HOME SUPPORT	PAT No.	%	CMFT No.	%	National
51.	Patient definitely given enough care from health or social services	7	58%	10	40%	59%
	HOSPITAL CARE AS A DAY PATIENT / OUTPATIENT	PAT No.	%	CMFT No.	%	National
52.	Staff definitely did everything they could to control side effects of radiotherapy	1	100%	2	100%	79%
53.	Staff definitely did everything they could to control side effects of chemotherapy	10	77%	4	50%	81%
54.	Staff did everything they could to help control pain	8	89%	9	44%	82%
55.	Hospital staff definitely gave patient enough emotional support	7	64%	13	54%	70%
	OUTPATIENTS APPOITMENTS WITH DOCTORS	PAT No.	%	CMFT No.	%	National
56.	Doctor had the right notes and other documentation with them	16	100%	16	88%	96%
	CARE FROM YOUR GENERAL PRACTICE	PAT No.	%	CMFT No.	%	National
57.	GP given enough information about patient's condition and treatment	11	85%	11	73%	95%
58.	Practice staff definitely did everything they could to support patient	10	71%	13	46%	66%
	YOUR OVERALL NHS CARE	PAT No.	%	CMFT No.	%	National
59.	Hospital and community staff always worked well together	12	71%	17	41%	63%
60.	Given the right amount of information about condition and treatment	17	94%	12	75%	88%
61.	Patient offered written assessment and care plan	5	31%	12	33%	22%

62.	Patient did not feel that they were treated as a "set of cancer symptoms"	11	65%	16	69%	81%
63.	Patient's rating of care "excellent' / ' very good'	17	80%	16	75%	89%

4.2. Progress

Some of the key issues that arose from the survey were:

- Patients felt they were seen as soon as necessary
- No full explanation of purpose of tests
- Poor written information
- Patients weren't informed they could bring along a relative or friend
- Many did not understand explanation of what was wrong
- Could do better in taking patients' views into account
- Treatment decisions were not always clear
- Some patients felt it was difficult to contact their CNS
- There were good results in regards to the research questions and many patients went on to take part in research
- Poor results on information on financial help
- Didn't feel there were enough nurses on the wards
- Patients felt they weren't able to discuss worries or fears with staff
- Written information regarding post-discharge treatment was poor
- Good overall score for their treatment or care

In late 2014 Manchester Cancer and Macmillan Cancer Support agreed to work in partnership to develop genuine user involvement in cancer services in Greater Manchester. This partnership agreement saw the commitment of over £300,000 from Macmillan to fund a dedicated five-strong user involvement team for Manchester Cancer. This team will be responsible for ensuring that Pathway Boards have good patient and carer representation and also for supporting the wider patient experience work of boards. The first members of this team began in post in June 2015 and the whole team will be in place by the end of August.

4.3. Challenges

The HPB Pathway Board has identified that there is an unequal provision of HPB Clinical Nurse Specialists (CNS) across the region. This has been escalated to the Manchester Cancer Medical Director for discussion at Provider and Cancer Lead Boards.

Table 4.2 HPB CNS Provision among Manchester Cancer Hospitals.

TRUST	**WTE**	**CASELOAD PA**
Bolton	35 hrs.	109 (15 benign)
CMFT	3.4	>600 CMFT / PAHT

Christie	1.0	356 & 117 NET
Macclesfield	1.0 +upper GI	no data
*Pennine	0	
Stockport	12 hrs.	125
Salford	1.0	47
Trafford	18hrs	new to post Dec 14
Tameside	0.50 not solely HPB	Tracked 90 saw 37
Wigan	1-0	162 (40 benign)
*Wythenshawe	0	

5. Increasing research and innovative practice

Research Report

The HPB Board regularly receives research reports and discusses these at Pathway board meetings. The research lead is Prof. Juan Valle, Professor & Honorary Consultant in Medical Oncology, University of Manchester.

The Hepato-pancreato-biliary Portfolio trials report is added as Appendix 3 of this annual report. Data source: NIHR Portfolio - Open Data Platform

Peer reviewed publications by HPB sMDT & Pathway Board members 2014-15

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5.1. Progress

5.1.1 The Manchester Cancer Jaundice Pathway:

The Manchester Cancer Jaundice Pathway sits within the HPB Pathway board's strategy for improving outcome in HPB cancer. Briefly, research, early diagnosis, timely referral and improved pathways, reduction in post-operative morbidity and mortality and improved oncology, have been identified as the five key areas by which this may be achieved. The MC Jaundice Pathway provides for earlier diagnosis as well as timely referral and improved pathways.

The MC Jaundice Pathway provides for earlier diagnosis as well as timely referral and improved pathways. The key innovations are twofold:

1. Same day definitive radiological imaging for patients presenting with obstructive jaundice not due to gallstones. The purpose is to provide for earlier diagnosis and timely referral and to improve patient experience.

2. Fast-track referral for jaundiced patients with pancreatic cancer for early surgery. The aim is to reduce overall complications and prolong survival.

Measuring the outcome:

The impact of this proposal will be measured in terms of Quality Improvement. The Institute of Medicine report "Crossing the Quality Chasm", defined quality based upon six aims for improvement, which have become accepted definitions of the dimensions of quality.

Effectiveness; "avoiding both the overuse of ineffective care and the underuse of effective care".

- *Post-operative Complication rates* (according to definitions of the Manchester HPB Quality Improvement Program).
- *Post-operative Mortality rate*
- *Pathological stage*; tumour size, nodal involvement, resection margin involvement
- *Disease-free and overall survival*

Efficiency; "The reduction of waste…and the total cost of care".

- *Time-to-diagnosis*
- *Time-to-treatment*
- *Total length of stay*
- *Total hospital costs*

Patient Centeredness; "respecting the individual patient's choices and needs".

- *Patient satisfaction questionnaire (CPES)*

Safety; "avoiding injuries to patients from the care that is intended to help them".

- *Complication rates*
- *Death rate*

Timeliness; "continually reducing waiting times and delays".

- *Time-to-diagnosis*
- *Time-to-treatment*
- *Total length of stay*

Equity; “closing racial and ethnic gaps”. This will be monitored via the patient satisfaction questionnaire and demographic data from patient registration.

The Manchester Cancer Jaundice Pathway - Progress to date:

We have successfully obtained funding for implementation of the Jaundice Pathway through the Acceleration, Coordination and Evaluation (ACE) program. This is co-funded by NHS England, Cancer Research UK and Macmillan Cancer Support.

Application Reference: C48863/A20664
Funding Scheme: Cancer Research UK’s Executive Board - ACE Programme
Application Title: The Manchester Cancer Jaundice Pathway
Award Review Category: Full Duration
Expected Start Date: 1 February 2015
Total Duration of Agreed Support: 12 months
Instalment Financial Summary: £68,000.00

Jaundice Pathways

Data from the initial site (Macclesfield General Hospital) to provide a one-stop diagnostic service for jaundiced patients was presented at the Manchester Cancer HPB Pathway Board meeting on 6 May 2015. Of 28 patients referred, 7 had a diagnosis of cancer. All had completion of investigation within 2 weeks. Similar pathways are being established at other referring hospitals (e.g. Stockport, Pennine Acute Trust).

Surgery

The amount of patients suitable for early surgery has decreased within the past 12 months, due to the introduction of clinical trials of neoadjuvant therapy (ESPAC5F) and the anticipated introduction of a Prehabilitation Program at Central Manchester Foundation Trust. Hence, the use of early surgery as an important outcome measure has assumed lesser significance compared with less morbidity & mortality and survival outcomes.

Recruitment of Jaundice Nurse and Data Collector

Both posts have been advertised internally within the Trust and externally. The opportunity to recruit to the jaundice nurse position at a recent clinical nurse specialist interview was unsuccessful as there was no suitable applicant.

Figure 5.1. Manchester Cancer Strategy for improving outcomes in HPB cancer

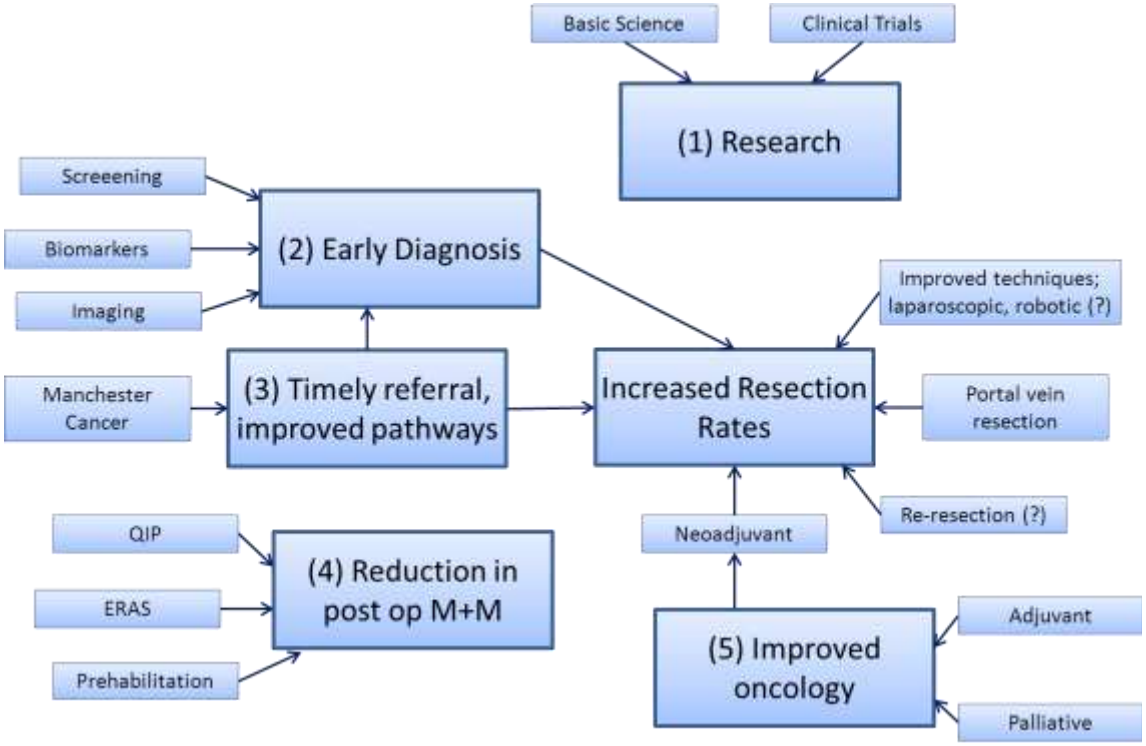
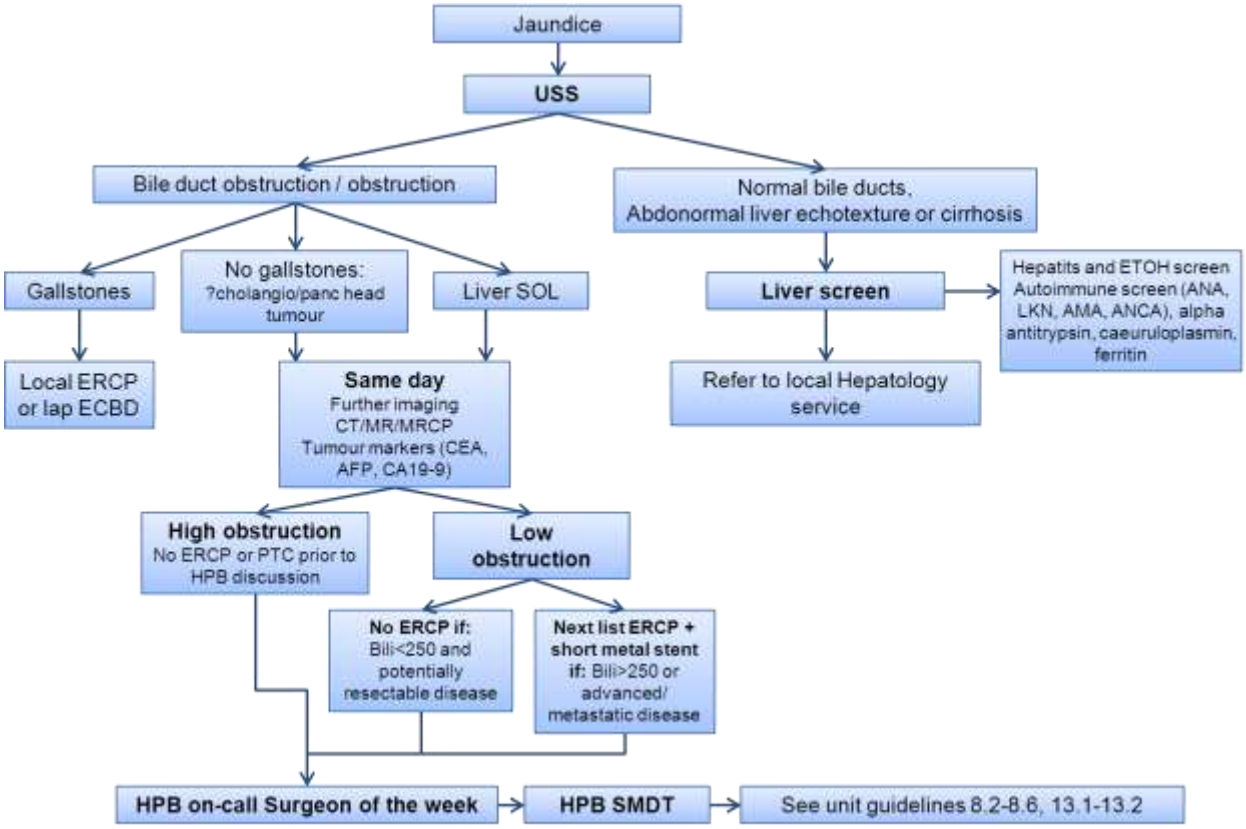


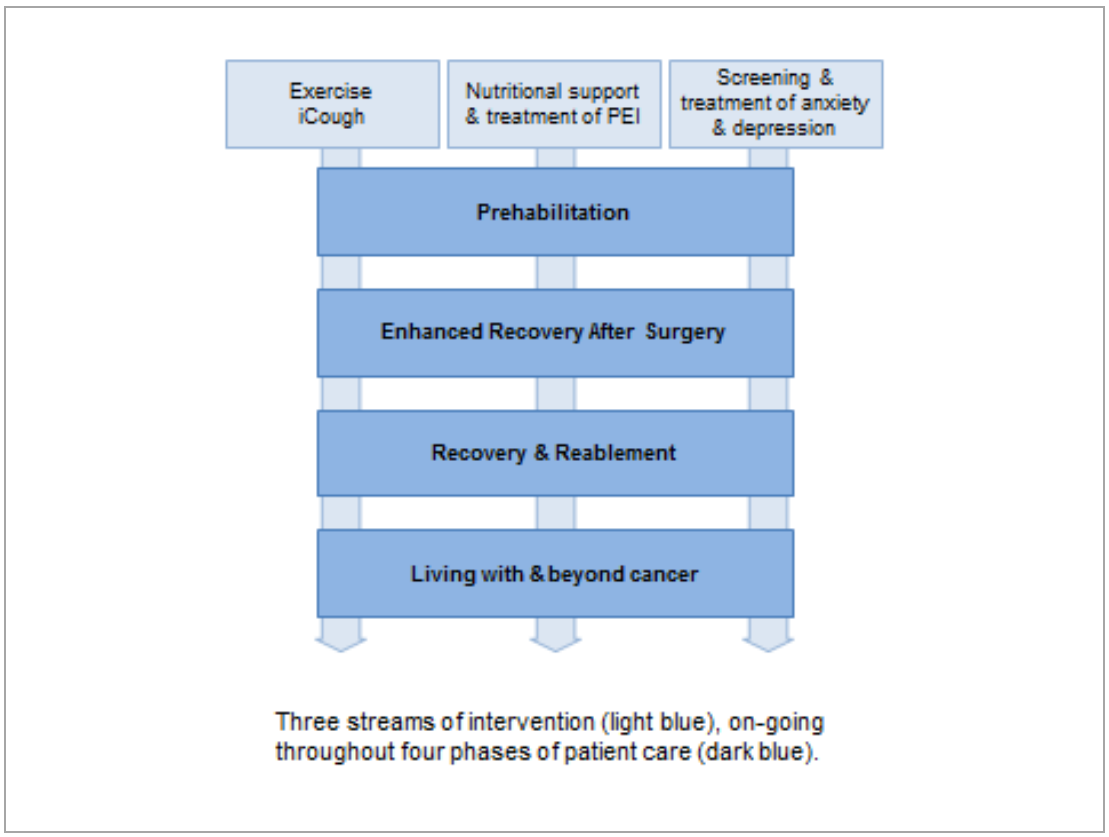
Figure 5.2. The Manchester Cancer Jaundice Pathway.



5.1.2 The Manchester Cancer Prehabilitation Program

The HPB Pathway Board submitted a grant application to the Macmillan Living With and Beyond Cancer Innovation Fund in January 2015. This was *"An Integrated program of Nutritional support; Exercise and improved general well-being; and Screening for anxiety and depression, right across the four phases of: Prehabilitation, Enhanced recovery, Recovery/reablement and Living with and beyond cancer".* Although unsuccessful, an invitation was extended to enter discussion with Macmillan with a view to a reapplication with a revised application.

Figure 5.3: overview of the integrated programme of exercise and wellbeing, nutritional support and screening for anxiety and depression



Prehabilitation

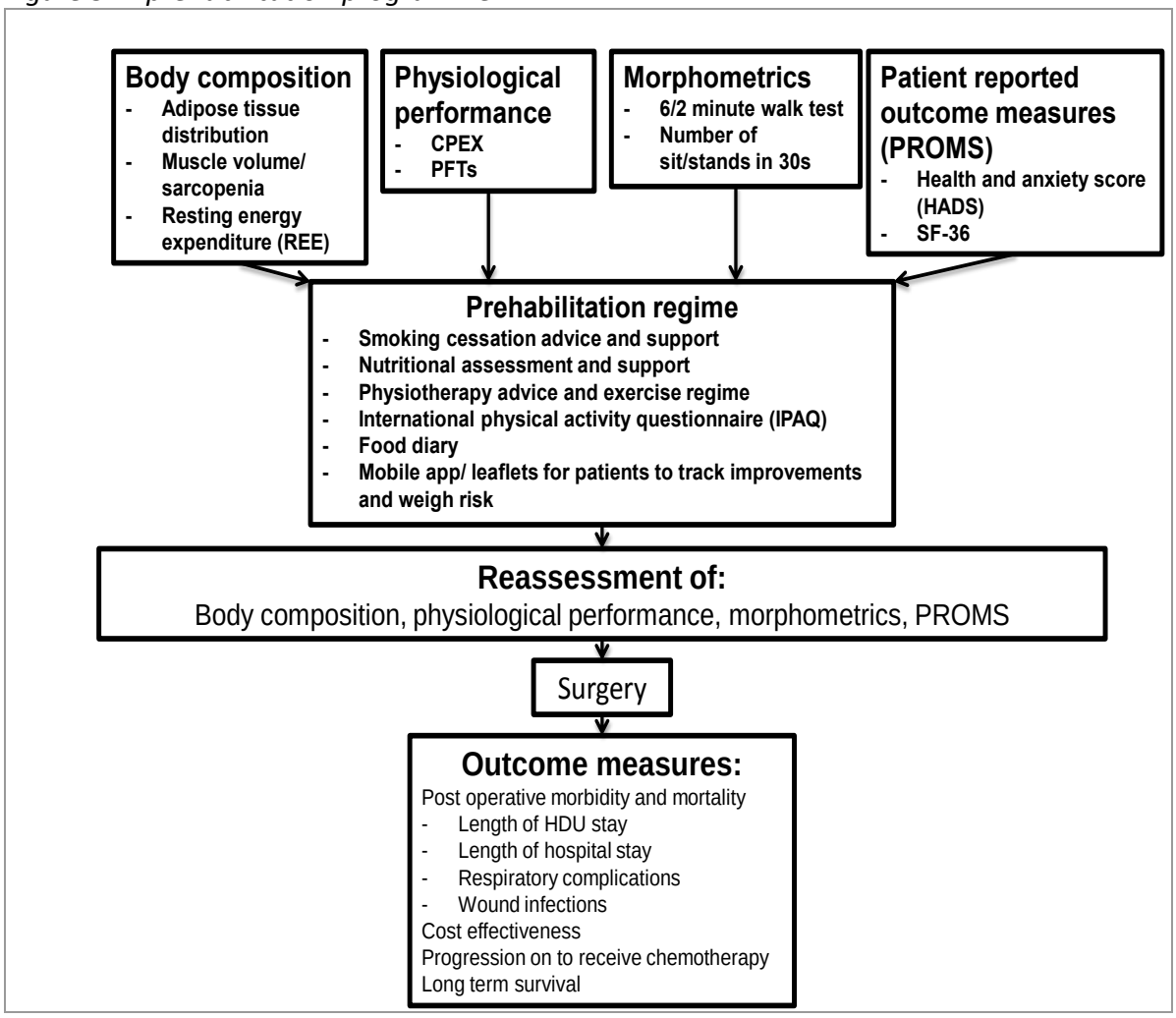
All new patients will be seen in a prehabilitation clinic prior to commencement of planned treatment. Patients with HPB cancer who are about to undergo surgery will have a comprehensive prehabilitation programme, providing:

- A structured exercise regimen – supported by the use of the international physical activity questionnaire (IPAQ)
- Nutritional assessment and food diaries
- Management of malnutrition caused by exocrine failure in pancreatic cancer

- Physiotherapy advice
- Psychological support (including for smoking and alcohol dependency)

Figure 5.4 below outlines the prehabilitation part of the programme.

Figure 5.4: prehabilitation programme



The programme will also include a prospective analysis of patients receiving a full nutritional assessment, pancreatic exocrine insufficiency (PEI) diagnosis tests and dietician education, to assess the impact on diagnosis, cancer-related treatment and outcome.

Enhanced recovery after surgery

An innovative form of enhanced recovery will be introduced that helps people recover more quickly after major surgery. A US multidisciplinary pulmonary care programme (ICOUGH) has been adapted and transferred into an NHS setting (iCoughUK) by CMFT in collaboration with Boston Medical Centre. iCough will be incorporated into an expanded ERAS programme (ERAS+) which also covers the 6 weeks before and after surgery (i.e. prehabilitation and rehabilitation).

The development of an ERAS+/iCoughUK responsive intranet will support patient prehabilitation exercise with patients able to interact with bespoke electronic patient diaries and mapping of exercise. It will be adaptive to different platforms: desktop, laptop, tablet and mobile devices. This will support the patient and staff information, education and training in the elements of ERAS+.

These innovations will be supported by video tuition tools and a new innovation 'Surgery School': a weekly outpatient meeting where ERAS+ is explained to patients and families alongside other aspects of anaesthesia and peri-operative care.

Recovery and reablement
The ERAS+/iCough programme will continue during the recovery and reablement phase.

Living with and beyond cancer
Patients will receive on-going dietary, exercise and psychological well-being support during the living with and beyond cancer phase with the overall aim of improving the well-being of HPB cancer survivors.

5.2. Challenges

Research and Innovation is strength of the HPB Pathway board with a strong track record of leadership in academic activities: exceeding trial recruitment targets; high impact peer-reviewed publications; and the introduction of innovative treatments.

The challenges for the next year are:

1. To increase recruitment to clinical trials and observational studies
2. To obtain high impact peer reviewed publications
3. To fully implement the Jaundice Pathway in as many trusts within the region as possible
4. To obtain funding for the Prehabilitation Program

6. Delivering complaint and high quality services

6.1. Information

From October 6, 2014, a single IOG compliant HPB Service has been located at the Manchester Royal Infirmary, Central Manchester NHS Foundation Trust (CMFT). This is the result of the merger of the two previous HPB Units at the MRI and North Manchester General Hospital, Pennine Acute Trust. Data collected on the Somerset system does not distinguish between HPB and Oesophago-gastric cancer MDT's; both are recorded as "Upper GI".

Table 6.1 CMFT Upper GI Cancer Performance - Quarterly Figures - 2014-15

	Q1 Pathways	Q1 Breaches	Q1 (%)	Q2 Pathways	Q2 Breaches	Q2 (%)	Q3 Pathways	Q3 Breaches	Q3 (%)	Q4 Pathways	Q4 Breaches	Q4 (%)
62 Day Urgent Referral to Treatment	8	3.5	56	3.5	0	100	11.5	1	91	19.5	4	79
31 Day First Treatment	20	0	100	8	2	75	46	0	100	50	0	100
2 Week Wait	130	0	100	149	5	96	165	3	98	192	5	97
62 Day Consultant Upgrade	2	1	50	0	0	N/A	10.5	0	100	6	1	83
31 Day Subsequent Treatment - Surgery	4	0	100	5	0	100	7	0	100	12	0	100

6.2. Progress

- The North Manchester General Hospital and Manchester Royal Infirmary (MRI) units merged on a single site at the MRI on 6 October. The merger process has been harmonious and successful.
- The Manchester Cancer Hepato-Pancreato-Biliary (HPB) Pathway Board has been successfully established. There is active representation for all ten trusts in Greater Manchester and Cheshire that comprise Manchester Cancer as well as primary care.
- An on-call rota of consultant HPB surgeons is available, 24/7, 365 days a year, for the MDT's post-operative patients and HPB emergencies, including trauma. An on-call rota of consultant interventional and vascular radiologists is also available, 24/7, 365 days a year, for the MDT's patients.
- A comprehensive set of clinical guidelines and treatment algorithms for HPB has been created. Thus, the entirety of HPB patient management is protocol-based and accords with the latest evidence and international guidance. This process has involved all members of the new sMDT, as well as representatives from the local referral/diagnostic teams. They may be found at: http://manchestercancer.org/services/hepato-pancreato-biliary/

    1. Preface, table of contents and introduction

    2. The Greater Manchester and Cheshire HPB sMDT

    3. HPB cancer service in Greater Manchester and Cheshire - model of care

    4. Manchester cancer pathways

    5. Assessment & management of liver metastases

    6. Hepatocellular carcinoma

    7. Benign liver conditions

    8. Perihilar and intrahepatic cholangiocarcinoma

    9. Management of gallbladder disease

    10. Acute pancreatitis

    11. Chronic pancreatitis

    12. Pancreatic cystic lesions

    13. Pancreatic cancer

    14. Neuroendocrine tumours

    15. General perioperative management

    16. HPB trauma

17. Selected references

- Comprehensive Chemotherapy algorithms have also been produced:

Table 6.2 HPB Pathway Board Chemotherapy algorithms. Standard (off-study) systemic therapy options if clinical trial is not an option (always consider clinical trial if available)

	Adjuvant	1st-line advanced	2nd-line advanced
Pancreas, adenocarcinoma	**Gemcitabine** **5-FU/LV (MdG)**	**Nab-paclitaxel-Gem** **GemCap** (PS 0-1) **Gem** (PS 2) **FOLFIRINOX** (PS 0-1) **CisGem** (PS 0-1) - (Likely more favourable if suspected BRCA mutation)	**OxMdG** **CisGem** - (Likely more favourable if suspected BRCA mutation)
Biliary Tract adenocarcinoma	Awaiting outcome of BILCAP adjuvant clinical trial – no standard therapy [Capecitabine or Gemcitabine offered in some institutions – no randomised evidence]	**CisGem** (PS 0-1) **Gem** (PS 2, but Valle et al. NEJM paper included PS 2 patients so should discuss with Consultant)	No standard treatment (consider clinical trial – ABC-06) **SIRT** a possibility if liver predominant disease
HCC	None	**Sorafenib** (CDF) or trial	Consider clinical trial
Pancreatic NET (G1/G2)	None	**Somatostatin analogue** **Everolimus** (CDF) **Sunitinib** (CDF) **Strep/Cap** **Tem/Cap**	**Everolimus** (CDF) **Sunitinib** (CDF) **Strep/Cap** **Tem/Cap**
GI NET (non-pancreatic) (G1/G2)	None	**Somatostatin analogue** **Strep/Cap** **Interferon-α**	
G3 NET	Consider **Cis/Etop**	**Carbo/Etop**	**Strep/Cap** **Tem/Cap** **Irinotecan/5-FU combination**

Table 6.3 Details of some more frequently used chemotherapy regimens

5-FU MdG	Folinic acid 350mg IV day 1; Fluorouracil 400mg/m^2 IV bolus day 1 followed by 2800mg/m^2 continuous infusion over 46 hours; 14-day cycle; 6-12 cycles *Neoptolemos JP, Stocken DD, Bassi C. et al. Adjuvant chemotherapy with fluorouracil plus folinic acid vs gemcitabine following pancreatic cancer resection: A randomized controlled trial. JAMA 2010;304:1073-1081*
Cis/Gem	Gemcitabine 1000mg/m^2 IV day 1, 8; and cisplatin 25mg/m^2 day 1, 8; 21-day cycle; 4-8 cycles *Valle J, Wasan H, Palmer DH. et al. Cisplatin plus gemcitabine versus gemcitabine for biliary tract cancer. N Engl J Med;362:1273-81)*
FOLFIRINOX	Oxaliplatin 85 mg/m^2 IV day 1; Leucovorin 400mg/m^2 IV day 1; Irinotecan 180mg/m^2 day 1; Fluorouracil 400mg/m^2 IV bolus day 1 followed by 2400mg/m^2 continuous infusion over 46 hours; 14-day cycle; 6-12 cycles *Conroy T, Desseigne F, Ychou M. et al. FOLFIRINOX versus gemcitabine for metastatic pancreatic cancer. N Engl J Med 2011;364:1817-25*
Gem/Nab-paclitaxel	Nab-paclitaxel 125mg/m2 IV followed by Gemcitabine 1000mg/m2 IV, days 1, 8, 15, 28 day schedule; 6 cycles as tolerated *Von Hoff DD, Ervin T, Arena FP. et al. Increased survival in pancreatic cancer with nab-paclitaxel plus gemcitabine. N Engl J Med 2013;369:1691-703*
Gemcitabine	Gemcitabine 1000mg/m^2 IV day 1, 8, 15; 28-day cycle; 3-6 cycles *Burris HA, Moore MJ, Andersen J et al. Improvements in Survival and Clinical Benefit With Gemcitabine as First-Line Therapy for Patients With Advanced Pancreas Cancer: A Randomized Trial. J Clin Oncol, Vol 15, No 6 (June), 1997: pp 2403-2413 2403*
GemCap	Gemcitabine 1000mg/m^2 IV day 1, 8, 15; and Capecitabine 830mg/m2 bd po days 1-21; 28-day cycle; 3-6 cycles *Cunningham D, Chau I, Stocken DD. et al. Phase III randomized comparison of gemcitabine versus gemcitabine plus capecitabine in patients with advanced pancreatic cancer. J Clin Oncol 2009;27:5513-8*
OxMdG	Oxaliplatin 85mg/m^2 IV day 1; Folinic acid 350mg IV day 1; Fluorouracil 400mg/m^2 IV bolus day 1 followed by 2400mg/m^2 continuous infusion over 46 hours; 14-day cycle; 6-12 cycles *Oettle H, Reiss H, Stieler JM. et al. Second-line oxaliplatin, folinic acid and fluorouracil versus folinic acid and fluorouracil alone for gemcitabine-refractory pancreatic cancer: outcomes from the CONKO-003 trial. J Clin Oncol 2014;32:2423-9*
Tem/Cap	Capecitabine 1500mg/m^2/day (orally, divided twice daily, maximum 2500mg/m^2) on day 1-14, and Temozolomide 150-200mg/m^2/day (orally divided twice daily) on days 10-14, with the next two weeks off, in a 28 day cycle: 6 cycles *Fine RL, Gulati AP, Tsushima D. et al. Prospective phase II study of capecitabine and temozolomide (CAPTEM) for progressive moderately, and well-differentiated metastatic neuroendocrine tumors. J Clin Oncol 2014;32 (suppl 3:abstr 179)*

6.3. Challenges

The Manchester Cancer endoscopic ultrasound audit
The HPB Pathway Board has identified endoscopic ultrasound (EUS) as a diagnostic technique suitable for a regional audit**.**

The aim of this audit is to fulfil the governance requirement to evaluate the performance and quality of EUS provided by a number of practitioners across five different Trusts in Greater Manchester & Cheshire (CMFT, UHSM, PAT, SRI and Wigan) under the independent auspices of the Manchester Cancer HPB Pathway Board.

Methods:

1. Approval will be obtained for this audit from the Manchester Cancer: HPB Pathway Board, the Medical Director (Mr. David Shackley), the Trust Leads Board and the Provider Board.

2. An organisational questionnaire will be sent to each Medical Director of trusts within the Manchester Cancer region for completion/delegation to complete (Table 1).

3. A retrospective audit of all EUS reports and consent forms will be undertaken based on the quality standards of the American Society for Gastrointestinal Endoscopy (ASGE) 2014 and the Joint Advisory Group (JAG) of the British Society of Gastroenterology (BSG) 2007, (Table 2 & 3).

4. The scope of the audit will be restricted to EUS performed for benign or malignant pancreatic or biliary disease.

5. The time period will be from 01.01.2014 to 31.12.2014.

6. Institutional Questionnaires, EUS reports and consent forms will be scored for compliance with predefined goals (Table 4 & 5).

7. Scoring will be undertaken independently by clinicians delegated by the EUS audit subcommittee of the Manchester Cancer HPB Pathway Board.

8. A positive score will be awarded for the correct performance of a quality indicator when there has been the opportunity for correct performance.

9. The results will be compiled and disseminated by the Manchester Cancer HPB Pathway Board; opportunities for improvement will be identified and recommended via the Manchester Cancer structure/Provider Board.

	Table 6.4 Quality Indicators for Manchester Cancer EUS Audit	**ASGE target (%)**	**JAG performance target**
1.	Frequency with which EUS is performed for an indication that is included in a published standard list (see Table 3) of appropriate indications and the *indication* is documented.	>80	
2.	Frequency with which consent is obtained, including specific discussions of risks associated with EUS, and fully documented.	>98	
3.	Frequency with which the appearance of relevant structures is documented: visualisation of the entire pancreas, evaluation of the pancreatic duct.	>98	
4.*	Frequency with which pancreatic cancers are T and N staged with the American Joint Committee on Cancer (AJCC)/Union for International Cancer Control (UICC) TNM staging system.	>98	
5.	Frequency with which pancreatic mass measurements are documented along with evaluation for vascular involvement, lymphadenopathy.	>98	
6.	Rate of adequate samples in all solid lesions undergoing EUS-FNA (an adequate sample is defined by the presence of cells/tissue from the representative lesion in question).	>85	>75
7. **	Rate of adequate samples in all cystic lesions undergoing EUS-FNA (an adequate sample is defined by the presence of cells/tissue from the representative lesion in question or diagnostic biochemistry).		
8.*	Diagnostic rates and sensitivity for malignancy in patients undergoing EUS-FNA of pancreatic masses.	>85	
9.*	Incidence of adverse events after EUS-FNA (acute pancreatitis, bleeding, perforation and infection).	Acute pancreatitis <2%, perforation <0.5%, bleeding <1%	Total <1%
10.	Use of flumazenil, naloxone, need for ventilation or oxygen saturation <90%		General Quality and safety indicators
11.	Unplanned admissions and/or operations within 8 days of procedure.		General Quality and safety indicators
12.	30-day mortality rate		General Quality and safety indicators
13.	Need for a repeat EUS procedure(s).		
14.	Time from date of SMDT decision to date of EUS (days)		

Table 6.5 Manchester Cancer HPB EUS Audit Group:

Name	Job Title	Organisation
Derek O'Reilly	Consultant HPB Surgeon & HPB Pathway Clinical Director	CMFT & Manchester Cancer
Giorgio Alessandri	HPB Clinical Fellow	CMFT
Harry Kaltsidas	Consultant Gastroenterologist	UHSM
Jo Puleston	Consultant Gastroenterologist	CMFT
Alistair Makin	Consultant Gastroenterologist	CMFT
Rob Willart	Consultant Gastroenterologist	CMFT
Luke Williams	Consultant Radiologist	SRI & CMFT
Richard Keld	Consultant Gastroenterologist	Wigan
Durgesh Rana	Consultant Cytopathologist	CMFT
Miles Holbrook	Consultant Cytopathologist	CMFT
Ajith Siriwardena	Professor of HPB Surgery	CMFT
Juan Valle	Professor of Medical Oncology	Christie

7. Objectives for 2015/16

1. To fully implement a Regional Jaundice Pathway

2. To implement a Prehabilitation Programme: *Nutritional Exercise and Psychological Assessment &Support.*

3. To conduct a regional EUS audit

4. To improve Patient representation on the pathway board and patient experience

5. To maintain recruitment to clinical trials and observational studies in excess of national targets

6. To maintain a high level of engagement in all ten trusts, including the provision of educational events.

For full details see the Board's full 2015/16 annual plan in the appendix 2.

Appendix 1 – Pathway Board meeting attendance

NAME	ROLE	TRUST	14/04/2014	24/06/2014	18/09/2014	13/11/2014	23/01/2015	20/03/2015	06/05/2015
Derek O'Reilly	Pathway Director		✓	✓	✓	✓	✓	✓	✓
Caroline McCall	Pathway Manager		✓	✓	**Tom Pharaoh**	✓	Apologies	**Melissa Wright**	**Tom Pharaoh**
Amanda Corfield-Halliwell	CNS	Bolton			✓	✓			✓
Dr Amanda Law	Consultant Radiologist								
Dr Mahesh Bhalme	Consultant Gastroenterologist/ Hepatologist				✓	✓			✓
Mr Joseph Varghese	Consultant Surgeon								
Dr Mairead Macnamara	Consultant in Medical Oncology	Christie			✓	✓		✓	
Professor Juan Valle	Consultant in Medical Oncology	Christie	✓	✓	✓	✓	Apologies	Apologies	✓
Professor Ajith Siriwardena	Consultant HPB Surgeon	CMFT			Apologies	✓			✓
Mr Thomas Satyadas	Consultant HPB Surgeon			✓	✓				
Claire Newton	CNS								
Dr Konrad Koss	Consultant Gastro-enterologist	East Cheshire	✓	✓		Apologies	Apologies	Apologies	✓
Anna Lewis	Upper GI Clinical Nurse Specialist						✓		✓
Dr Ramasamy Saravanan	Consultant Gastro-enterologist								✓
Debbie Clark	Hepato-Biliary Nurse Specialist	CMFT	✓	✓	✓	Apologies	✓	✓	
Dr Emma Donaldson	Consultant Gastroenterologist	SRFT	✓						
Sr Sharan Ingram	Hepato-Biliary Specialist Nurse						✓	✓	

NAME	ROLE	TRUST	14/04/2014	24/06/2014	18/09/2014	13/11/2014	23/01/2015	20/03/2015	06/05/2015
Dr Mong-Yang Loh	Consultant Radiologist	Stockport	✓	✓		Apologies	✓	✓	✓
Andrew Macdonald	Consultant OG Surgeon	UHSM	✓						
Javaid Iqbal	Consultant Gastroenterologist								
Dr Harry Kaltsidis	Consultant Gastroenterologist			✓	Apologies	✓		✓	✓
Dr Guvinder Banait	Consultant Gastroenterologist	WWL			✓	✓	✓	✓	✓
Vicki Stevenson-Hornby	HPB Cancer Nurse Specialist			✓	✓	Apologies	✓	✓	
Hans-Ulricke Laasch		Christie		✓				✓	✓
Dr Rafik Filobbos	Consultant Radiologis	Pennine		✓	✓	✓	Apologies	✓	✓
Dr Vinod Patel	Consultant Hepatolog	Tameside			✓	Apologies			
Imran Alam		WWL			✓				
Dr Kevin Finn	GP Representative					✓			
Dr Adrian Tang	Consultant Radiologis	Macclesfield				✓		✓	✓
Kirsty Williams	CNS	Stockport				✓	✓	✓	✓
Durgesh Rana	Cytopathologist	CMFT				✓			
Jo Puleston		CMFT					✓	✓	
Dr Martin Prince	Consultant Hepatolog	CMFT				Apologies	Apologies	Apologies	
Luke Williams		SRFT					Apologies	✓	
Melanie Dakha-Taeidy	CNS	Tameside						✓	✓
Khalid Barakat		East Cheshire							✓

Appendix 2 – Pathway Board Annual Plan 2015/16

HPB Pathway Board Annual Plan 2015-16

Pathway Clinical Director:	Derek O'Reilly
Pathway Board Members:	See Annual Report Section 1
Pathway Manager:	Rebecca Price
Date agreed by Pathway Board:	June 2015
Review date:	June 2016

Summary of objectives:

No	Objective	Alignment with Provider Board objectives
1	To fully implement a Regional Jaundice Pathway	1. Improving outcomes, with a focus on survival 2. Improving patient experience 3. Increasing research and innovative practice 4. Delivering high quality, compliant, coordinated and equitable services
2	To implement a Prehabilitation Programme: *Nutritional Exercise and Psychological Assessment &Support.*	1. Improving outcomes, with a focus on survival 2. Improving patient experience 3. Increasing research and innovative practice 4. Delivering high quality, compliant, coordinated and equitable services
3	To conduct a regional EUS audit	1. Improving outcomes, with a focus on survival 2. Improving patient experience 3. Increasing research and innovative practice 4. Delivering high quality, compliant, coordinated and equitable services
4	To improve Patient representation on the pathway board and patient experience	2. Improving patient experience 4. Delivering high quality, compliant, coordinated and equitable services
5	To maintain a high level of engagement in all ten trusts, including the provision of educational events.	1. Improving outcomes, with a focus on survival 2. Improving patient experience 3. Increasing research and innovative practice 4. Delivering high quality, compliant, coordinated and equitable services

Objective 1: To fully implement a Regional Jaundice Pathway

Objective:	*To fully implement a Regional Jaundice Pathway.*
Rationale:	*To reduce diagnostic and treatment delays for patients with pancreatic cancer presenting with jaundice.*
By (date):	*July 2016*
Board measure(s):	• *Post-operative Complication rates (according to definitions of the Manchester HPB Quality Improvement Program,* • *Post-operative Mortality rate* • *Pathological stage; tumour size, nodal involvement, resection margin involvement* • *Disease-free and overall survival* • *Time-to-diagnosis* • *Time-to-treatment* • *Total length of stay* • *Total hospital costs* • *Patient satisfaction questionnaire (CPES)* • *Complication rates* • *Total length of stay*
Risks to success:	*Failure to sustain funding beyond ACE funding commitment. Local commissioners have given support in principle to sustaining funding if project objectives can be achieved*
Support required:	*Support from Manchester Cancer to encourage commissioners to provide on-going funding.*

Work programme

Action	Resp.	By (date)
Recruitment of Jaundice CNS	DOR	August 2015
Recruitment of data collector	DOR	August 2015
Establish ongoing funding commitments from local commissioners	DOR, Manchester Cancer	Feb 2016
Establishment of fast track pancreatic surgery at CMFT	DOR, AS	Mar 2016
Establishment of further one-stop diagnostic sites	DOR, MYL, RF, AT	Mar 2016
Data analysis and completion of initial report	DOR	July 2016

Objective 2: To implement a Prehabilitation Programme: *Nutritional Exercise and Psychological Assessment & Support.*

Objective:	*To implement a Prehabilitation Programme: Nutritional Exercise and Psychological Assessment &Support.*
Rationale:	*To improve mental and physical fitness for surgery, thereby reducing post-operative complications and improving survival.*
By (date):	*July 2016*
Board measure(s):	• *Post-operative morbidity and mortality* • *Prospective assessment of PEI prevalence in the pancreatic malignancy cohort* • *Prospective assessment of anxiety and depression prevalence in HPB cancer patients* • *Length of HDU stay* • *Length of hospital stay* • *Respiratory complications* • *Wound infections* • *Cost effectiveness* • *Rate of progression on to receive chemotherapy and completion rate of chemotherapy* • *Long term survival measures (relapse-free survival and overall survival)* • *Friends & Family Test* • *Cancer patient Experience Survey*
Risks to success:	*Failure to obtain funding for the additional staff members to successfully implement this programme.* *Mitigation: Further grant applications have been made to Macmillan. On-going talks are also being held with CMFT management and Transformation team.*
Support required:	*Support from Manchester Cancer with obtaining Project grants from Macmillan and other outside sources.*

Work programme

Action	Resp.	By (date)
To establish funding for additional personnel (Physio, dietician)	DOR, TP	Nov 2015
To establish a Prehabilitation programme at CMFT	DOR, AS	Feb 2016
To ensure elements of the program continue into LW&BC phase	DOR, TP	July 2016
Initial data collection and analysis in annual report	DOR, RP	July 2016

Objective 3: To conduct a regional EUS audit

Objective:	*To conduct a regional EUS audit*
Rationale:	*To fulfil the governance requirement to evaluate the performance and quality of EUS provided by a number of practitioners across five different Trusts in Greater Manchester & Cheshire (CMFT, UHSM, PAT, SRI and Wigan) under the independent auspices of the Manchester Cancer HPB Pathway Board.*
By (date):	*July 2016*
Board measure(s):	*A retrospective audit of all EUS reports and consent forms will be undertaken based on the quality standards of the American Society for Gastrointestinal Endoscopy (ASGE) 2014 and the Joint Advisory Group (JAG) of the British Society of Gastroenterology (BSG) 2007.See: Table 6.5.*
Risks to success:	*Failure of engagement by Trusts and failure to provide data.* *Mitigation: A broad based writing group has been established from all Trusts involve (See Table 6.5).*
Support required:	*Support from Manchester Cancer to ensure data returns and to inform local commissioners of outcomes.*

Work programme

Action	Resp.	By (date)
To send EUS document and covering letter to all Trust Medical Directors	DOR, RP	August 2015
To send Organisational questionnaire to all Trusts	DOR, RP	August 2015
Data analysis	DOR, RP	Jan 2016
Report & paper written	EUS audit writing group	June 2016
Report Launch	EUS audit writing group	June 2016

Objective 4: To improve Patient representation on the pathway board and patient experience

Objective:	*To improve Patient representation on the pathway board and patient experience*
Rationale:	*To provide a patient voice on the HPB Pathway Board. To ensure that the Pathway changes have patient interests at the centre.*
By (date):	*March 2016*
Board measure(s):	*Named Patient Representative on HPB Pathway Board* *National Cancer Patient Experience Survey Results*
Risks to success:	*Failure to recruit a suitable patient representative.* *Mitigation: Macmillan User involvement lead now appointed. Named patient mentor on pathway board.*
Support required:	*Support from Macmillan User Involvement team to recruit and train patient representative(s).*

Work programme

Action	Resp.	By (date)
Macmillan User Involvement team to present at HPB Pathway Board	DOR, TH	Sept 2015
Presentation of National CPES data at HPB Pathway Board meeting	DC	Jan 2016
Manchester Cancer badged Patient information leaflets	SI	Jan 2016
Provision of training and mentorship to patient representative	TH, MDK, DC	Mar 2016

Objective 5: To maintain a high level of engagement in all ten trusts, including the provision of educational events.

Objective:	*To maintain a high level of engagement in all ten trusts, including the provision of educational events.*
Rationale:	*To fulfil the role of education to as wide a range of public and professional audiences as possible. To provide information on the work of the HPB Pathway Board. To engage clinicians in all Trusts in the improved patient pathways*
By (date):	*July 2016*
Board measure(s):	• *Rotation of pathway Board meetings at each Manchester Cancer Trust.* • *Provision of educational events at each Trust* • *Cancer Symposium* • *GP Education event*
Risks to success:	*Non-engagement by clinicians at Trust events. Failure to secure funding/sponsorship for educational Events.* *Mitigation: All events are well advertised to local MDT's and the wider hospital community. The GP event in 2015 was effective and well attended. Good relationships with Industry have been established.*
Support required:	*Support from Manchester Cancer*

Work programme

Action	Resp.	By (date)
Educational Event , Bolton	DOR, ACH, MB	04.09.2015
Educational Event, Tameside	DOR, MDT, VP	18.11.2015
HPB Research Prize event	DOR, JV	November 2015
GP Educational Event	DOR, RL	Feb 2016
Manchester Pancreas Cancer Symposium 2106	DOR, RP	April 2016

Table 9.1. Key to named personnel responsible for achieving HPB Pathway Board objectives.

DOR	Derek O'Reilly
AS	Ajith Siriwardena
MYL	MY Loh
RF	Rafik Filobbos
AT	Adrian Tang
TP	Tom Pharaoh
RP	Rebecca Price
TH	Tanya Humphreys
MDT	Melanie Dadkhah-Taeidy
DC	Debbie Clark
ACH	Amanda Corfield-Halliwell
SI	Sharan Ingram
MB	Mahesh Bhalme
JV	Juan Valle
EUS Audit Writing Group	Derek O'Reilly, Giorgio Alessandri, Harry Kaltsidas, Jo Puleston, Alistair Makin, Rob Willart, Luke Williams, Richard Keld, Durgesh Rana, Miles Holbrook, Ajith Siriwardena, Juan Valle.

Appendix: Manchester Cancer Provider Board objectives

1. Improving outcomes, with a focus on survival

We aim to:

- have a cancer survival rate for all cancers one year after diagnosis that is consistently higher than the England average for patients diagnosed beyond 2012
- have a one-year survival rate higher than 75% for patients diagnosed in 2018
- narrow the gap with Sweden's one-year survival rate from 12% (now) to 6% for patients diagnosed in 2020
- approach Sweden's one-year survival rate by 2025, and
- have greater than 70% of cancer patients diagnosed in 2020 survive at least five years

2. Improving patient experience

We aim to:

- improve year-on-year the patient experience across the region (as measured by the National Cancer Patient Experience Survey), and
- have the best performance in core patient experience questions of any major city area in England by 2015

3. Increasing research and innovative practice

We aim to:

- increase the proportion of patients involved in clinical trials from 30% to more than 40% by 2019

4. Delivering high quality, compliant, coordinated and equitable services

We aim to:

- support our specialist commissioning colleagues to deliver compliance in the four historically non-compliant specialist cancer surgery services (oesophago-gastric, hepato-pancreato-biliary, gynaecology and urology) by December 2015, and
- maintain regional compliance with the national cancer 62-day waiting time target

Appendix 3 - Hepato-pancreato-biliary Portfolio trials report

HEPATO-PANCREAT
O_Trials_report_FY2(