Greater Manchester
Cancer Services
part of Manchester Cancer

HPB PATHWAY BOARD MEETING

MINUTES

DATE: 14/04/2014

In Attendance:

Mr. Derek O'Neill	**HPB Pathway Director**
Ms. Caroline McCall	**Manchester Cancer Pathway Manager**
Prof. Juan Valle	**Consultant Medical Oncology, The Christie**
Dr. Konrad Koss	**Consultant Gastroenterologist, East Cheshire**
Ms. Debbie Clark	**HPB Clinical Nurse Specialist, Pennine**
Dr Emma Donaldson	**Consultant Gastroenterologist, SRFT**
Dr Mong-Yang Loh	**Consultant Radiologist, Stockport**
Mr. Andrew MacDonald	**Consultant OG Surgeon, UHSM**
Dr. Jac Livsey	**Consultant Oncologist, The Christie**

- **Overview of Manchester Cancer**

CMC gave an overview of the development of Manchester Cancer, including a comparison of adverse cancer survival outcomes for the UK with other European countries as well as regional disparities within the UK, whereby the Greater Manchester has poorer outcomes. She outlined the formation, leadership and composition of the Manchester Cancer provider board and the formation of 20 pathway boards.

- **Aims & Priorities**

The aim of the Manchester Cancer HPB Pathway Board is to improving outcomes. In particular, this means improving survival rates and patient satisfaction.

The key to this is to develop patient-centred diagnostic and referral pathways, which minimise delay and inconvenience.

A survey of board members revealed that failures in a HPB pathway that had had a negative effect on clinical outcome and/or patient experience for a HPB cancer patient were due to both inadequate access to the sMDT/tertiary centre and difficulties in obtaining adequate information from referring hospitals.

Solutions included: a better referral system, clearer clinical guidelines and better bed management.

Great improvements have been seen with the appointment of specialist HPB nurses in a number of referring hospitals. There should be at least 1 HPB CNS in each referring DGH and 4 HPB CNS in the tertiary centre.

There needs to be more frequent contact between the referring clinicians and the sMDT than the weekly MDT meeting. The feasibility of the concept of a daily review of SMDT referrals by a HPB clinician (e.g. the on-call HPB surgeon of the week) should be re-explored. Action may then be taken in time sensitive cases, pending further discussion at the weekly MDT.

The personal links between HPB surgeons and local colorectal and upper GI MDT's are valuable in facilitating speedy referral and patient management and should be retained.

It is essential to remain compliant with the terms of National Cancer Peer Review whereby all new cancer patients should be reviewed by a multidisciplinary team for discussion of initial treatment plan.

***Action – To work to achieve an adequate number of HPB CNS in each hospital (All)**
DOR/JV to raise greater responsiveness of the SMDT to referrals at the HPB Joint Implementation Group (JIG) meeting 16.04.2014.

- **New Jaundice Pathway**

DOR presented data indicating the median times from initial ultrasound scan to further investigations and to surgery (appendix 1) as well as survival data from the current North Manchester Unit (appendix 2). He proposed a new jaundice pathway (appendix 3), the key features of which are:

- Same day CT scanning for patients with obstructive jaundice not due to gallstones (Radiologist to make the decision)
- More patients to proceed straight to surgery (within 1 week) without preoperative biliary drainage (if bilirubin <250).

A similar pathway is already in place at East Cheshire NHS Trust and reported to be working well. Sharing what is working well and innovative within each trust is a powerful function of the Pathway Board.

***Action – DOR to raise the new jaundice pathway at the JIG and begin the process of developing a generic business case (DOR/CMC)**

- **Patient and Primary Care Involvement**

It is recognised that to have patient and primary care representatives on the pathway board is essential to making changes and improvements.

There is a MacMillan Patient event planned in June.

DC has two useful forums whereby she may be able to identify and recruit patient representatives. JV also knows a few patients that may be interested and suitable.

Other proposals for finding suitable patient representatives were advertising.

JV also suggested incorporating primary care physicians who already have some knowledge of HPB through clinical sessions or other board membership.

ED raised the issue that clear expectations need to be set out not only for the role of the patient representative but also with regards to what happens at "the end" of the project, e.g., an exit strategy for the patient rep.

***Action – Caroline McCall to distribute details of the MacMillan Patient Event**
DC to identify suitable patients to attend this event
JV to also identify suitable potential patient and primary care representatives.

- **Incorporating Research – Juan Valle**

The incorporation of research aims into the work of the pathway board was emphasised. The aim is to have more patients participating in clinical trials.

Survey data was presented summarising the perceived obstacles to recruitment of patients into HPB clinical trials. These were: lack of awareness of clinical trials by doctors, patient inconvenience (especially the need to travel), lack of patient fitness/poor performance status, lack of suitable clinical trials and poor research infrastructure (especially lack of research nurses and research time for clinicians).

JV emphasised: participation in NCRN studies, developing "Manchester led" studies, the need for more non-intervention studies (e.g. biomarker and quality of life studies)

***Action – JV to update the next meeting about current patient enrolment in clinical trials and review the current portfolio of trials available.**

Database & Data Collection – Jac Livsey

JL presented the Christie centralised system for MDT referral, recording of MDT outcomes, procedures and survival. Specific data fields of interest can be added for each tumour group. This will not only enhance data collection but also facilitate MDT working and patient management. This system has received the support of the Manchester Cancer Provider Board. It allows for the essential function of knowing our outcomes and results, which is essential to the success of Manchester Cancer as well as being a specification requirement of NHS commissioning board

***Action – DOR and JV to pursue development of a HPB system and seek its adoption and implementation in time for the commencement of the new merged HPB service.**

- **Date & Venues for Future Meetings**

Future HPB pathway board meetings will be held at different venues and will be held on different days.

***Action – opinion to be sought by Doodle poll and dates & venues to be circulated (DOR/CMC)**

Appendix 1. Audit of time between investigation and treatment for patients with pancreatic cancer presenting with obstructive jaundice.

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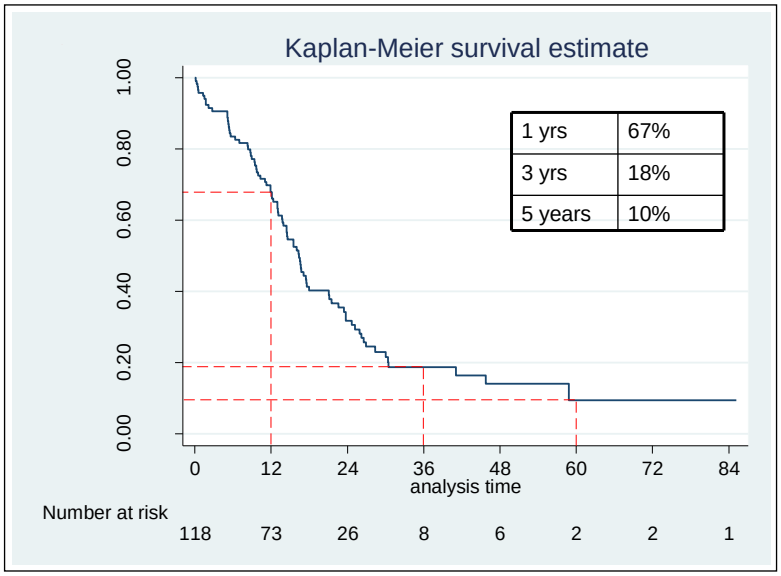
Jaundice; problems with current pathway

- **USS to:**
  - USS to CT time 7 days (median) range (1-156)
  - USS to ERCP time 10 days (median) range (1-189)
  - USS to op time 57 days (median) range (4-156)

- **CT scan to surgery**
  - Median time 33 days (range 1 – 153)
- **ERCP to surgery**
  - Median time 30 days (range 7 – 146)

Appendix 2. Current survival analysis for patients with pancreatic cancer after surgery.

Overall Survival for resected Pancreatic Ductal Adenocarcinoma



Appendix 3. Proposed new Manchester Cancer jaundice pathway