Manchester Cancer

HPB PATHWAY BOARD MEETING

Minutes of the meeting held on 24 June 2014, 2-4pm, at The Christie

IN ATTENDANCE	
Derek O'Neill	Pathway Director
Caroline McCall	Pathway Manager
Juan Valle	Medical Oncology Consultant, The Christie
Konrad Koss	Consultant Gastroenterologist, East Cheshire
Debbie Clark	HPB Nurse Specialist, Pennine
Harry Kaltsidis	UHSM
Dr Mong-Yang Loh	Consultant Radiologist, Stockport
Rafik Filobbos	PAT
Thomas Satyadas	CMFT
Vicki Stevenson-Hornby	WWL
Hans-Ulrick Laasch	Christie
Apologies:	Ajith Siriwardena

Agenda Item	Action
1. Minutes of the inaugural meeting of 14 April 2014 & Matters arising. The minutes of the inaugural meeting of 14 April 2014 were accepted and agreed as a true record of the meeting. Issues arising: It was agreed that further work to pursue funding for the Jaundice Pathway be undertaken.	**DR/CMC to write business case for MC to review**
2. MC Briefing #2: Patient & Carer Involvement & Report of Patient Involvement Event of 23 June 2014. CMC reported on this patient-centred event, which sought ideas on how best to involve patients in the work of Manchester Cancer. There is a requirement for 1-2 patient representatives on each Pathway Board.	**CMC to provide clarification on MC strategy for patient involvement**
3. Patient Feedback and complaint. DC provided a detailed, anonymised complaint from a patient's family with malignant biliary obstruction, identifying opportunities for improvement particularly with: provision of PTC; delays in inter-Trust transfer, communication between Trusts; doctor patient communication. Permission for this use of a formal complaint had been obtained. Regarding the provision of PTC within the MC network, DOR outlined the principles of the NHS Peer Review Manual for Cancer Services Hepato-Pancreato-Biliary Cancer Measures (Appendix 1). Elective PTC is defined as level 2 care and requires the	**DOR & AS to pursue clarification from each of the 10 MC Trusts as to their future plans regarding the provision of PTC. TS to clarify the bed management**

treatment plan to be decided by the specialist HPB MDT. The personnel and the allowed sites are restricted to ones agreed in the network patient pathways, i.e. The MC HPB Pathway Board. Emergency PTC is defined as level 3 care and requires discussion of the case with a core member of the specialist MDT with agreement that only level three care is needed.	**policy at CMFT for jaundiced patients requiring intervention. DC & DOR to feedback to patient's relatives.**
4. MC Briefing #1; Peer Review It is agreed that network-level peer review in 2014/15 will be the responsibility of these Manchester Cancer Pathways Boards with the support of the Manchester Cancer core team.	**None**
5. MC Briefing #3: data and outcome measures It was accepted that the HPB Pathway Board should agree a small number of meaningful measures (typically 10-15) that it will monitor closely. These should be measures that would make sense to a member of the public. MC recommends that core measures in most clinical areas are *likely to include*: i) % of cancers **diagnosis by stage** ii) % cancers **diagnosed as emergencies** iii) cancer **survival** (especially at one year) iv) measures of **patient satisfaction** v) measures of **treatment toxicity** vi) measures of **research involvement** of patients vii) **screening** data, where available.	**DOR & CMC to prepare the draft measures for HPB, to be included in the annual report (due 31.07.14) and agreed at subsequent Pathway Board meetings.**
6. HPB Unit Guidelines; adoption as MC HPB Guidelines DOR outlined the background to the development of a comprehensive set of clinical guidelines for HPB to facilitate working at the new merged sMDT at CMFT. These guidelines are in draft form and cover all aspects of HPB malignancy as well as complex tertiary benign and inflammatory HPB conditions. The draft guidelines have been circulated to both HPB MDTs at PAT and CMFT, as well as the MC HPB Pathway Board, to seek corrections and amendment. It was agreed in principle that the finalised document would be adopted as the MC HPB Pathway Board set of clinical guidelines, as well as that of the new HPB sMDT at CMFT (due to commence Oct 6 2014).	**DOR to collate responses and submit the finalised, corrected document to the CMFT Clinical Governance committee and the merger Project Board.**
7. Research Update JV presented an update on the current state of patient involvement in HPB clinical trials (Appendix 2). It was noted that our recruitment exceeds NCRN Recruitment Targets: 7.5% Cancer/Pre-malignant patients recruited to NIHR Interventional Studies. 20% Cancer/Pre-malignant patients recruited to NIHR studies. JV recommended that continued gains may be made by: further participation in	**JV to provide further research updates as required.**

NCRN studies; developing "Manchester-led" studies; and the need for more non-intervention studies (e.g. biomarker and quality of life studies)	
8. Annual Report The requirement for an annual report and annual plan was discussed. CMC discussed the format and deadline for this report. It was noted that this will be a provisional interim report, given that the MC pathway board directors had only been appointed in Jan 2014. Subsequently, dissemination to HPB Board members and discussion as agenda item at next board meeting.	**DOR and CMC to write a draft plan and report to be submitted by the deadline of 31.07.14.**
9. Membership roles It was acknowledged that Pathway Board members play a key role in the dissemination of information. They should act as a conduit of information between the Pathway Board and their clinical team, sharing freely documents and minutes. They should also link into any local or regional professional groups. Pathway Boards members were reminded of their responsibility to try to prevent any claims of lack of information and involvement from those not on the Board. New Board members (VSH & HK) were warmly welcomed. RF was agreed as the radiology lead; HUL offered his support where interventional radiological expertise was required.	**Deputy representatives are required from each Trust, where these do not already exist.**
10. Dates & Venues for Next meetings Future HPB Pathway Board meetings are scheduled to take place at two monthly intervals. These will take place at each of the ten participating Trusts in turn, with the additional feature of a wider meeting/educational event for the benefit of the local MDT. The day of the meeting will alter on a rolling basis. 18/09/2014 - Wigan 13/11/2014 - CMFT 23/01/2015 - Stockport March 2015 - Wythenshawe May 2015 - Macclesfield It was agreed that the first annual educational event is to be organised for the Spring of 2015.	**VSH to lead on organisation of next meeting in Wigan. DOR to outline plans for annual educational event at next meeting.**
11.AOB. CMC reported that a Manchester Cancer website has been developed at **www.manchestercancer.org**. The website is a means of both internal and external communication and engagement.	

APPENDIX 1.

NHS Peer Review Manual for Cancer Services Hepato-Pancreato-Biliary Cancer Measures

- **Level one care consists of:**
  - Tumour surgical resection
  - Tumour ablative procedures
  - Palliative, biliary, surgical bypass procedures.
  - Nuclear medicine treatment.
  - Percutaneous interventional procedures including SIRT and PVE, except for percutaneous biliary drainage.

- **Level one care needs:**
  - Discussion
  - ...treatment plan decided by...
  - delivery by and..
  - in the specialist HPB MDT's named single site for that treatment.

NHS Peer Review Manual for Cancer Services Hepato-Pancreato-Biliary Cancer Measures

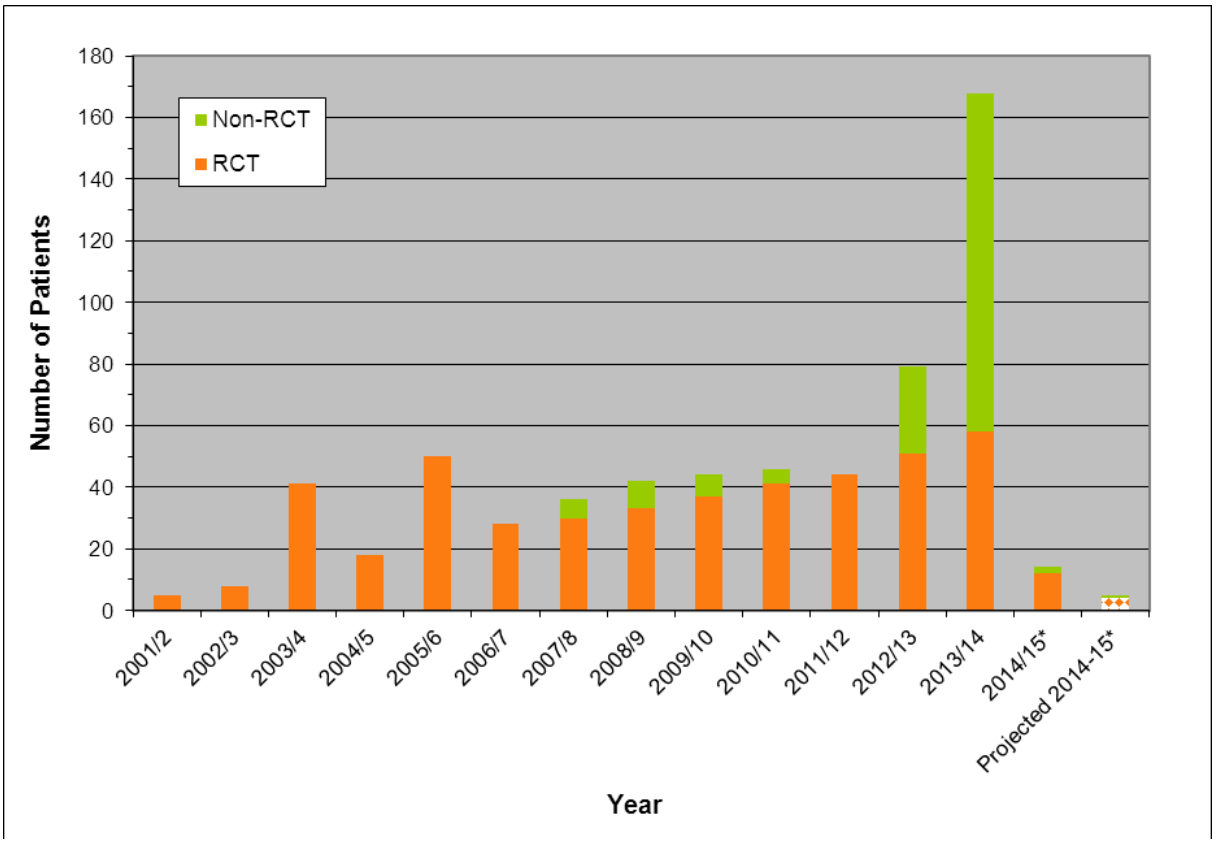
- **Level two care consists of:**
  - Elective percutaneous biliary drainage.
  - All systemic anticancer therapy.
  - Non-palliative radiotherapy.

- **Level two care needs:**
  - Discussion...
  - Treatment plan decided by the specialist HPB MDT.
  - The personnel and the allowed sites ...restricted to ones ***agreed in the network patient pathways***.

NHS Peer Review Manual for Cancer Services
Hepato-Pancreato-Biliary Cancer Measures

- **Level three care consists of:**
  - Emergency percutaneous biliary drainage.
  - Endoscopic, palliative, biliary and/or duodenal stenting.
  - Palliative radiotherapy.
  - Palliative and supportive care
- **Level three care needs:**
  - Discussion of the case with a core member of the specialist MDT with agreement that only level three care is needed.

APPENDIX 2. Number of HPB Cancer/Pre-Malignant Patients Recruited to NIHR Cancer Studies by Year



NCRN Recruitment Targets:
7.5% Cancer/Pre-malignant patients recruited to NIHR Interventional Studies.
20% Cancer/Pre-malignant patients recruited to NIHR studies.

Recruitment Targets for HPB Cancer
RCT = 31 patients
Overall = 82 patients

2014-15 HPB Cancer Recruitment Performance
In 2014-15* has recruited 11 patients to Portfolio cancer/pre-malignant HPB studies, including 9 patients to RCTs and 2 patients to non RCTs.
2013-14 HPB Cancer Recruitment Performance.
In 2013-14, 168 patients were recruited to Portfolio cancer/pre-malignant HPB studies, including 58 patients to RCTs and 110 patients to non RCTs.