Manchester Cancer

HPB Pathway Board

Minutes of meeting on Friday 20th March 2015, Committee Room, Education and Research Centre, UHSM

Attendance	
Name	**Pathway Representation**
Derek O'Reilly	HPB Pathway Director
MY Loh	Stepping Hill Hospital
Luke Williams	Salford Royal
Vicki Stevenson-Hornby	CNS Wrightington, Wigan and Leigh NHS Foundation Trust
Debbie Clark	CNS, CMFT
Rafik Filobbos	CMFT/PAT
Mairead McNamara	The Christie
Hans-Ulrich Laasch	The Christie
Melanie Dadkha-Taeidy	Macmillan acute and rarer cancers CNS, Tameside
Sharan Ingram	HPB CNS Salford Royal Infirmary
Adrian Tang	East Cheshire
Harry Kaltsidis	UHSM
Kristy Williams	CNS, Stepping Hill Hospital
Jo Puleston	CMFT
Melissa Wright	Manchester Cancer
Apologies:	Konrad Koss, Martin Prince, Luke Williams, Juan Valle, Gurvinder Banait.

Agenda Item	Action
DOR welcomed everyone to the meeting. He explained that the meeting would be audio recorded to ensure that the minutes were accurately recorded.	
1. **The minutes** of the meeting of 20th March 2014 were accepted and agreed as a true record of the meeting.	
2. Objective no 1 – Improving outcomes / survival rates **a. Jaundice Pathway/ACE update** DOR reported that this project will attempt to speed up the pathway for those patients with obstructive jaundice, not due to gall stones, to have a same-day CT scan. The patient would be referred to a Jaundice CNS and would also be assessed for suitability for fast-track surgery, with this taking place within a week. The challenge with the revised pathway is ensuring that radiologists within all Trusts were engaged and allocating surgery time for patients within CMFT. DOR indicated that Macclesfield Hospital had adopted a similar model of care some years ago. MYL reported that he was exploring this actively at Stockport.	**Each Trust representative to discuss feasibility and barriers to implementation of the new pathway with their radiology departments in preparation for discussion at next pathway board meeting**
3. Objective no 2 – Improving the patient experience **a. National Cancer Patient Experience Survey 2014** DC explained that the Upper GI data had been split from oesophago-gastric which identified that Pennine had 19 HPB questionnaires returned and CMFT had 17, which DC reflected was a poor response rate. DC highlighted some of the key issues that arose from the survey: see appendix 1.	**DC to clarify the percentage return of questionnaires.**
4. Objective no 3 – Research and clinical innovation **a. EUS Patient Pathways & Audit** **Terms of Reference** DOR explained that the Pathway Board has a set of Terms of Reference, contained within the Annual Report, which indicate that meetings need to be quorate. A Quorum consists of the Pathway Clinical Director plus five members of the Pathway Board or their named deputies. He stated that issues should be resolved by consensus but if this could not be obtained, he proposed that voting may need to take place. The following was agreed for incorporation into the HPB Pathway Terms of Reference: *"Decisions will be made by consensus as far as possible. In the event that this is not achieved, a vote will be taken. Each of the ten trust representatives has an equal vote. The patient and primary care representatives are also voting members. The Pathway*	

Director will not normally vote, except in the event of a tied vote. Deputies may vote in place of the Trust representative if they the latter are absent. A vote is binding if the meeting is quorate". DOR also explained that for the purposes of National Peer Review, the HPB Pathway Board, under the auspices of Manchester Cancer, was the agreed network for Greater Manchester and East Cheshire. The National Peer Review HPB Measures document does not specify where EUS should take place but states that there should be a network arrangement to review and approve the organisation of treatment. DOR emphasised that decision making should take place by identifying what is best for the patient and not be determined by vested interests of trusts or clinicians. **EUS Patient Pathways** DOR explained that there is potential confusion within the current network due to this lack of national guidance on EUS. He explained that he would recommend a single "tertiary" service for Endoscopic Ultrasound (EUS) and complex HPB endoscopy but no change to the provision of these services at secondary care for that hospital's local catchment area. He highlighted that this was the service model that the commissioners specified in their document: *"A Framework Commissioning Specification- The Delivery of 'World Class' Specialist Cancer Surgery Services in the Greater Manchester and Cheshire Cancer System,* i.e. "a single Greater Manchester & Cheshire HPB specialist surgical service operating from a single university teaching hospital site". DOR felt that the level of volume undertaken within the new single unit will improve outcomes, as high volume units reduce mortality from prompt interventions when complications occur and that strong tertiary endoscopy and interventional radiology departments are essential in achieving this. **Regional EUS Audit** DOR also discussed the proposed EUS audit. The draft Audit document has been circulated. The methods for the conduct of the audit are outlined in Appendix 2. **Round Table Discussion:** HK indicated that he felt that he would have been the ideal candidate to lead the audit due to his experience and credentials and rejected any implication that he would be seen as partisan; that clinical decision making for UHSM took place at the SMDT and at the local MDT, attended by a CMFT HPB surgeon, similar to the model for many other trusts; that the South Sector Alliance were in the process of designating UHSM as the ERCP centre; that issues of patient delay for EUS at CMFT had been raised; and that a significant amount of referrals from MC hospitals come directly to UHSM. JP informed the meeting that CMFT has expanded their number of ERCP practitioners to three and there will soon be six EUS clinicians and had the capacity to cope with additional EUS referrals; that there was an implicit understanding that both tertiary surgery and EUS would be centralised as part of the recent HPB merger; that CMFT were not trying to take away local services, that she was happy for Trusts to undertake EUS on patients within their own catchment, subject to audit, but that the	**Members to contact DOR regarding amendments to the EUS Audit document**

establishment of a second "tertiary referral unit" for complex ERCP and EUS Fine Needle Aspiration was unwarranted. AT accepted the importance of having adequate endoscopic support and expertise to deal with surgical complications at the tertiary centre but that providing diagnostic tests locally was important to patients at East Cheshire. LW felt that there had been a lack of coordination in regards to developing services; that individuals and units should be doing the necessary numbers to maintain expertise; would prefer if there was a system of nominating two or three centres to undertake the procedure. KW indicated that Stockport had a large catchment area and many patients were elderly and frail and highlighted that from a patients' perspective, providing a service at a hospital that is more local may be advantageous. SI agreed with this and highlighted that transport to other hospitals may be difficult. VSH thought that the EUS service provided at WWL was excellent and patient choice was crucial, especially with regards to diagnostic services. RF would like to see greater collaboration rather than competition. DC agreed the patients' needs must come first and they should have access to timely diagnostic services.	**Further discussion on the EUS patient pathway at the next meeting** **Decisions regarding where the treatment takes place to be made at the MDT**
b. EUS at the Christie HUL explained that the Christie will be building a new procedure unit with two new interventional rooms which could include provision of EUS-FNA. This would be for patients with locally advanced disease but considered for active management. The majority of cases would be NET or non-HPB cancers and tissue sampling would be mainly for research purposes. It is at preliminary planning stage but he wished to inform the board of this potential development.	**DOR asked HUL to keep the Board informed of developments.**
c. Macmillan Innovation Fund applications DOR and AT explained that both HPB Pathway Board applications to this fund had not been successful.	**DOR to have on-going discussions with LW&BC Pathway Director and Macmillan about future possible funding opportunities for the HPB Board.**
5. Objective no 4 – Improving & standardising high quality care across the whole service **a. Colorectal/Liver METs follow up** DOR explained that Sarah Duff, Pathway Director for Colorectal Cancer, is preparing a document on the management of colorectal liver metastases, based on the HPB Pathway Board Guidelines. It will also likely recommend that these patients will undergo follow-up surveillance by their local referring colorectal departments.	

b. Standardisation of patient information As part of the objective to provide consistent, optimal, written patient information, SI & VSH are working on a biliary stent leaflet and have spoken to patients at Salford Royal to obtain their views.	**SI to email the draft leaflet document to Board members.**
c. The management of Gall Bladder polyps MYL indicated that he had reviewed the algorithm suggested by the UpToDate website. MYL and LW proposed that for polyps of 6-9 mm, the scan should be repeated at 12 months and then 36 months rather than every 6 months. DOR said that he was happy for the pathway to be amended but suggested that the algorithm in the existing HPB guideline document should be retained, for polyps 6-9 mm in high risk groups.	**MYL & LW to produce final management algorithm**
d. Referring patients to the Christie MMN described the referral checklist for HPB patients, which has been developed by the Christie consultants, to standardise the information that they receive and aid optimal patient experience and treatment; see Appendix 3.	
e. Manchester Cancer Briefing #8 – The Responsibilities of Pathway Board members DOR stated that this document sets out the responsibility of Pathway Board members and it was essential for members to communicate the work of the Pathway Board to their departments and to share minutes and communications widely within their trust, to include their local referring MDT's and relevant Clinical Directors.	
6. AOB DOR thanked the local organiser (HK) for his work in organising the venue and hospitality. A MC Educational Event followed lunch with the local MDT (see Appendix 4)	
7. 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, 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.	**Trust representatives to arrange date, times, appropriate venues and refreshments. Organisation of a**

Forthcoming meetings: 06/05/2015 – Macclesfield 04 Sept 2015 – Bolton 26-27 November- this year's Pancreatic Society meeting in Norwich, http://maximillionevents.co.uk/psgbi2015/ 02 Dec 2015 – Tameside Jan 2016 – Salford Royal Infirmary	**lunchtime educational event for the local MDT is encouraged.**

Appendix 1. National Cancer Patient Experience Survey 2014 from PAT & CMFT

Key issues arising from the HPB patient survey:

- Patients felt there 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

Appendix 2. Manchester Cancer HPB Pathway Board
Audit of Pancreato-Biliary Endoscopic ultrasound.

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.

Appendix 3. The Christie HPB Patient Referral Checklist

Hepatobiliary, pancreas, neuroendocrine team:
Medical Oncology
The Christie NHS Foundation Trust, Manchester M20 4BX

Prof. Juan Valle
Dr. Richard Hubner
Dr. Mairéad McNamara

Fax number: 0161-446-3468

Check list of *essential* requirements for new patient referral to accompany letter: (To avoid treatment delay)
(Please complete / tick boxes below and *include all* supportive documentation)

Name (may affix patient label):
Address:
Date of birth:
NHS number:

Eastern Co-operative Oncology group performance status (ECOG PS): ☐

Histological diagnosis with report (required for ALL referrals): ☐

Imaging reports-full staging imaging; Thorax/Abdomen/Pelvis is essential: ☐

Blood results (all referrals) including: ☐

- **Full blood count**
- **Urea and electrolytes**
- **Liver function tests**
- **Tumour markers if appropriate**

Additional requirements specific to hepatocellular carcinoma: ☐

- **Coagulation screen**
- **Alpha-fetoprotein**
- **Evidence of hepatitis B/C status**
- **Report of screening gastroscopy** ☐

Patient informed of diagnosis: ☐

If second opinion; treatment history: ☐

Appendix 4. Local Educational Event at UHSM

A MANCHESTER CANCER EDUCATIONAL EVENT

DATE: 20.03.2015

TIME: 12.30 to 13.30

VENUE: Committee Room in the Education & Research Centre, University Hospital of South Manchester

SPEAKERS

"Hepato-biliary & Pancreatic (HPB) services in the Manchester Cancer Region"

Mr. Derek O'Reilly, HPB Pathway Clinical Director, Manchester Cancer

"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.

.

LUNCH AND MEETING SPONSORED BY BOSTON SCIENTIFIC