HPB PATHWAY BOARD MEETING

Minutes of the meeting of the HPB Pathway Board, held on 19th May 2016 at North Manchester General.

IN ATTENDANCE	
Derek O'Reilly	Pathway Director
Claire O'Rourke	Pathway Manager
Lucie Francis	Macmillan Patient User manager
Steve Sawyer	Patient Representative
Melanie Dadkhah-Taeidy	Macmillan HPB CNS
Saurabh Jamdar	Consultant HPB surgeon
Dr G Banait	Consultant, Gastroenterologist
Debbie Clark	HPB CNS CMFT
Neil Bibby	Dietician CMFT
Jo Puleston	Consultant Gastroenterologist
Saurabh Jamdar	CMFT deputy rep
Sajjad Mahmood	PAT rep
Harry Kaltsidis	UHSM rep
HU Laasch	Christie, consultant radiology
Mairead McNamara	Christie deputy rep
Apologies:	

Agenda Item	Action
1. Minutes of the pathway board meeting of 24th March 2016 DOR introduced latest version of the minutes of the last meeting. **DOR confirmed NICE guidance for Pancreatic Cancer has been adopted and this is fantastic news patient information from MD-T and SS was invaluable** The minutes of the meeting were accepted and agreed as a true record of the meeting. Request to upload minutes as planned. **Matters arising not on the agenda**	

Jaundice pathway-To be discussed and presentation will be given today. **HPB-patient experience survey and questionnaire: DOR discussed the survey:** questions have been adopted from the national survey: **SS** has used and it takes 5 minutes to complete, will be able to give real time data so we will await an update on this. **DOR** expressed the importance of this. **LF** waiting in clinic to do survey, problems being filled out, surveys taken away not often completed. Salford use IPads for all surveys in endoscopy and outpatients and patient survey. **DOR** which hospital did the patient have treatment to track pathways. Completed after treatment 4 weeks- relevant information and this will provide rich data an. **DOR** confirmed we need to review IPad's. Salford can provide all the information regarding governance/ infection control and security. **DOR** discussed patient consent and we need to provide patients with more information, based on supreme court ruling and we need to ensure we are planning to review electronic solutions. **MRI John Moore:** equipment has been ordered just need to ensure the infrastructure is in place to support. **DOR discussed NR funded study for Lap Col:** patients will get a link to the website and patients will have access to the information and asked about their experience and tested on this. **COR** discussed App for patients to access information to be request from PMO team at the Christie. **DOR** updated on the Vanguard brief given at the last board by TF and the current objectives of the HPB board are fulfilling the criteria which is to improve outcomes, advance patient experience and consistent with Research report which JV presented at the last board was noted, no update today but **DOR** will discuss a new adjuvant study later in the meeting.	**Action:** obtain IPads for use at the Christie and CMFT. COR to check information on app
2. Jaundice pathways: **One stop Jaundice Clinic at Pennine: presented by Sajjad Mahmood.** SM is the HPB lead and the work at Pennine. SM started in October 2015 and immediately recognised that a number of patients were experiencing delays in diagnosis and treatment and this was having a significant impact on outcome. Several patient experience examples were discussed and all highlighted inconsistent and delays, all having profound impact on patients as a result. One example young patient 2 week wait referral, patient ended up being admitted to A&E with deranged bloods and delays in ERCP testing potentially operable treatment SM therefore devised a one stop clinic. The Liver CNS nurses look through the referrals on Monday. The referral pathways at present at:	

- Direct GP
- HPB referral
- GP/ ultrasound
- A&E/ MAU, STU (pathway not currently used yet)

Service only cancer patients.

Patients are triaged into the one stop clinic; inappropriate patients for the clinic are referred to SM's normal clinic if required (for example frail patients or patients with dementia).

There have already been tangible benefits to patients, earlier identification of operable cases, earlier interventions such as drainage.

Results 6 clinics 9 patients seen, waiting time to GP to clinic is now 5 days (reduction from 2 weeks). There are dedicated slots in CT/ ERCP intervention within 24 hours, all patients had interventions completed within this time. MDT discussion within 1 week. Results so far indicate that from GP referral to diagnosis is now 12 days, which is a significant improvement based on the examples given as the start of the presentation and his clinic has demonstrated the potential significant impact on patient experience.

The results so far from the clinic have been 2 cancers found both were operable; however the patients had significant co-morbidities which prevented surgery. There were a high number of benign patients, but all have been offered appropriate treatment interventions.

There is a review meeting planned in a month to evaluate the progress and outcomes of the clinic so far.

Work needs to be done to advertise to GP community, this work is still on-going at present to increase the use of the clinic.

DOR congratulated SM on his presentation and highlighted what a fantastic piece of work this has demonstrated so far.

JP discussed poised the question to DOR and SM that this clinic has so far been a lot of work, capturing a small number of patients and would there be benefit of a north/ south regional clinics, in which all patients appropriate for the one stop clinic pathway could be referred into, as it is a resource intense clinic. SM felt that the low number were due to clinicians and GP's being aware of the pathway and numbers will increase significantly.

DOR recognised that a jointed up approach would be required and the potential of joint business case and a review of patient experience this this pathway would be hugely beneficial.

HL asked if there was an improvement on diagnostic waits for patients in this clinic in comparison with patients who were inpatients, concerns that this clinic may delay inpatient waits, however SM thought this was not the case, but obviously this is in the early stage of intervention.

HL asked regarding the patients who are operable but require drainage is there a standard

for this. SM reported that all patients with a bilirubin of 250 have been drained within 24 hours. DOR discussed that this is a standard that needs to be reviewed by the board. For example Macclesfield offer a fantastic service and have been offering this for a number of years. Pennine and CMFT have just started, but DOR recognised a more consistent approach to this is needed. ED discussed the current pathway at Salford. All patients come in on a 2WW pathway , pulling out all UGI patients for example. All patients are contacted and informed that they require additional tests (imaging/ bloods) therefore at clinic attendance all the interventions have been completed, thus speeding up the process. Ward attended not as an inpatient to the investigation unit. There is a similar process of inpatients, to aid discharge. Patient then referred back into investigation clinic. Emma requested to present results of this pathway at the next board. **NWarr (sorry didn't get the correct name)-**stop one jaundice clinics Stockport-to review the plan with senior team for gastroscopy, so a lot of work still required. Tameside-MD-T discussed that there are some significant manpower issues at present and they are often using the ambulatory care team, currently there is a business case in work up for CNS support. DOR requested that the momentum must be kept up on new services and plans and outcomes will be reviewed over the summer.	**Action:** Emma Donaldson from SRFT to report back to next board on development in service at SRFT.
3. Fast Track service at CMFT: One stop Jaundice clinic. Aileen: unable to today so DOR presented. DOR presented that patients are reviewed by Aileen in clinic, review of patient then history taking/ examination. Clinic. Patients refereed for ultrasound- 2 allocated ultrasound slots currently. This is then reported on and Aileen will request interventions as required, i.e. ERCP. Any suspected cancer patients will have CT the same day, currently there are 2 allocated CT slots. There has been excellent support from the radiology team at CMFT and CT scan can be reported the same day. DOR discussed the 6% of pancreatic cancer patients that will be operated on, it essential that these are triaged and treated early. Fast trackers pancreatic Cancer surgery- so far there has been 20 patients referred. 7 operated on main reason for non-referral (13) for surgery-fragility and age. Referrals from across the sector. CNS Natalie at Salford referring on this pathway. Mel and CNS's have been key in getting referrals in. 7 operated on (all cancers). Previously time to Ultrasound was 60 days down to 3 days. CT scan and surgery 1 week. Outcomes for patients have been excellent, shortened LOS and some minor complications. All now progressing to adjuvant chemotherapy, which is a significant improvement on outcome. Processes are working well. HL discussed how allocation of surgical staff is secured, DOR stipulated that there has been some negotiation with clinics and the clinicians on the on call rota keeps list for	**Action:** all to report back on Jaundice pathways and to progress sites that are not as well advanced.

these allocated patients. JO was not aware this clinic was up and running, therefore she will inform all the gastro team as they see a lot of jaundice patients in the haep/gastro clinic. Final summary from DOR: all agreed to progress the less advanced sites and report back to next pathway board. DOR to distribute Aileen's contact details.	
4. Presentation: Neil Bibby (CMFT) Macmillan specialist dietician. DOR discussed the need for patients prior to surgery having work up regarding nutritional assessments and how important this is to maximise patient's compliance for surgery and treatment. Gary the physiotherapist was unable to attend today so Neil is presenting. NB discussed that the new service has been running now for 6 weeks since the 4th April 2016. There have been 26 patients assessed in total, all high risk patients. Patients complete an assessment tool. Weight, history and symptoms are taken by the team. All of the patients had a PG=SGA scores >9 (average 12.5) and patients therefore were identified as needing urgent nutritional assessment. 11 patients for were for whipples, 1 for surgery that this week (at time of meeting). 3 pancreatectomy patients were identified, 2 progressed to surgery and 3 resection patients which have been highlighted as high risk. Every patient seen had lost weight. The current scope of the clinic does not include inpatients. NB discussed that they used a gastro scoring matrix for patients for symptoms. So far average Score is 14, indicating high scores and patients therefore requiring symptom management input. MB discussed a new system of carrying out a nutritional assessment of patients through bloods tests and so far found that a number of patients are deficient in Vitamin D and zinc (for example). NB then writes to the GP to advice and discusses with patients. NB also a new pathway to Screen for diabetics. NB suggested that many patients are undiagnosed, so far one patient found which had raised levels, which will need review. NB has been in contact with the diabetic consultant teams to discuss a plan regarding this. *Results so far*: the review of 2 patients and the outcomes: • First patient had attended for second contact, weight had increased and stabilised. PG =SGA had reduced from 6 to 0. • 2 patient weigh had increased after first contact reporting considerable weight loss. SGA score reduced from 17-2.	

JP commented on the excellent work Neil and the team have done so far and DOR also confirmed this has been an excellent piece of work and recognised the importance of patients requiring a nutritional input and a screen for diabetic early on in the patient pathway. MM discussed the provision of support at the Christie; there is a dietician in clinic which proved invaluable support as well as diabetic nurse support. DOR asked the question to the clinicians what type diabetics will the patients have post removal of pancreas. ED suggested type 2 is often undiagnosed and many patients following surgery will have induced diabetics and require long term insulin usage, after having a cancer diagnosis this has a significant impact on patients. JP suggested there is currently inadequate research in this area and she has endeavoured to get the diabetic consultants, (**Dr Lala-not sure of name**) involved. DOR discussed about the impact on patients and the need to have frank discussions with patients regarding information about the disease and length of time of appointment and those individuals patients come in contact with. DOR asked for a patient view point on this. SS discussed that face to face contact was essential as you are there all day. SS felt that it was essential that clinical staff explain things at each step of the appointment as often they are lengthy appointment, support is essential. SS seeing lots of specialist and he felt a follow up phone call from the specialist nurse would help patients whilst waiting and ease some of the anxiety. DOR discussed the need to review the tele-medicine service for the next board meeting. **Action: telemedicine to be discussed- Saurabh Jamdar lead? Check this was an action**	
5. Jo Puleston presentation on EUS (Endoscopic ultrasound) audit. JP recognised that she has been significantly supported from Jo Geraghty on this project but he could not attend today. JP discussed there is a lengthy plans in place for centralise HBP services in GM and setting out clear performance indicators for this. World case service and better outcomes. In line with new guidance to improve quality, performance in 5 areas with ASGE, with 14 quality indicators. The audit reviewed the last 50 EUS HPB cases in 2014, benign disease Included. 64 sets of notes 14 excluded. The audit only reviewed a month worth of work. Most not FNA, only 3. Massive chronic pancreatitis practice was highlighted, which has affected the quality of the data. The service is carrying out 400 EUS's, radial biliary tree preferred option. Patient's numbers have increased. More EUS operated and more demand	

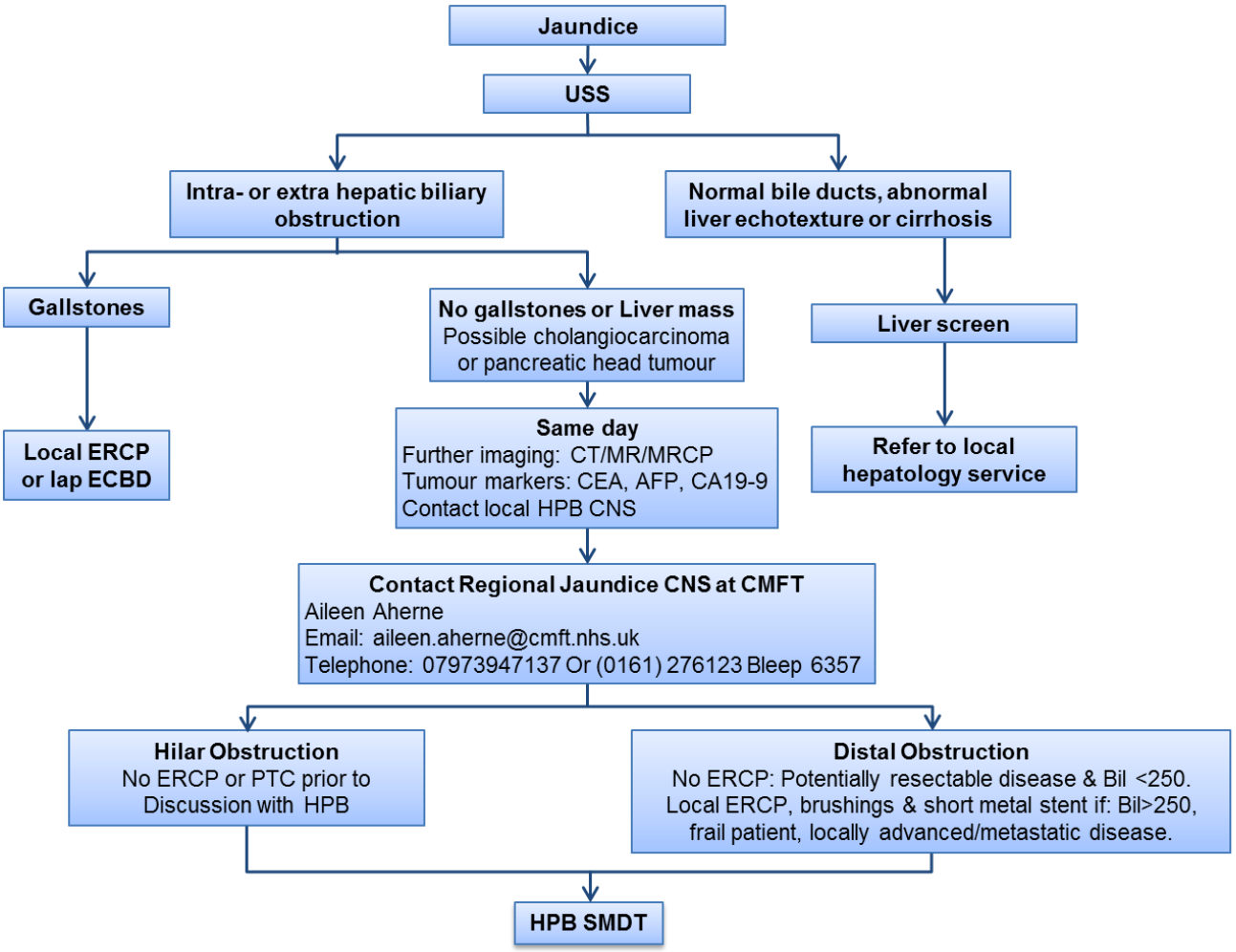
and more slots, increasing demand on services Prefer to use radial EUS over MRI route. 100% were appropriate in comparison to the ASG targets. Consent forms were found for all patients apart from one. MRI outcome 100%. TMN staging not very good at this, but concern is EUS is over-staging, at the moment this is not completed. DOR asked if a prospective study could be done on this. Pancreatic measurements 100%, so no performance issues on this. Adverse events reported 0. 1 patient admitted with abdominal pain, but she did have Botox treatment. 30 day mortality 0%. 1 repeat procedure, chronic pancreatitis. Time to seen mean was 26, but most are benign disease. I patient not referred for 105 days. *Conclusions:* • Compliance with quality indicators • High quality service is being provided • High volumes of diagnosis EUS's. *Recommendations:* • Better documentation • Coding-coded as gastroscopies-effecting tariff development of services • service evaluation-using uni-soft-looking at data • Time to decision for EUS needs reviewing and monitoring and gather data and gather information across the 4 trusts. *Action plan:* • Reporting systems • Re audit and delays increasing capacity. DOR congratulated JP on her presented and work and highlighted the team are the first to present data on this. DOR reiterated that the audit has demonstrated the quality of the data provides the quality assurance that there is a high quality service being provided. DOR requested Pennine team to carry out similar audit and present data back in September. DOR also requested a similar review occurred at Wigan.	**Action**: Sajjad Mahmood to review pennine data.

6. Trial update DOR discussed importance of the recently opened ESPAC5 F trial of neo-adjuvant therapy in pancreatic cancer the trial, in which patients are selected for the trial following MDT discussion. There are 3 arms to the study with different chemotherapy regimens offered through randomisation. DOR discussed that 2 patients have been discussed in MDT that could go in the study. Patients need to be fit to enter the trial. DOR and MM discussed that some will have chemotherapy and may progress on treatment and will not get the surgery. Progressing on Chemotherapy is an unfortunate issue for those patients with aggressive disease. DOR will keep the team updated on progress of trial recruitment with MM support.	
7. AOB/Dates of Future Meetings • 23rd September 2016, 10am-12pm– Manchester Royal Infirmary • 18th November 2016 – The Christie pm(to confirm time) • 1-2 December 2016 **Pancreatic Society of Gt.Britain and Ireland** Annual meeting, Manchester • 24th Jan 2017, 14.00 -16.00: Wigan Infirmary • March 2017-Salford (Emma to sort room and time) • May 2017-potential Macclesfield?	

APPENDIX 1

Manchester Cancer

The Manchester Cancer Jaundice Pathway



APPENDIX 2: ESPAC5F Trial schema