HPB PATHWAY BOARD MEETING

Meeting of the HPB Pathway Board, 22nd January 2016

The Christie

IN ATTENDANCE	
Derek O'Reilly	Pathway Director
Rebecca Price	Pathway Manager
Vicki Stevenson-Hornby	WWL
Lucie Francis	Macmillan Patient User manager
Mong-Yang Loh	SSH
Melanie Dadkhah-Taeidy	Tameside
Steve Sawyer	Patient Representative
Aileen Aherne	Jaundice CNS
Rebecca Leon	GP representative
Konrad Koss	Macclesfield
Karen Ridyard	Jaundice Pathway Data Co-ordinator
Jo Puleston	CMFT
Raymond Callaghan	CMFT (medical student)
Raisah Sawati	CMFT (CT doctor)
Rafik Filobbos	PAT & CMFT
HU Laasch	Christie
Apologies: Mairead McNamara, Juan Valle, Sharan Ingram, Mahesh Bhalme, Michelle Storey, Debbie Clark	

Agenda Item	Action
1. Minutes of the pathway board meeting of 18th November 2015 DOR introduced latest version of the minutes of the last meeting. The minutes of the meeting of **18th November 2015** were accepted and agreed as a true record of the meeting. **Matters arising not on the agenda** **EUS Audit:** - DOR asked trust representatives at CMFT, PAT, SRI, UHSM and WWL to chase the status of the EUS audit in their trust if they have	

not already done so. **Gallbladder Polyp Pathway:** MYL produced the final version of the Manchester Cancer Gallbladder Polyp Pathway (see appendix 1).	
2. Jaundice pathway: Update DOR updated the board informing them that the Jaundice pathway Data co-ordinator (Karen Ridyard) had now started in post and the Jaundice CNS (Aileen Ahearn) has also been appointed. Aileen Ahearn gave a presentation outlining the work she had been involved in since starting in late 2015. AA explained in detail the purpose of role and the services that she will conduct In order to improve the overall efficiency of the Jaundice patient care pathway. AA encouraged the board to pass her information on to their local trusts as she is currently actively self-promoting the jaundice pathway and the work she will be doing. The board welcomed Aileen to her new role and look forward to her future updates around the developing service.	**DOR/AA to present updated data to the ACE**
3. Macmillan plans for patient involvement Lucie Francis introduced Steve Sawyer as the appointed patient representative for the board. Steve discussed his patient story and his reasons for wanting to be involved with the work that the Manchester Cancer Pathway boards are doing and expressed his enthusiasm to welcome onto the board. The boarded welcomed Steve and thanked him for agreeing to assist the board in future. Melanie Dadkhah-Taeidy is the HPB Pathway Board patient mentor.	**LF & MDT to lead on creation of a "jargon buster" document of HPB terms, to explain the basic terminology of HPB cancer.**
4. Vanguard Briefing DOR gave a presentation informing the board of the proposed plans that are being developed by the Greater Manchester Vanguard team. The rationale and purpose of the vanguard was explained. Greater Manchester Cancer forms part of the single National Cancer	

Vanguard and will be addressing many of the recommendations for action in the recently published national cancer taskforce plan **Achieving world-class cancer outcomes: a strategy for England 2015-2020**

http://www.cancerresearchuk.org/about-us/cancer-taskforce

The key principles of the Cancer Vanguard are:

- Cancer vanguards are needed to test new models
- Vanguard providers to take system accountability for standards
- Pilot system-wide population-based cancer budget
- Radical upgrade in prevention and early diagnosis
- Focus on living with and beyond cancer and patient experience
- Reduce unnecessary variation
- Comprehensive system dashboards

In order to address the challenge of fragmentation; to improve care across the whole pathway; and to strengthen accountability for cancer care the Vanguard plans to do the following:

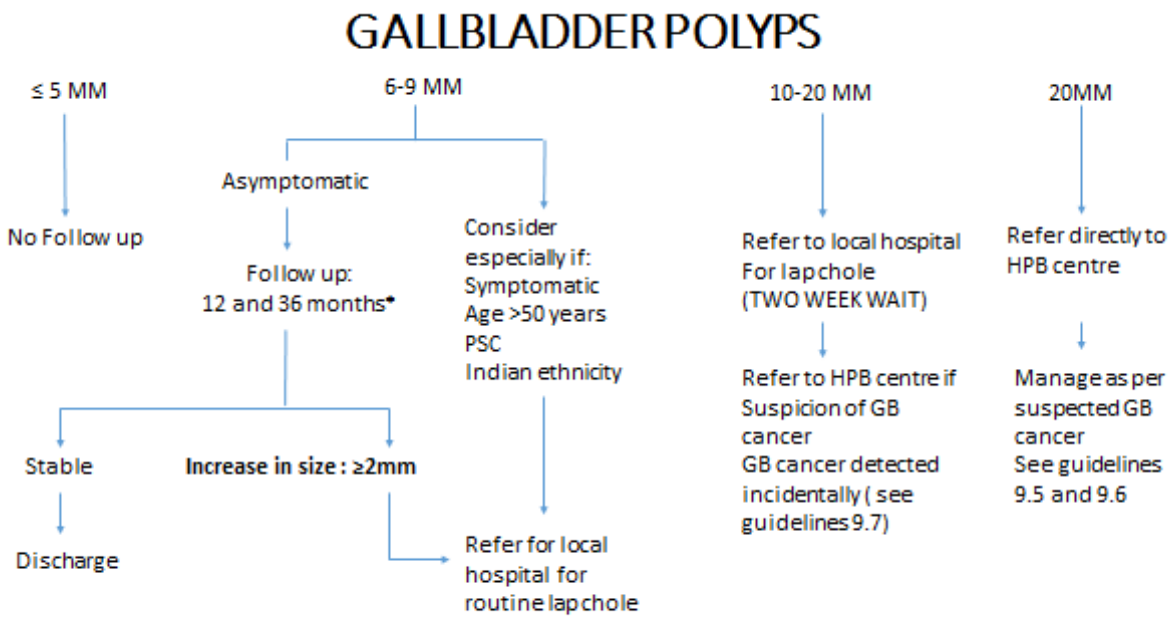
- Co-produce new and challenging clinical and operational standards across all pathways
- Create a single cancer system for Greater Manchester
- Introduce a single point of commissioning for cancer
- Create a single system leader that can be held to account for cancer outcomes and experience in GM
- Introduce a cancer intelligence unit to give the system and our patients the information needed to make sure that
- standards are being met
- money is being spent most effectively
- Launch a local campaign to raise awareness of cancer

➢ Develop convenient, local one-stop diagnostic services ➢ Explore new ways of diagnosing people earlier, like self-referral for tests & identifying those at highest risk of cancer ➢ Reliably deliver the recovery package and new models of aftercare for those living with and beyond cancer ➢ Appropriate supportive and end of life care 24/7	
5. GP 2WW referral form Dr Sarah Taylor, (Clinical lead for Cancer and End of Life Care South Manchester CCG, MacMillan GP, GP Cancer Early Diagnosis Lead for Greater Manchester, GMLSCSCN, CRUK) attended the pathway board meeting to discuss with the board the newly developed GP 2ww referral forms that she is currently updating. This is in line with the recently published NICE guideline, ***Suspected cancer: recognition and referral Published: 23 June 2015 nice.org.uk/guidance/ng12*** Firstly, DOR expressed his gratitude that ST had ensured that HPB referral forms are to be separated from Oesophagogastric referral forms, previously under the guise of a "Upper GI" form. It was agreed that clearly the form should incorporate all NICE criteria: e.g. for Pancreatic cancer 1.2.4 Refer people using a suspected cancer pathway referral (for an appointment within 2 weeks) for pancreatic cancer if they are aged 40 and over and have jaundice. [new 2015] 1.2.5 Consider an urgent direct access CT scan (to be performed within 2 weeks), or an urgent ultrasound scan if CT is not available, to assess for pancreatic cancer in people aged 60 and over with weight loss and any of the following: ➢ diarrhoea ➢ back pain ➢ abdominal pain ➢ nausea ➢ vomiting ➢ constipation ➢ new-onset diabetes. [new 2015]	**ST to update referral form and circulate for review.**

It was also suggested that the diagnosis of pancreatic cancer should be considered in patients with adult onset diabetes who have no predisposing features or family history of diabetes, as per BSG and ESMO guidelines. Furthermore, referrals should be made to Manchester Cancer One-Stop Jaundice clinics, where these exist. ST thanked the board for their feedback and will recirculate the revised version upon completion for review (see appendix 2).	
6. Patient Experience Survey DOR presented to the board the recently developed Patient experience survey. This is based on the NHS National Patient Experience Survey, with 2 added advantages: it is shorter and is online. It is hoped that this will produce a greater quantity of patient experience, in real time, to assist with improving this important outcome. The survey can be found at: https://www.surveymonkey.co.uk/r/HPB_patient_experience_service	**LF & SS to review and edit Patient survey.**
7. CMFT HBP transfer policy DOR circulated the draft CMFT HBP transfer policy The Background; Rationale for timely transfer; Mechanism for acceptance of patients for transfer; and Oversight and Scrutiny arrangements are outlined in this document. Some discussion of acceptable timeframes for patient transfer took place. See appendix 3 for final minimum acceptable waiting times. KK asked DOR if this was a "guarantee" from CMFT to achieve transfer by these times; DOR replied that it would be impossible to provide a "guarantee", given the pressure on NHS beds, but that these were standards the CMFT HPB unit had set; endeavour to achieve; and audit.	
8. Review of Biliary Drainage and Stenting at MRI Raymond Callaghan conducted a presentation on a single centre-review of biliary drainage and stenting performed at CMFT. Summary of the presentation found that – • PTC is an effective procedure in providing symptom relief of obstructive Jaundice. • Mortality-rates remain high post-PTC • Survival is low post-PTC	**Presentation available upon request to DOR**

9. EUS Audit – CMFT Results JP explained that data from CMFT was not being presented at this meeting, as she was ensuring that a truly consecutive sample was been audited, to ensure an absence of bias.	**JP to present CMFT EUS audit data at future Pathway Board meeting.**
10. AOB/Dates of Future Meetings 23rd March CMFT, 10-12 Main Boardroom, Cobbett House, CMFT. • **14 April 2016 – The Manchester Pancreatic Cancer Symposium, Town Hall, Manchester** • 19th May 2016 – Pennine Acute Trust 10.00 – 12.00 • 23rd September 2016, 10am-12pm– Manchester Royal Infirmary • 18th November 2016 – The Christie • Jan 2017: Wigan Infirmary	

APPENDIX 1 FINAL VERSION OF THE GALLBLADDER POLYP PATHWAY



* Follow up can be done at Primary Care level, following discussion with GP and Hospital Clinician

APPENDIX 2 PROPOSED HPB REFERRAL PATHWAY

PATIENT ENGAGEMENT – THIS IS A MANDATORY FIELD	
1. Has the patient been counselled regarding this referral as per the NICE guidelines i.e. advised why they have been referred to a cancer service and offered appropriate information including where to seek additional support? **If no, please explain why:**	Yes ☐ No ☐
2. Has the patient been advised that they need to be available within the next two weeks?	Yes ☐ No ☐
3. Have you ensured that the telephone contact details are correct?	Yes ☐ No ☐

4 Is the patient fit for straight to test investigations and procedures yes no
5 Is the patient capable of giving informed consent yes no
If no has the next of kin been asked to attend yes no
6 Is the patient taking anti-coagulants yes no
If yes please give details ……
7 Is the patient diabetic yes no
If yes is the patient taking metformin yes no
8 Please give `the patients eGFR` **……**
`If not done within 6 months please check`

CULTURAL, MOBILITY, IMPAIRMENT ISSUES
Does the patient require Translation or Interpretation Services? YES ☐ NO ☐ **If so which language ……..** Please list any other impairments requiring specialist help …… Is the patient from overseas? YES ☐ NO ☐ Is the patient a temporary visitor? YES ☐ NO ☐

Suspected Pancreatic Cancer (Please ensure that you attach clinical information) Patient aged 40 and over with jaundice Abnormal CT suggestive of pancreatic cancer (or USS if CT not available) *please remember to attach the report* New onset diabetes in patient age 60 or over with BMI<30	YES☐ NO☐ YES☐ NO☐
Gallbladder (Please ensure that you attach clinical information) USS suggestive of gall bladder cancer *please remember to attach the report*	YES☐ NO☐
Liver Cancer (Please ensure that you attach clinical information) USS suggestive of liver cancer *please remember to attach the report*	YES☐ NO☐

Appendix 3. Table 1 from CMFT HPB Transfer Policy. Indications for transfer and minimum acceptable waiting times.

HPB Diagnosis	Maximum permitted time to transfer	Rationale
Acute Cholangitis	24 hours	Immediately life-threatening condition usually requiring decompression with ERCP
Fast-track Jaundice Pathway	48 hours	To undergo preparation for fast-track surgery or decompression of obstructed biliary system
Liver abscess	48 hours	Will require percutaneous drainage as well as initial antibiotic treatment
Iatrogenic Bile duct injury	48 hours	May require further drainage or reconstructive surgery
Liver trauma	24 hours	Should be under the care of a HPB surgeon, especially if non-operative management is undertaken
Pancreatic Trauma	24 hours	As above
Acute Severe Pancreatitis	48 hours	Indications for transfer are radiological, endoscopic or surgical intervention.