GMCA GREATER MANCHESTER COMBINED AUTHORITY

NHS in Greater Manchester

Greater Manchester Cancer

HPB Pathway Board

Hepato-Pancreato-Biliary Oncology Pathway Board
Minutes and Actions

Meeting time and date: Thursday 2nd May 2019 14:00-16:00 (Lunch 13.30)

Venue: Northern Tennis Club, Palatine Rd, Manchester M20 3YA

Members in attendance		
Name	**Role**	**Organisation**
Thomas Satyadas (TS)	Chair/HPB Consultant	Manchester University NHS Foundation Trust
Claire Goldrick (CG)	Pathway Manager	GM Cancer
Hans-Ulrich Laasch (HL)	Consultant Radiologist	The Christie NHS Foundation Trust
Sue Sykes (SS)	Cancer Programme Manager	Greater Manchester Commissioning Hub
Juan Valle (JV)	Medical Oncologist	The Christie Foundation Trust
Dr Luke Williams (LW)	Consultant Radiologist	Salford Royal NHS Foundation Trust
Dr Lucy Foster (LF)	Histopathologist	Manchester University NHS Foundation Trust
Sharon Barker (SB)	HPB CNS	Manchester University NHS Foundation Trust
Claire Newton (CN)	HPB CNS	Manchester University NHS Foundation Trust
Steph Gooder (SG)	HPB CNS	Stockport NHS Foundation Trust
Pillar Del Valle Martin (PVM)	HPB CNS	Stockport NHS Foundation Trust
Javaid Iqbal (JI)	Consultant	Manchester University NHS Foundation Trust
Harry Kaltsidis (HK)	Gastroenterology Consultant	Manchester University NHS Foundation Trust
Michael Clinton (MC)	Macmillan RP Manager	Salford Royal NHS Foundation Trust
Neil Bibby (NB)	HPB Specialist Dietician	Manchester University NHS Foundation Trust
Joe Geraghty (JG)	Consultant Gastroenterologist	Manchester University NHS Foundation Trust
Mairead McNamara (MM)	Medical Oncologist	The Christie Foundation Trust
Vinod Patel (VP)	Consultant	Tameside and Glossop
Laura Elliott (LE)	Cancer Manager	Manchester University NHS Foundation Trust
Zahid Mahmood (ZM)	Consultant Gastroenterologist	Stockport NHS Foundation Trust

Guests in attendance		
Name	**Role**	**Organisation**
Zahra Batool (ZB)	Senior Team Administrator	GM Cancer
Anne Marie Rafferty (AMR)	Supportive Care Management Group Pathway Director	GM Cancer/The Christie Foundation Trust
Baber Uppal (BU)	FI Doctor Gastroenterology	Stockport NHS Foundation Trust
Dave Waterman (DW)	Palliative Care Lead	Stockport NHS Foundation Trust
Rizwana Rahman (RR)	Medical Student	Manchester University NHS Foundation Trust /The Christie Foundation Trust

GMCA GREATER MANCHESTER COMBINED AUTHORITY

NHS in Greater Manchester

Greater Manchester Cancer

HPB Pathway Board

Apologies		
Name	**Role**	**Organisation**
Chun Seng Lee	Consultant Gastroenterologist	Wrightington, Wigan and Leigh NHS Foundation Trust
Ganesh Radhakrishna	Consultant Clinical Oncologist	The Christie NHS Foundation Trust
Melanie Dadkhah-Taeidy	HPB CNS	Tameside and Glossop
Gurvinder Banait	Consultant Gastroenterologist	Wrightington, Wigan and Leigh NHS Foundation Trust
Sharon Ingram	Clinical Nurse Specialist	Manchester University NHS Foundation Trust
Rebecca Leon	GP	East Cheshire – representing GM
Vicki Stevenson-Hornby	HPB Clinical Nurse Specialist (CNS)	Wrightington, Wigan and Leigh NHS Foundation Trust
Alison Armstrong	Programme Lead	GM Cancer
Mahesh Bhalme	Consultant Gastroenterologist	Bolton NHS Foundation Trust
Debbie Clark	HPB CNS	Pennine Acute Trust
Richard Hubner	Consultant in Medical Oncology	The Christie NHS Foundation Trust
Nick Wang	Gastroenterology Consultant	Bolton NHS Foundation Trust
Angela Lamarca	Consultant Medical Oncologist	The Christie NHS Foundation Trust
Rafik Filobbos	Consultant Radiologist	Pennine Acute Trust
Ajith Siriwardena	Consultant Hepatobiliary and General Surgeon	Manchester University NHS Foundation Trust
Nicola de'Liguori Carino	Consultant Hepatobiliary and Pancreatic Surgeon	Manchester University NHS Foundation Trust
Natalie Barratt	HPB CNS	The Christie NHS Foundation Trust

1. Welcome and Introductions	
Discussion summary	TS welcomed members and guests to the board meeting and introduced the agenda. Apologies of members were noted. TS noted that following his appointment and the changes at GM Cancer Board level, the membership of each board is currently being reviewed. Members are expected to attend 75% of meetings allowing each meeting to be quorate. TS noted that over the coming months the membership of the board would be reviewed to ensure that the Trusts and specialities across GM are represented in the board.
Actions and responsibility	

2. Minutes of the last meeting	
Discussion summary	Minutes from the last board meeting were accepted as a true record.
Actions and responsibility	- **CG to finalise the minutes and upload them to the GM Cancer website.**

3. Palliative Care: Advanced Care Planning/Education	
Discussion summary	AMR and DW presented their ideas to the board and informed members of plans around cancer and aims in regards to palliative care. AMR discussed the importance of incorporating patient views in end of life care focusing on the Greater Manchester area. She recognised the significance of palliative and supportive care for the HPB pathway and focused on how care could fit around HPB cancer patients. DW informed the board that the GMHSC are devising a framework around palliative care which is currently being developed with 16 key commitments including carer support and bereavement. AMR recognised the involvement of Macmillan and informed the board that their investment has improved the 7 day palliative care project across Salford and Wigan NHS Trusts. AMR discussed enhanced supportive care and her own experience working with Oncology to identify patients at the end of life and working together to provide support. AMR and DW stressed the importance of patient voice and the early stages of palliative care and how early conversations make a difference to patients. Palliative care is an issue which needs to be discussed more openly with patients. DW encouraged the board to think about a certain group of patients where progress isn't being made in their health. DW informed the board that this needs to be addressed and there are certain triggers to look out for. For example, DW stressed the importance of recognising a decline in a patient and being aware of interventions if they are needed or wanted by the patient. Advanced care planning was discussed where the patient has capacity to make decisions about their own care planning in advance. DW suggested that advanced thinking in clinical terms and advanced care planning need to go hand in hand and complement each other. DW further informed the board of a North West standardised education programme which is run across Greater Manchester. The key message around this programme is discussion. JV and DW discussed how the pathway board can be responsible in regards to palliative and supportive care and how to recognise when a patient may need this service. DW noted the importance of recording the patient's wishes. AMR agreed with this and suggested that documentation around palliative care needs to be clearer. MC informed the board of the recovery package programme and how the model embraces shared decision making. MC agreed that advanced care planning fits in well and ties in with personalised care.
Actions and responsibility	NA

4. Supportive Care Programme	
Discussion summary	TS discussed an idea to launch a supportive care programme at Manchester NHS Foundation Trust which will provide access on a weekly basis for patients to engage with a range of specialists to help to improve quality of life. TS's vision is that if this initiative proves to be a success, it could be rolled out across other NHS Foundation Trusts.
Actions and responsibility	- TS to continue engaging with relevant specialists to set up programme.

5. EUS guided biliary drainage in distal obstruction: for which patients and when?	
Discussion summary	JG presented to the group an evaluation of EUS guided biliary drainage. He explained that this is a procedure which is niche and it is a new drainage technique drainage which first began as a diagnostic procedure 15-20 years ago. JG explained that in pancreatic cancer, jaundiced patients need treating straight away as it impedes on chemotherapy. The first instance should be ERCP but where this fails, the standard is usually that's someone more experienced should perform the procedure when it is accessible. Other pathways and routes should be considered when there is a failure in ERCP according to JG. JG discussed some alternative methods such as PTC and PTDB but discussed the practicalities of EUS-BD. It was noted that the success rates of this procedure are published but the complications are not discussed as much. JG discussed whether EUS-BD should be a front line approach and informed the board that there is a longer patency with EUS-BD compared to PTC and other options available. The approaches to this procedure were explored and each one was clinically discussed. JG noted that each approach does have its complications no matter how minor or common. Complications occur in the other procedures and JG noted that there are pros and cons to each method. Further to JG's presentation, HUL agreed with the overall idea but questioned what the need was to perform this procedure when a patient has complications such as septicaemia. HUL informed members that EUS doesn't allow for a stoppage and argued that other methods are proven to be more successful especially ones where you can apply an external drain for 2 days maximum which allows clinicians to be more flexible with a patient. LW suggested that we need to conduct randomised trails where ERCP fails and this procedure is chosen to be conducted in order to follow success rates and complications. HK commented that he liked that EUS-BD was an alternative approach and could prove to be useful but was under the impression that data needed to be collated before this procedure was going to continue. HK suggested that moving forward, the board should take part in a trial and the data stipulated in the 2007 guidelines should be revised.
Actions and responsibility	NA

6. Challenging the current pathway for pancreatic cancer: shaking the kaleidoscope	
Discussion summary	JV presented a challenge to the current pathway for pancreatic cancer. Pancreatic cancer should be treated as a medical emergency and currently it is not being dealt with appropriately. JV suggested that some things may be being overlooked which is causing delays. Currently there is no clear structure to time values of each step and changes need to be incorporated. When it comes to MDT meetings, the decision making isn't complex because there are 3 groups of patients: - Fit for treatment - Unfit for treatment - Operable/borderline disease JV informed members that half of pancreatic cancer patients are being diagnosed through emergency facilities such as A&E. PCUK are focusing on early diagnosis of pancreatic cancer. This is twofold: - The pathological/physiological aspect - Quick treatment focused on time. JV noted that the pathway needs to be changed to better service the needs of pancreatic cancer patients. The pathway board should complete an audit of MDT outcomes to support the case for

	change. He asked for volunteers to support this project from radiology, surgery, pathology etc. HK agreed that the jaundice pathway would complement this pathway very well. JV made clear that there shouldn't be a devolution of decision making but there needs to be clarity in regards to some patients and whether they can be referred, which is why a sample of patients need to be tested. SG and PV agreed with JV's proposal and informed the board that they have tried to improve the data and info given to MDT. HU also agreed with this proposal and suggested that it will increase efficiency of the MDT which will help delay times to reduce. MC informed the board that there is work underway across the North West around diagnosing patients faster. Holistic needs assessments are being trialled across the NHS and conversations are being started in regards to patients and what matters to them.
Actions and responsibility	- Board members to express interest in this project to CG. - CG to arrange first meeting for project group.

7. Malignant Jaundice Pathway	
Discussion summary	ZM and BU presented to the board the jaundice pathway at Stockport NHS Foundation Trust. The Jaundice Pathway ensures that patients are referred in a timely manner and has been piloted since March 2018. BU informed the board that the main aim was to diagnose HPB cancers as soon as possible. BU explained that two audits had taken place: 1. Jaundice Pathway referrals. 2. Patients referred via emergency routes with 'Jaundice'. From the data in the audits, BU concluded that the Jaundice Pathway is well established and had no breaches. Future plans include HPB referral forms being distributed and raising awareness about the pathway. BU informed the board that 25% of patients came through the pathway and the other 75% arrived from other routes. SS was unaware that this has been piloted at Stockport and suggested that this information should have been shared earlier. TS addressed the MFT Jaundice Pathway which would incorporate Jaundice and the 2 week wait. The pathway would also ensure CT, Clinic and Endoscopy slots every day or on a regular basis. TS explained that having inbuilt patient experience measures would help to measure how the pathway is succeeding. SS welcomed ZM's proposal to present more data at the next meeting and suggested that there should be a comparison with this pathway with other ideas if other Foundation Trusts are going to be involved. This will allow for clarity around what works and what does not. This was agreed across the board. VP suggested that each pathway should be localised for each area. VP informed the board of his concerns about resources especially in his area which is leading in liver disease and patients have jaundice. SB informed members that securing PET scans for patients should be equal to fast tracked patients. SS agreed to take this feedback back to NHS England.
Actions and	- ZM to provide data of pilot and timing of scans at the future pathway meeting.

responsibility	

8. Board Membership	
Discussion summary	TS briefly discussed board membership and changes may take place in membership and attendance obligations in the near future.
Actions and responsibility	- CG/TS to communicate with board members as appropriate.

9. AOB	
Discussion summary	No AOB matters were discussed.
Actions and responsibility	