Manchester Cancer

Central Manchester University Hospitals NHS
NHS Foundation Trust

Greater Manchester and Cheshire HPB Unit Guidelines for the Assessment & Management of Hepatobiliary and Pancreatic Disease

Chapter 4

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4. Manchester Cancer Pathways

4.1. *Manchester Cancer*

Greater Manchester Cancer Services
Part of Manchester Cancer

Manchester Cancer Structure and Overall Aim

Manchester Cancer is an integrated cancer system. It has three arms: a Provider Board, responsible for the service and clinical delivery arm of Manchester Cancer, as well as research and education arms. See: *Figure 1, Pg 34*.

The overall aim of Manchester Cancer is to achieve world class outcomes and experience for patients with cancer in Greater Manchester and Cheshire through well led coordinated clinical services, innovation, research and education.

Greater Manchester Cancer Services Provider Board

The Greater Manchester Cancer Services Provider Board is responsible for the service and clinical delivery arm of Manchester Cancer, Greater Manchester's integrated cancer system. Manchester Cancer has two other arms: research and education. The Provider Board is independently chaired and consists of the Chief Executive Officers of the ten acute hospital trusts in the Greater Manchester area:

Bolton NHS Foundation Trust
Central Manchester University Hospitals NHS Foundation Trust
East Cheshire NHS Trust
Pennine Acute NHS Trust
Salford Royal NHS Foundation Trust
Stockport NHS Foundation Trust
Tameside Hospital NHS Foundation Trust
The Christie NHS Foundation Trust
University Hospital of South Manchester NHS Foundation Trust
Wrightington, Wigan and Leigh NHS Foundation Trust

The HPB Pathway Board

The HPB Cancer Pathway Board is a cancer care specific board with responsibility to improve cancer outcomes and patient experience for local people across Greater Manchester and areas of Cheshire (a catchment population of 3.2 million). This area is synonymous with the old Greater Manchester and Cheshire Cancer Network area, which it supersedes.

The Pathway Board is led by a Pathway Clinical Director (Mr. Derek O'Reilly) and is formed of a multidisciplinary team of clinicians and other staff from all of hospital trusts that are involved in the delivery of HPB cancer care in Greater Manchester. The Pathway Board also has membership and active participation from primary care and patients' representatives.

Purpose of the HPB Pathway Board

The purpose of the Pathway Board is to improve cancer care for patients on the Greater Manchester HPB cancer pathway. Specifically, the Pathway Board aims to save more lives, put patients at the centre of care, and improve patient experience. The Board will represent the interests of local people with cancer, respecting their wider needs and concerns. It is the primary source of clinical opinion on this pathway for the Greater Manchester Cancer Services Provider Board and Greater Manchester's cancer commissioners.

The Pathway Board will gain a robust understanding of the key opportunities to improve outcomes and experience by gathering and reviewing intelligence about the HPB cancer pathway. It will ensure that objectives are set, with a supporting work programme that drives improvements in clinical care and patient experience.

The Pathway Board will also promote equality of access, choice and quality of care for all patients within Greater Manchester, irrespective of their individual circumstances. The Board will also work with cancer commissioners to provide expert opinion on the design of any commissioning pathways, metrics and specifications.

HPB Pathway Board Membership

All member organisations of Greater Manchester Cancer Services will have at least one representative on the Pathway Board unless they do not wish to be represented.

Provider trusts not part of Greater Manchester Cancer Services can be represented on the Pathway Board if they have links to the Greater Manchester HPB cancer pathway.

All specialties and professions involved in the delivery of the pathway will be represented.

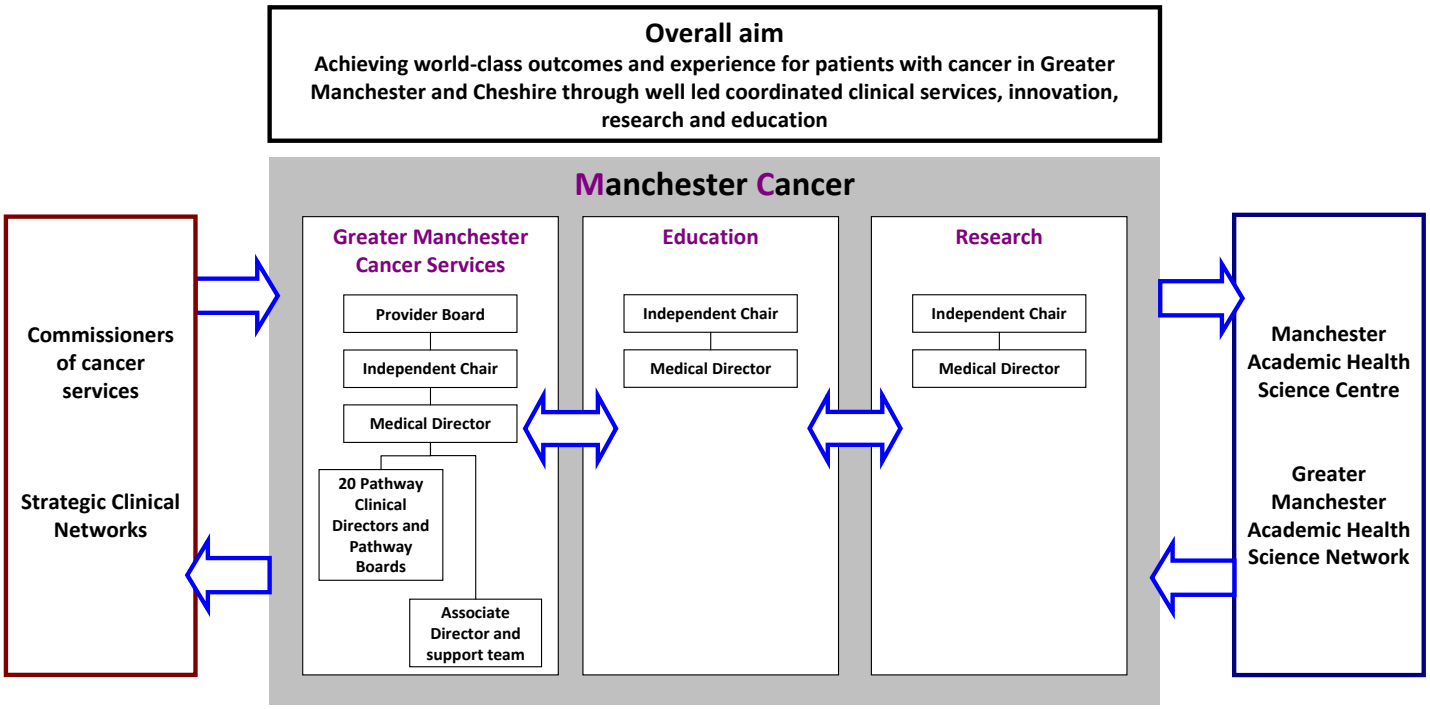
The current Pathway Board membership is as follows:

Name	Role/Trust Representative
Mr. Derek O'Reilly	HPB Pathway Clinical Director
Miss. Caroline McCall	Manchester Cancer Pathway Manager
Prof. Ajith Siriwardena	Central Manchester University Hospitals NHS Foundation Trust
Dr. Mahesh Bhalme	Bolton NHS Foundation Trust
Dr. Konrad Koss	East Cheshire NHS Trust
Ms. Debbie Clark	Co-opted member
Dr. Emma Donaldson	Salford Royal NHS Foundation Trust
Dr. Guvinder Banait	Wrightington, Wigan and Leigh NHS Foundation Trust
Dr. Mong-Yang Loh	Stockport NHS Foundation Trust
Dr. Vinod Patel	Tameside Hospital NHS Foundation Trust
Dr. Harry Kaltsidas	University Hospital of South Manchester NHS Foundation Trust;
Prof. Juan Valle	The Christie NHS Foundation Trust
TBC	Patient Representative(s)
Dr. Kevin Finn	Primary Care Representative
Dr. Rafik Filobbos	Pennine Acute NHS Trust
Dr. Martin Prince	Co-opted member

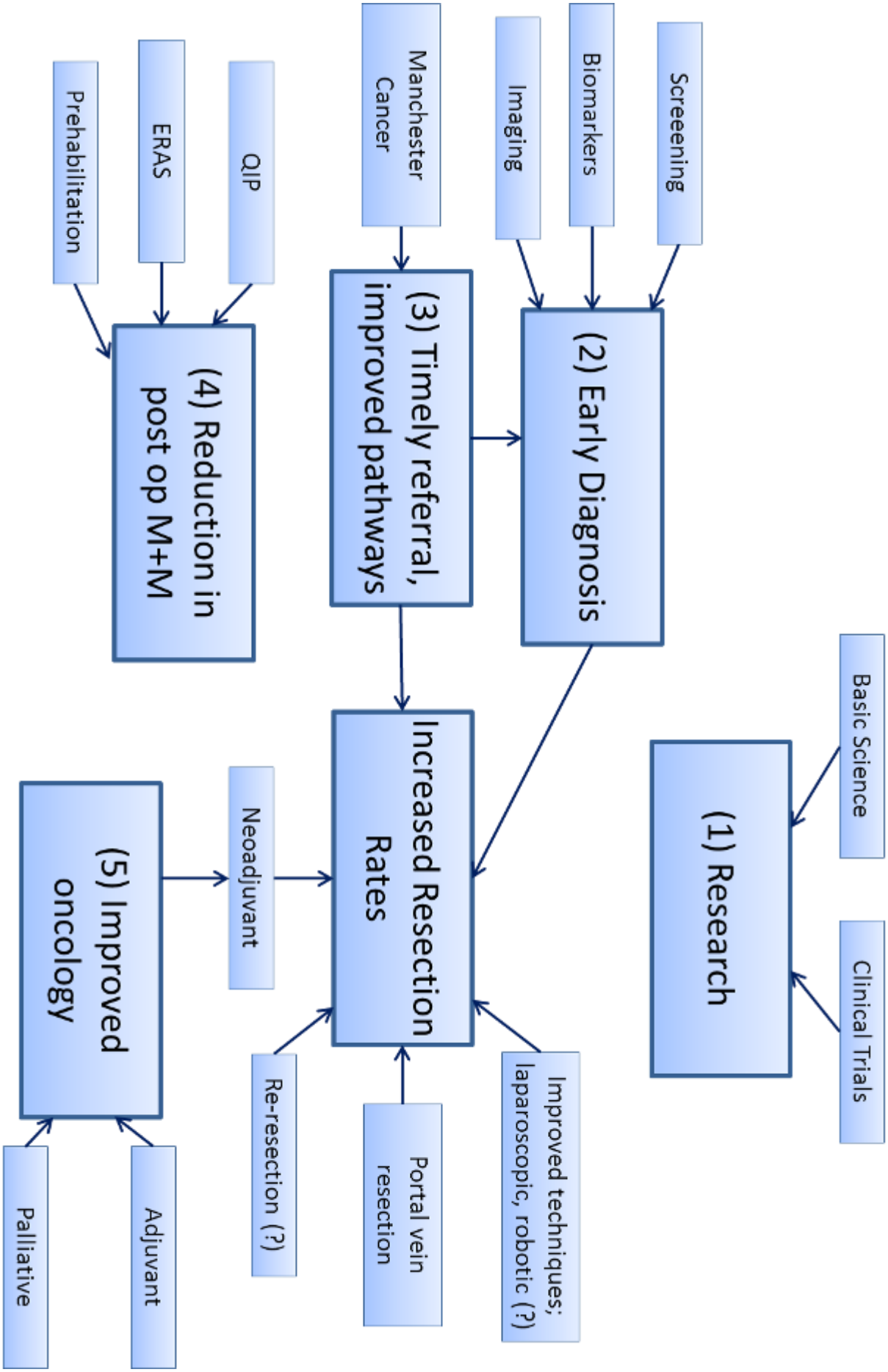
Further information

http://www.manchestercancer.org/

Figure 1. **The Manchester Cancer Strategy for Improving Outcomes in HPB Cancer**



4.2. *Strategies for improving outcomes in HPB cancer*



4.3. *Suspected Cancer Referral Pathway Liver, Pancreas & Bile Duct*

From the NHS GMCCN HPB NSSG

General Practitioners should refer suspected HPB cancer patients to their local hospital.

A decision will be made about local testing and referral to the tertiary centres.

The following symptom types (esp. those in bold) should trigger an urgent USS of the abdomen and the consideration of referral under the two week suspected cancer rule.

- **New jaundice**
- **Extremes of pain (inc. painless jaundice)**
- **Epigastric mass**
- **Unintentional weight loss**
- Abnormal liver function tests (greater than twice the norm)
- New diabetes mellitus
- 50 years of age

URGENT USS abdomen

Refer on urgent 2WW basis to local gastroenterology or surgical outpatients

Patients who are systemically unwell should be admitted. Those likely to have viral hepatitis (e.g. ALT>500) or decompenstation of alcoholic liver disease should be referred to clinic on a non-2WW urgent basis.

Notes:

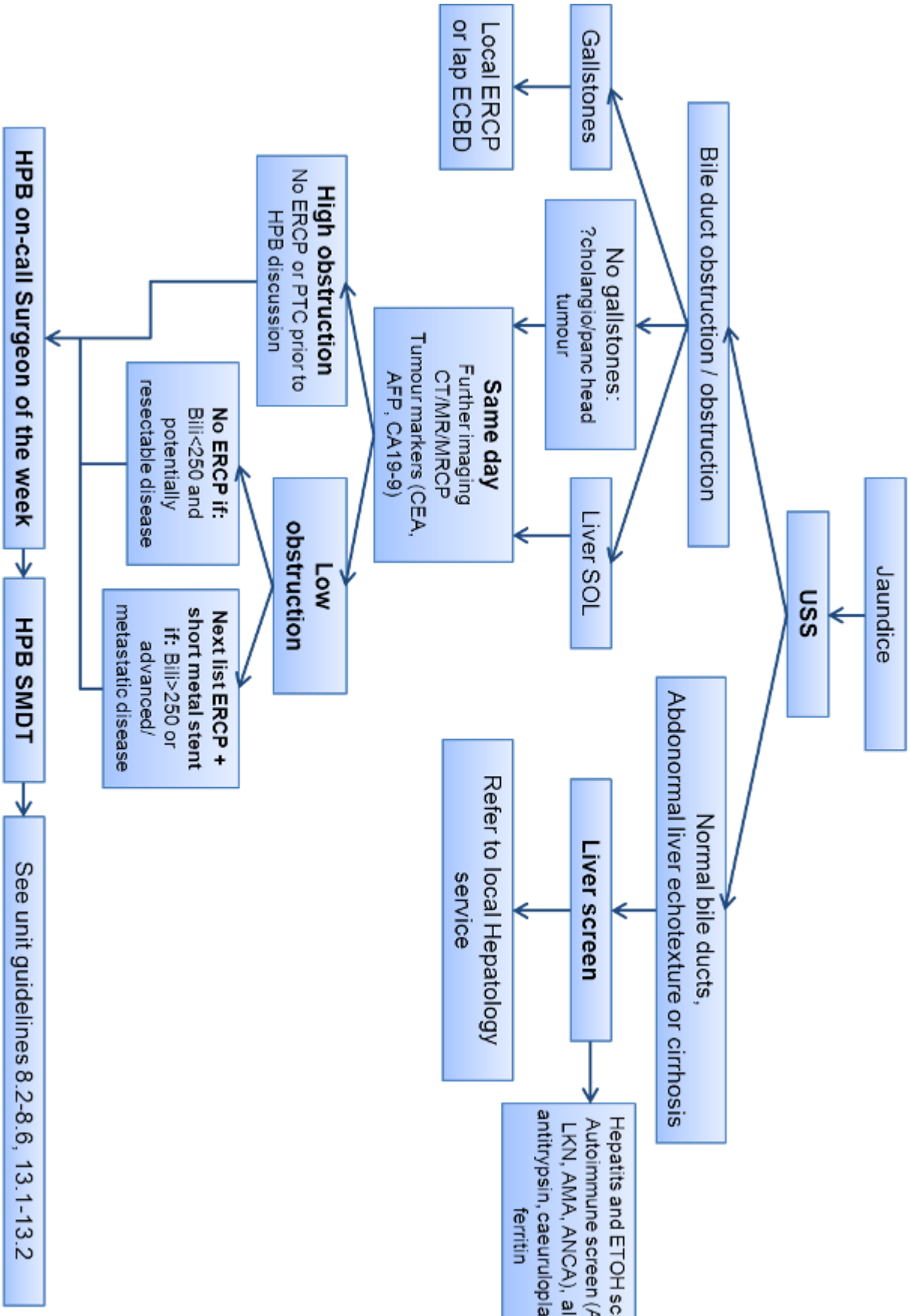
Most patients with these symptoms do not have cancer and there is likely to be another explanation.

Clinical judgement when referring is important, but in order to 'capture' early cancer these groups should be referred.

There should be a nominated clinician for HPB referrals at each hospital to whom cases can be referred under the two week rule.

Ultrasound investigation should be the norm at or before the first appointment and local arrangements will vary as to how this is organised.

4.4. *Manchester Cancer Investigations Pathway for Jaundice*



4.5. *Guidelines for referral of patients with known or suspected colorectal liver metastases*

From The NHS GMCCN Colorectal Clinical Subgroup:

1. All patients with known or suspected hepatic metastases where initial imaging has suggested that disease is confined to the liver should have their case (and imaging) reviewed at a recognised specialist HPB MDT incorporating liver surgeons.

2. In addition, selected patients with potentially resectable extra-hepatic recurrent disease in addition to liver metastases (in particular those with operable lung disease) should be referred to the HPB MDT.

3. The referring colorectal MDT maintains responsibility for the long term care and follow-up of colorectal cancer patients who are referred to the HPB MDT with liver metastases. The HPB MDT however assumes responsibility for the case whilst they are treating the patient's liver metastases.

4. For general guidance, the GMCCN colorectal clinical subgroup adheres to the national guideline document on the management of colorectal metastases produced by the AUGIS. *Guidelines for resection of colorectal cancer liver metastases, OJ Garden et al, Gut 2006; 55 (Suppl III): iii1-iii8*

4.6. *Criteria for referral of a patient with suspected HPB malignancy to the merged Greater Manchester specialist HPB MDT*

Referral can either be to a named consultant by letter or by listing a patient for discussion at the HPB sMDT by completion of the electronic proforma available to all NHS provider Trusts (https://cmftreferrals.cmft.nhs.uk/). The HPB sMDT complies with IOG guidance for discussion of all patients with a newly diagnosed or suspected HPB malignancy.

At least one of the following criteria must be met in order for the patient to be listed for discussion. If a referral is received with no criteria listed, it will be returned and the responsibility for correct listing rests with the referrer.

Criteria	Please place cross as appropriate
Pancreatic tumour	
Newly diagnosed or suspected pancreatic tumour on CT	
Pancreatic resection for discussion of histology	
Pancreatic cytology (EUS-FNA or brush biopsy)	
Follow-up after previous treatment where clinical criteria/imaging suggest that a change in treatment should be considered	
Colorectal hepatic metastases	
Patient with newly diagnosed or suspected liver metastases of likely colorectal origin	
Liver resection for discussion of histology	
Follow-up after previous treatment where clinical criteria/imaging suggest that a change in treatment should be considered	
Non-colorectal liver metastases	
Patient with newly diagnosed or suspected liver-limited metastases of likely non-colorectal origin	
Primary tumour of liver, gallbladder or biliary tree	
Newly diagnosed or suspected primary tumour	
Other	
Newly diagnosed or suspected primary tumour of relevance to HPB sMDT	
Other case with individual case-specific indications for discussion at HPB sMDT	