HBP Pathway Board

#	Date Created	Status	Discussion summary	Action	Action Lead	Update
7	06/10/2020	Open	**Title: PERT - The Christie Audit continued** **To: Inform** **Owner: NB** The findings included: • The Algorithm was completed for 80% of patients, deliverable by both dietician and CNS's. • Symptom resolution reported in 42%, 43% and 33% of patients at 1st, 2nd and 3rd Review. • On Average 2 reviews were required per patient. The average was16 minutes per patient. • Patient compliance to our advice ranged between 63% and 83%, the highest rate reported on 2nd review. • 20% of patients fulfilled criteria for faecal elastase testing. 8% fulfilled criteria for gastro referral. **Next steps:** - Developing a symptom diary that can be used from diagnosis through to interventions and treatments - Submission to medical journey - Looking at designing an electronic assessment form and email alert system to work on managing this in a more effective way - Share the pathway across GM and adopt as a GM wide pathway/algorithm.	**CG to share algorithm for comments and ratification at next board**	**CG**	
10	08/12/2020	Open	**Title: Introduction** **To: Discuss** **Owner: TS** TS welcomed all members to the board. Matters arising - MSI testing: AL updated that in the last meeting this matter was discussed. Nivolumab is now available for patients that have MMR deficiency. AL has been looking into the funding and collating data from literature to support this testing being added to the standardised patient pathway as it is now part of NICE guidance. JV noted that this would be beneficial to a small number of patients, therefore, there we may need to develop a criteria rather than test all patients. The test should be requested once a metastatic diagnosis has been confirmed in MDT, therefore, the results would be available when the patient is seen at The Christie rather than cause an additional delay. AL noted that LF was concerned regarding the funding should the demand for testing increase. Previous meeting actions: all actions that related to on-going agenda items have been closed on this log but carried forward in the meeting.	**A: AL will collate the numbers and estimate the number of patients that may need this test to present. They noted that the pathway board should support this as part of the standard of care.** **A: CG to organise a meeting between AL/LF/JV/SS/TS/CG to discuss further.**	**AL** **CG**	
11	08/12/2020	Closed	**Title: Fast Track resection for Periampullary malignancies in GM – Early Results** **To: Inform** **Owner: Nicola de'Liguori-Carino (Consultant HPB Surgeon)** NLC presented early results on the implementation of the fast-track surgical pathway for patients presenting with obstructive jaundice caused by a periampullary malignancy (usually pancreatic cancer). Pancreatic cancer presents very late, most patients have adverse outcomes which has not improved for many years and incidence is increasing. Around 20% of patients are potential candidates for surgery which is the only hope for curative treatment. We therefore need to treat this cancer as a medical emergency. Time is very constrained and these patients should be referred quickly and treated as soon as possible. The fast track pathway was developed following the recommendations of a jaundice pathway in each Trust. It has been proven in randomised trials that it is safe to operate on patients with jaundice therefore negating the need for pre-operative biliary drainage. Data regarding the implementation of this pathway from Nov 2015 – May 2019 data has been reviewed. The results show that: - 216 with obstructive jaundice caused by resectable, non-metastatic, periampullary tumours were considered for resection following discussion at the HPB specialised MDT. Of these 216, 70 followed the fast-track pathway to surgery, 146 instead had biliary drainage and then only 122 proceeded to surgery. - This suggests that 20% of patients that have pre-operative biliary drainage don't proceed to surgery, this has been caused by two reasons, complications relating to the drainage procedure, and disease progression in the interim making them then unfit for surgery. To avoid bias they have conducted a propensity score match analysis between the groups of patients that had surgery and pre-operative drainage. Of the total number of patients that had surgery, there was no difference in the success of the surgery between those that were on the fast track pathway and those that weren't.	**NA**	**NA**	
11b	08/12/2020	Closed	**Title: Fast Track resection for Periampullary malignancies in GM – Early Results - Continued** **To: Inform** **Owner: Nicola de'Liguori-Carino (Consultant HPB Surgeon)** - They used four factors of age, co-morbidities, ASA score and radiological staging to eliminate bias, following this they were left with 55 patients in each group which showed no difference in bilirubin levels. - They also found no difference in complications following surgery or 90 days mortality, re-admission rate. There was a significant difference in length of surgery which was faster in the fast track group. No difference in the rate of patients receiving neo-adjuvant chemotherapy, the histopathology results prior/post matching. One of the criticisms of the fast-track pathway was that there wasn't enough time to get full histopathology results prior to surgery. There was a risk of undergoing major resection on benign disease, however, this was not found in the results. There was a significant difference found in the time between MDT to surgery for the patients on the fast track pathway with an average of 8 days (5 weeks faster). Time from CT scan to surgery was quicker. The time from chemotherapy to surgery is the same as all patients had had surgery. In conclusion there was a significant improvement in time from diagnosis to treatment for patients in the fast-track pathway. 20% less patients went to surgery that had had a pre-operative biliary drainage than those that went straight to surgery. NLC asked the group to continue to refer patients through the fast-track pathway; they welcome any patient of any age and bilirubin level with a resectable tumour to be referred. There is a 24/7 service available and please do contact the team to refer. NLC noted that the data is too premature and the numbers are too small to make any judgements on survival data as yet.	**NA**	**NA**	

12	08/12/2020	**Open**	**Title: Rapid Diagnostic Centre** **To: Inform/Discuss** **Owner: SS/Charlotte Griffiths** The 5 year RDC programme is now in year 2, the aim is to implement non site-specific RDCs and to adopt RDC principles into the site specific diagnostic pathways across GM. NCA and MFT have been chosen for the implementation of RDCs for this year, this decision was made by the programme board as they took part in the original ACE programme which trialled this approach. Pre COVID NCA and MFT were aiming to implement non site-specific RDCs this year; however, due to COVID some timelines have been shifted. The programme of work has continued throughout this year as there is an understanding that the implementation of RDCs will aid the recovery of cancer services. There has been a focus at MFT on site-specific RDCs of which the HPB pathway has been one. NCS went live with their non site-specific RDC in June. 364 referrals have been received, 294 have been deemed appropriate referrals (some were sent to site specific pathways and some were deemed not suspected cancer referrals). The time of receipt of referral to diagnosis is 7 days, there have been 20 cancers diagnosed (4 pancreatic cancers) showing a 6.5% conversion rate and 9.6% conversion rate of non-malignant but serious condition. SS introduced Charlotte Griffiths (project manager for RDCs at MFT). CGr presented the HPB RDC pathway which will be implemented in Feb21, every patient that is referred on a HPB suspected cancer referral form will go through this pathway therefore it follows the same structure as the overarching Best Timed Pathway that we have developed. CGr has worked with TS/CG/JI to develop the pathway. The patients will be referred by the GP as normal, they will then be clinically triaged and sent for a CT scan within 24-48 hours of referral. The team are exploring point of care testing for eGFR which would mean that GPs would not need to wait for blood test results prior to referral for clinically jaundice patients. CGr is working with the team at MFT to understand how this pathway can be operationalised. This may differ slightly between Trusts, however, the clinical pathway needs to be approved by the pathway board in order to be replicated across GM. TS noted that there is currently inequity of access to these services due to the staged roll out across GM, therefore, in the meantime, teams are looking at alternative ways to implement rapid access to CT scans. The team at Stockport are looking at providing next day access to CT through ambulatory care for patients that arrive at the emergency department but are well enough to come back the following day.	**A: The board is asked to consider the pathway and make comments to Claire Goldrick by COB Wednesday 16th December; if no further comments are received the pathway will be ratified.** **A: CG to connect SS with the team at WWL to start discussions around the implementation of RDCs.**	**ALL** **CG**	
13	08/12/2020	**Open**	**Title: MDT Reform** **To: Inform** **Owner: TS/SB** TS introduced a survey that has been conducted across core members of the MDT in order to start working on improving the function of the specialist MDT. There is a project in GM Cancer led by Kate Williams (Oncoplastic Consultant Breast Surgeon), the remit of which focuses on improving the standardisation of referral forms, efficiency of the meetings and outcomes etc. In order to ensure the MDT supports the implementation of the best timed pathway the team at MFT have been looking at making changes to the frequency of the meetings and the way they are run. The current HPB Pancreas Specialist MDT runs weekly between 8:00-10:30. The average number of cases discussed is 35 and the average time spent discussing each case is less than 4mins. The attending MDT members do not always have direct involvement in the patients care and patients are often discussed with incomplete referral details. The online survey comprising of 17 questions was sent to 143 stakeholders and 24% responded. 53.6% of stakeholders were 'somewhat satisfied' with the efficiency of the MDT. Suggestions were made of improvements to the MDT which will be taken into account and discussed with the MFT team and the GM Cancer MDT Reform project team. TS asked if it should be made mandatory for the referring clinician to present their patient at the MDT. Feedback from the group was that it may be difficult to organise for each clinician to join at the correct time. It is important to ensure that the correct information is present on the referral form to allow effective decision making.	**A: CG/TS to link the GM Cancer team with the lead of the MDT at MFT to progress this work in a joined up approach.** **A: SB/TS to send patient questionnaire to our service user representatives for their input to the design prior to sending out.** **A: Conduct an audit of MDT documented vs actual outcomes.**	**CG** **SB/TS** **SB/TS**	
14	08/12/2020	**Open**	**Title: Best Timed Pathway** **To: Inform/Discuss** **Owner: TS/CG** TS presented the proposed optimal pathway for patients with suspected pancreatic, Ampullary and bile duct cancer in GM. The pathway is aspirational with the understanding that there would need to be investment in the services to meet a 14 day pathway from referral to treatment. As NLC presented earlier in the board meeting, pancreatic cancer should be treated as an emergency and it is proven that a fast track service can be implemented to reduce the time from diagnosis to surgery. It is felt that there should be the same treatment for patients that are unsuitable for surgery as a quarter of patients do not receive any treatment at all. Unfortunately, this financial year there has been no funding available to implement this pathway. therefore, we are working on approving the pathway and creating a baseline gap analysis so that when funding becomes available things can move more quickly. TS noted that the team are aware that this pathway is improving upon the national standard of 28 days from referral to a Y/N to cancer. However, taking into consideration all of the evidence that supports speeding up this pathway it is felt that it is clinically important to create a faster pathway. TS noted that the RDC in MFT will allow for access to a CT scan within 24-48 hours of referral, therefore, it should be replicable around GM. There has been some feedback regarding the histology turnaround times which will be explored further to see what can be done to achieve this goal. NB commented that nutrition is `noted as part of the INDASH assessment, TA confirmed that he would like to see all patients screened regarding nutritional support. NB noted that all patients would benefit from dietetic input but that might not be equitable across GM.	**A: Pathway board members to review the pathway and provide comments by COB 16th December, following which the pathway will be ratified.**	**ALL**	
15	08/12/2020	**Open**	**Title: AOB** **To: Inform** **Owner: ALL** **Not discussed at meeting but added here for additional information.** PERT Algorithm: At the previous meeting an algorithm was presented by the team at The Christie and circulated for further comment prior to being ratified. The board is asked to make any final comments by COB 16th December after which the document will be ratified. CNS forum: The CNS forum has been re-established following a break during COVID. The team will meet every 2-3 months to discuss matters arising and educational needs for the group. Should anyone wish to join the distribution list or attend/present at a meeting please contact Claire Goldrick. Patient support group: The team at Maggie's centre at The Christie are going to introduce the HPB support group in a virtual format in January 2020. Further information will be circulated once the final details are worked out, but in the meantime please make a note of any patients that may wish to join.			