Scottish HepatoPancreatoBiliary Network (SHPBN)

Pancreatic Collaborative review 2019

Co-chairs: Mr Ross Carter
Dr Lucy Wall

Summary:

(1) Broad brush outline of audit process and data sources

(2) Outline of Executive Summary findings

(3) Summary of some of the problem areas

(4) Discussion of where we may focus effort for the best return

(5) Propose some potential changes with potential to affect positive change and act as a basis for subsequent group discussion

Scottish HepatoPancreatoBiliary Network (SHPBN)

Pancreatic Collaborative review 2019

Name	specialty	Region	Name	specialty	Region
Stephen McNally	Surgeon	NoNCAN	Vicki Save	Pathology	SCAN
Angela Rollo	CNS	NoSCAN	Jo Bowden	palliative care	SCAN
Asa Dahle-Smith	Oncology	NoSCAN	Abdullah Al-Adhami	Radiologist	WoSCAN
Christoph Kulli	Surgeon	NoSCAN	Booth, Kimberley	CNS	WoSCAN
Elaine Henry	Gastro	NoSCAN	Derek Grose	Oncology	WoSCAN
Iain Tait	Surgeon	NoSCAN	Duthie, Fraser	Pathology	WoSCAN
Ishtiaq Zubairi	Oncology	NoSCAN	Elspeth Cowan	CNS	WoSCAN
James Milburn	Surgeon	NoSCAN	Euan Dickson	Surgeon	WoSCAN
Neil Jamieson	Gastro	NoSCAN	Lynn Kennedy	CNS	WoSCAN
Sandeep Siddhi	Gastro	NoSCAN	Milne, Jen	CNS	WoSCAN
Umesh Basavaraju	Gastro	NoSCAN	Ross Carter	Surgeon	WoSCAN
Walter Mweka	Oncology	NoSCAN	Thomson, Sarah Jane	CNS	WoSCAN
Andrew Healey	Surgeon	SCAN	White, Mark	oncology Trainee	WoSCAN
Beverley Wallace	Dietician	SCAN	Debbie Provan	TCAT	
Ian Penman	Gastro	SCAN	Fiona Brown	PCS	
Jac McGhie	CNS	SCAN	georgia papacleovoulou	PCUK	
Lucy Wall	Oncology	SCAN	Rachel Richardson	PCUK	
Ravi Ravindran	Surgeon	SCAN	Sarah Bell	PCUK	
Karen Henderson	Dietician	SCAN			

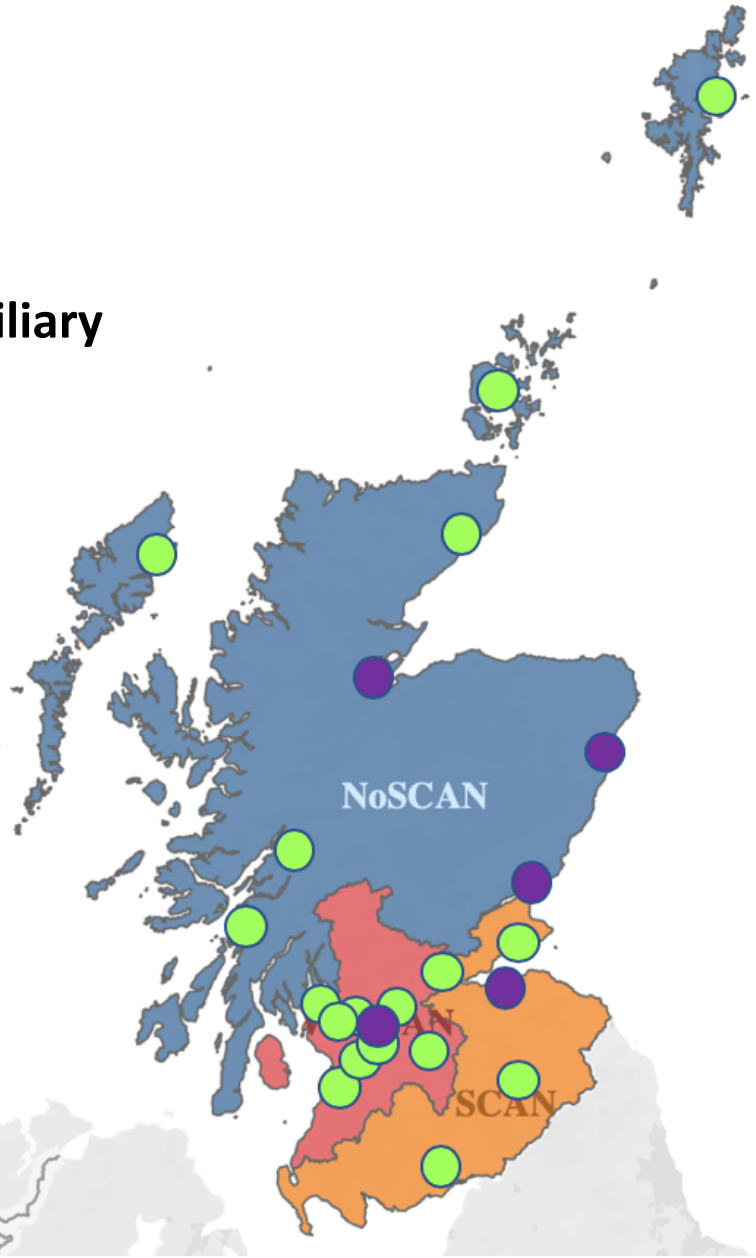
Scottish HepatoPancreatoBiliary Network (SHPBN)

Pancreatic Collaborative review 2019

Comprehensive questionnaire completed by secondary and tertiary care units

Scottish HepatoPancreatoBiliary Network (SHPBN)

WOSCAN:
Glasgow Royal Infirmary
Queen Elizabeth UH
Royal Alexandra Hospital
Inverclyde Royal Infirmary
University Hospital Crosshouse
University Hospital Ayr
University Hospital Monklands
University Hospital Wishaw
University Hospital Hairmyres
Forth Valley Hospital



NOSCAN:
Aberdeen Royal Infirmary
Ninewells Hospital
Perth Royal Infirmary
Raigmore Hospital
Bedford Fortwilliam
Wick Hospital
Lerwick
Balfour Hospital Orkney
Stornoway
Lorne and the isles

SCAN:
Victoria Infirmary
Royal Infirmary of Edinburgh
Borders General Hospital
Dumfries and Galloway

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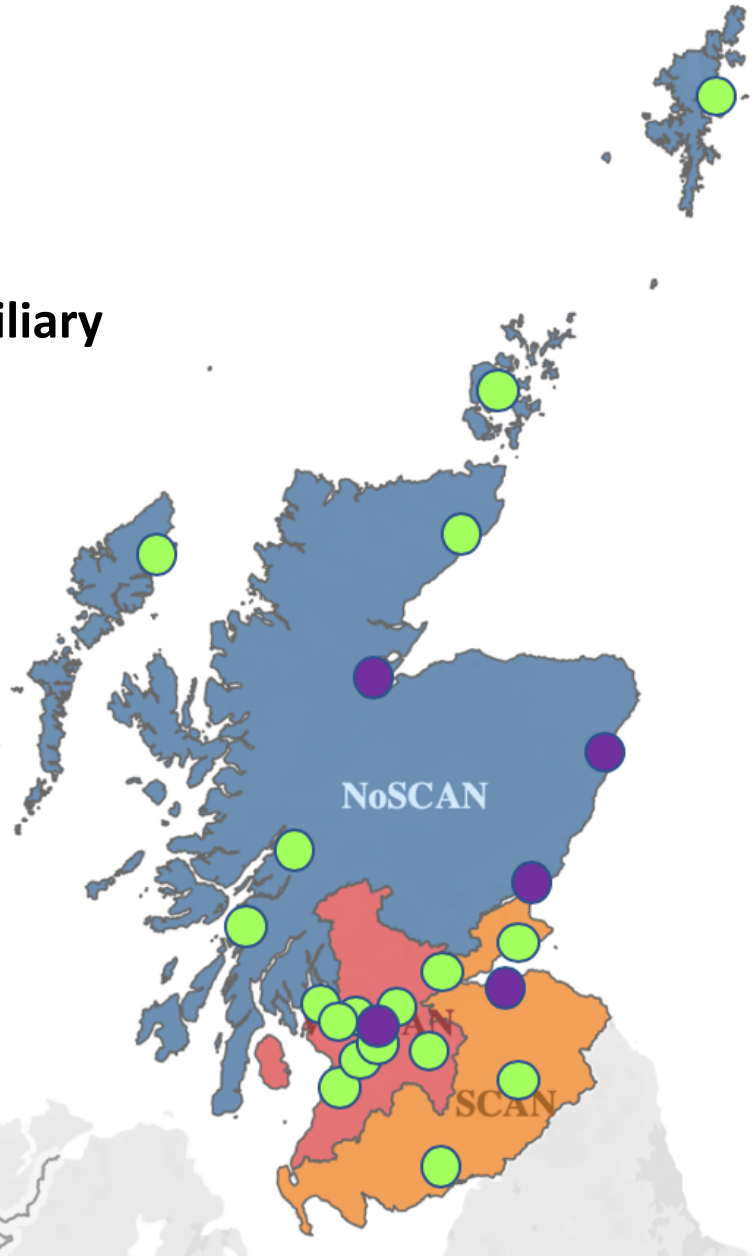

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.. A big thank you to all involved …

Scottish HepatoPancreatoBiliary Network (SHPBN)

Pancreatic Collaborative review 2019

Section 1: Diagnosis to Regional MDM Referral pathway

Delineation of local pathways / delays in imaging etc
Communication of suspicious imaging findings
Communication and support of patients
Existence of local MDM meetings
What local services are available
Communication with GP, CNS, Palliative care

Section 2 - Regional MDM to initiation of treatment

Regional pathways
Duration of staging / waiting times for interventions
Communication of findings with patients and primary care

Section 3 - Delivery of MDT proposed Treatment

Details of where and what is available
Standard regional pathways / preferred options
Problems with delivery of proposed care
Recruitment to trials / research

Section 4 - Follow up, holistic care and anticipatory care provision:

Detail of holistic support (CNS, dietician, psychologist, palliative care)
Anticipatory care planning

Scottish HepatoPancreatoBiliary Network (SHPBN)

Pancreatic Collaborative review 2019

Local audit

SHPBN Network reports

Comprehensive questionnaire completed by secondary and tertiary care units

Executive summary findings:

Phase 1:

(1) There is inconsistent patient referral, investigation and management pathways across Scotland,

(2) Individual clinician preference can influence referral pathways leading to inconsistencies in communication

(3) There are variable delays in reporting of staging investigations

(4) The finding of a pancreatic lesion suspicious of pancreatic cancer are not routinely red flagged by radiology to the referring clinician.

(5) Most staging pathways involve sequential “imaging-report- MDT-imaging” cycles leading to protracted staging pathways, rather than in parallel “bundle” investigation of suspicious lesion.

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Phase 2:

(6) MDM meetings in District General Hospitals results in dual discussion and potential delay referral to a Regional MDT.

(7) Referral information pre MDT is inconsistent / incomplete.

(8) Communication of outcome to patients, referring clinicians and general practitioners pre MDT is inconsistent and often poor.

Executive summary findings: (cont)

(9) Time to initiation of treatment, particularly in patients with potentially curable disease, regularly exceeds 62 days from referral as a result of the staging pathways

(10) Delays in staging pathways can require repetition of outdated imaging prior to treatment

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(12) Only ~ 50% of patients receive active treatment / < 5% get into trials the main block being resource

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Phase 3:

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Phase 4:

(13) Significant specialist nurse time is taken up organising staging investigations/ administrating MDTs rather than maximising direct patient contact.

(14) There is variable CNS, community palliative care, dietetic, and psychological support and less than required

(15) Universally limited best supportive care resource / community access to support

Problem areas:

Surgery: Time between decision and surgery between 2-6 weeks
18 surgeons performing pancreatic resection in 5 sites
Problems: High surgeon / volume number

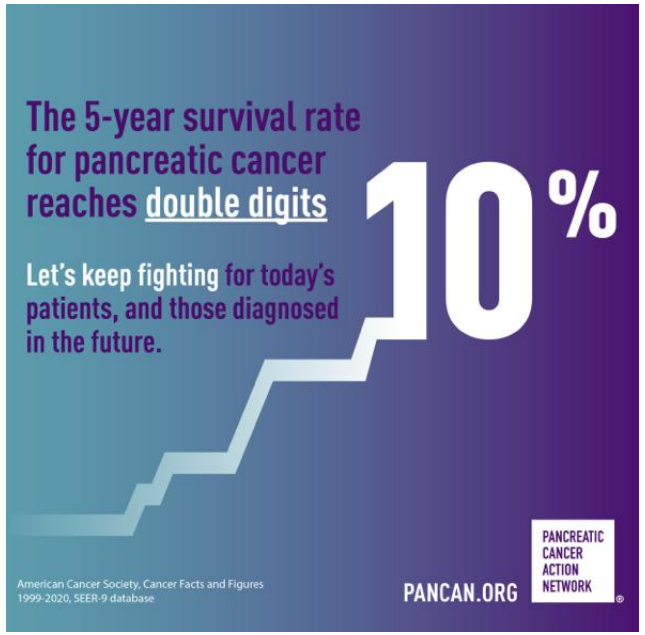
Chemotherapy: Variability of access to regimes across regions
consolidation CRT in Glasgow and Aberdeen
central belt (Forth / Lanarkshire pathway for surgery / oncology inconsistent
Problems: Inconsistent pathways
Low trial recruitment / deterioration in performance status

Provision of endoscopic , percutaneous or interventional radiological services.:
Intermittent availability for palliation of jaundice
Not always 24hr IR cover in some hospitals
Radiological ablative techniques(RFA, Microwave, IRE) not routinely available
Problems: MDT communication problems and intermittent availability

Palliative care: Poor communication with patients during and after staging process
Symptom control (esp. non active treatment patients) poor
deterioration in performance status during assessment and treatment
Problems: Late referral to palliative care services
communication sporadic

Summary statistics for pancreatic cancer

Scotland	Males	Females	Persons
Rank - incidence (2017)	11	9	12
Rank - mortality (2018)	5	4	6
Percentage frequency of all cancers - incidence (2017)	2.5%	2.4%	2.5%
Percentage frequency of all cancers - mortality (2018)	5.1%	5.0%	5.0%
Number of new cases diagnosed in 2017	409	404	813
Number of deaths recorded in 2018	419	392	811
Change in incidence from 2007 to 2017	-0.6%	+5.2%	+2.0%
Change in mortality from 2008 to 2018	+2.5%	+0.9%	+1.8%
1 year relative survival for patients diagnosed between 2007 and 2011	17.7%	17.1%	17.4%
5 year relative survival for patients diagnosed between 2007 and 2011	3.3%	4.5%	3.8%



… is it time for change?

Summary statistics for pancreatic cancer

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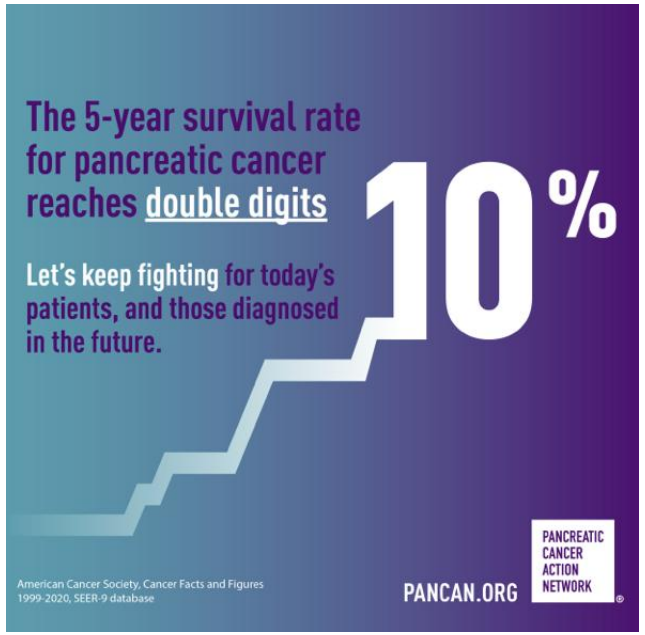
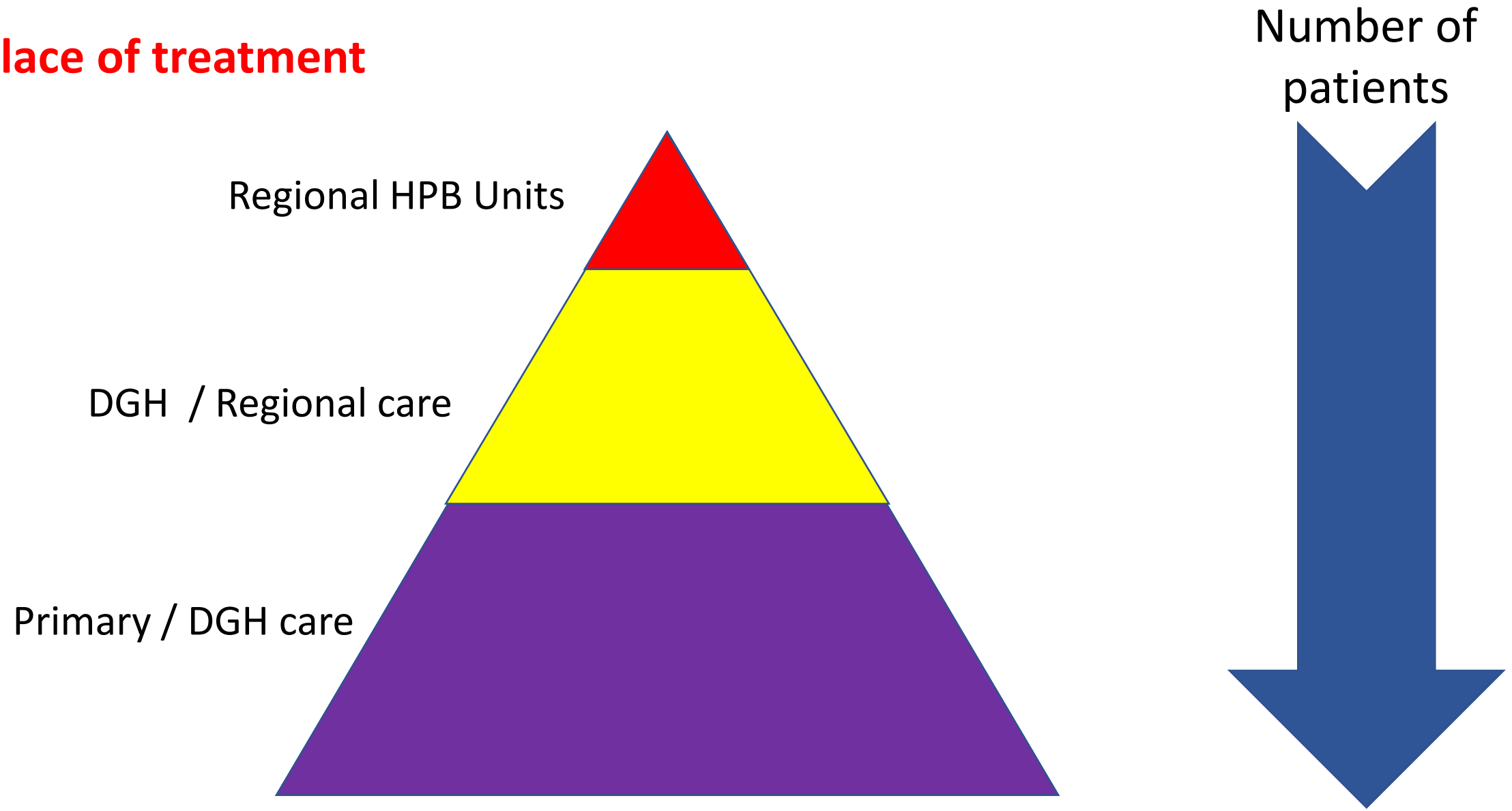
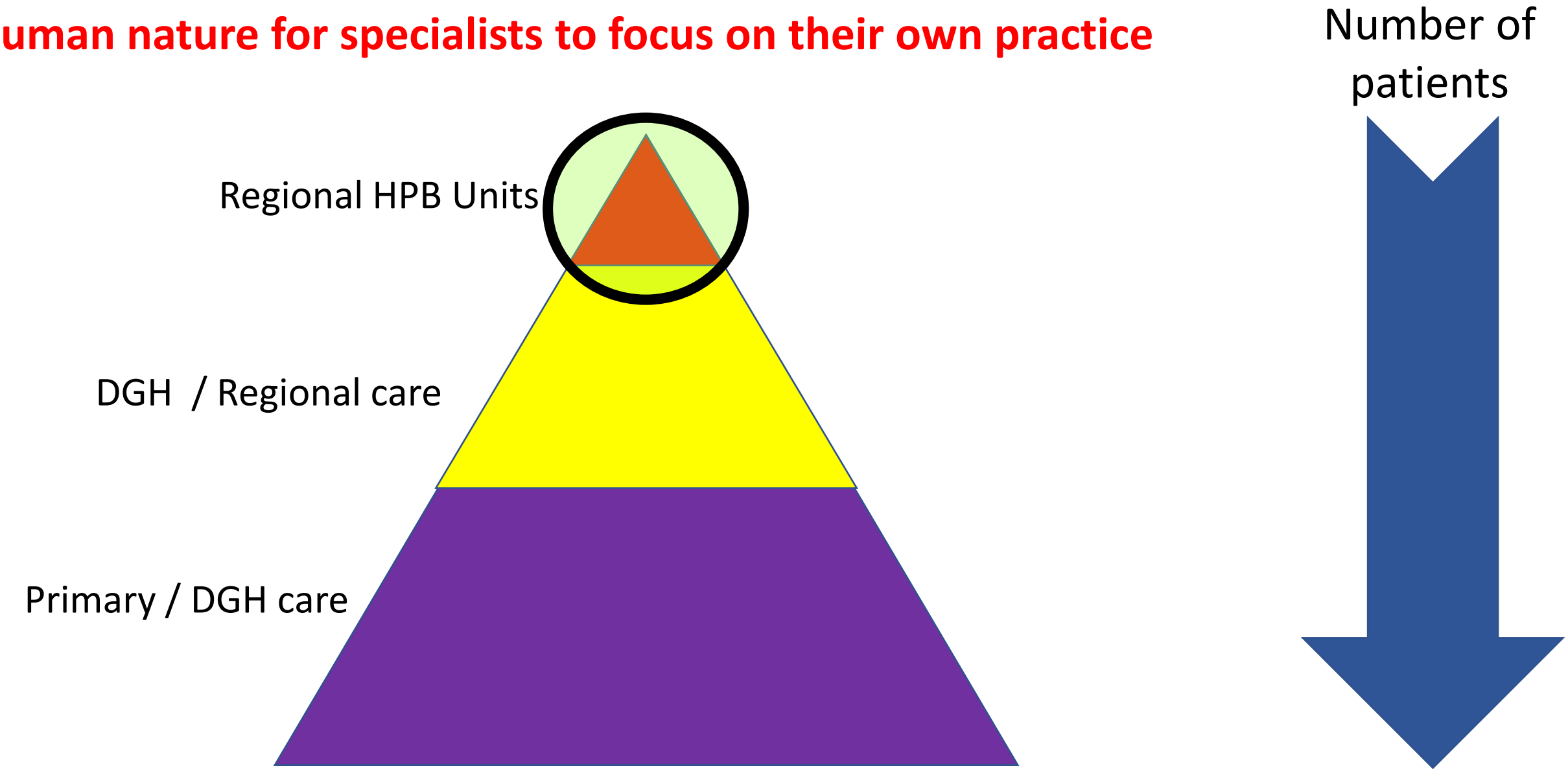


… but what to change?

Place of treatment

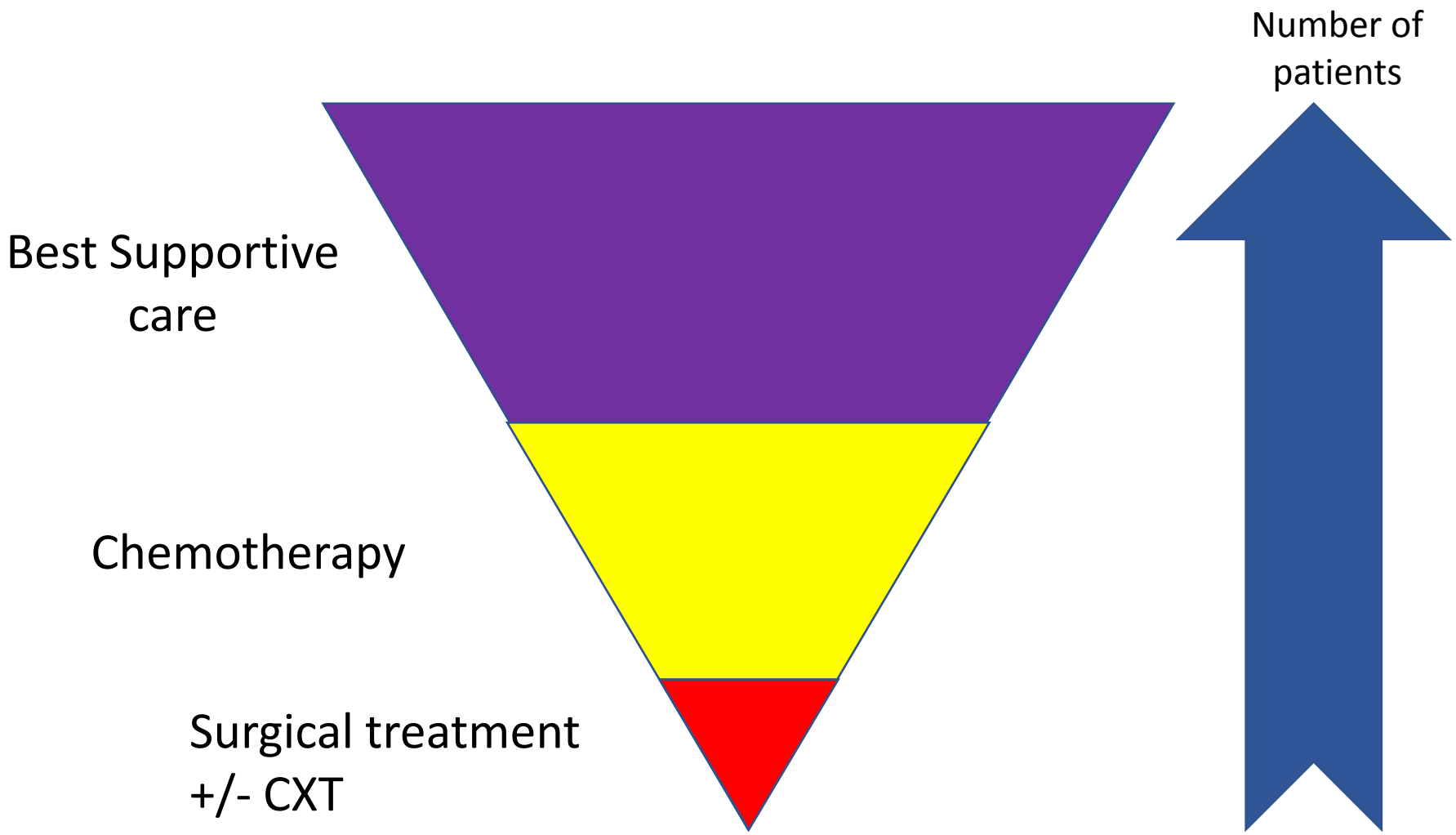


Human nature for specialists to focus on their own practice



Even big improvements within a small number of patients will have a small overall 5YS effect

Even a small improvement in every patients will have a significant overall 5YS effect



Need to focus on aspects of management which affect everyone (optimizing the assessment/ staging phase)

Everyone doing their best, but….

Procrastinated referral / investigation period

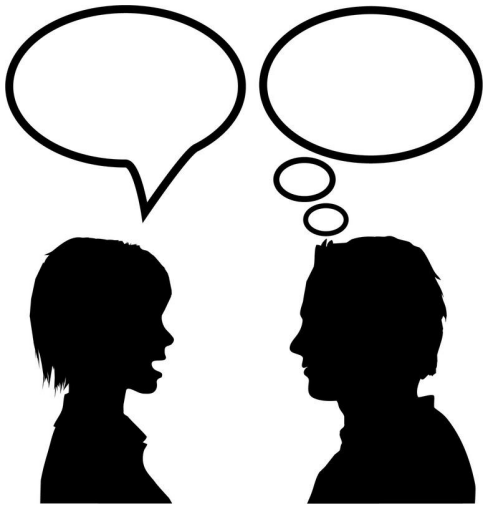
Deteriorating performance status often limits options

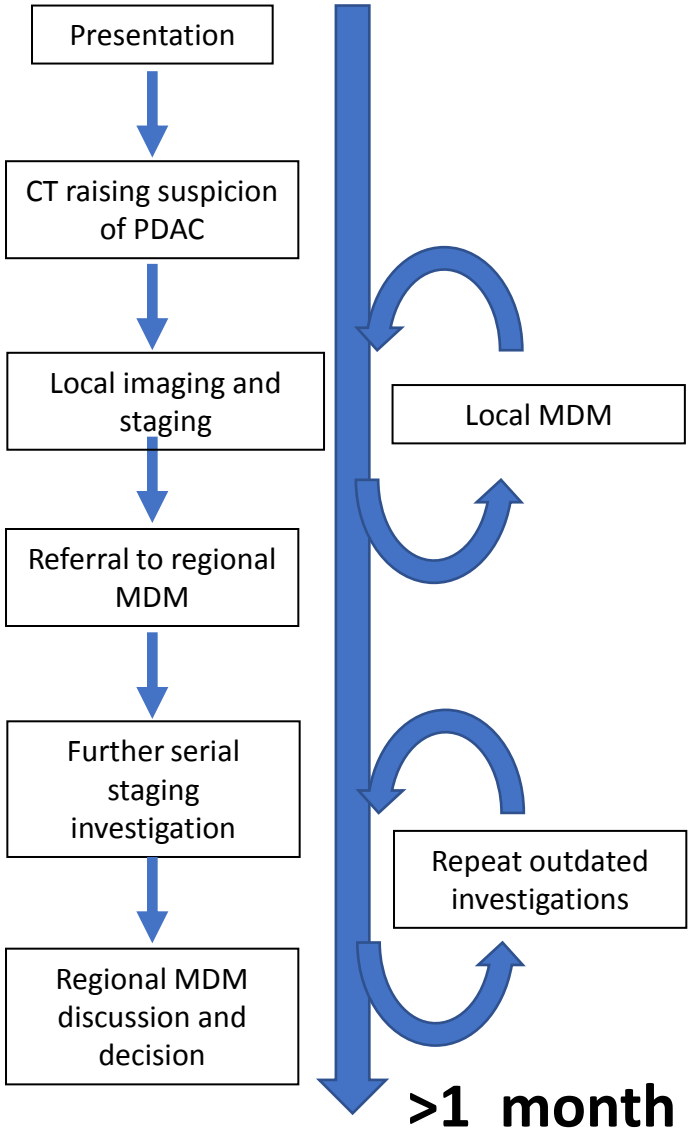
Reduced nutritional intake

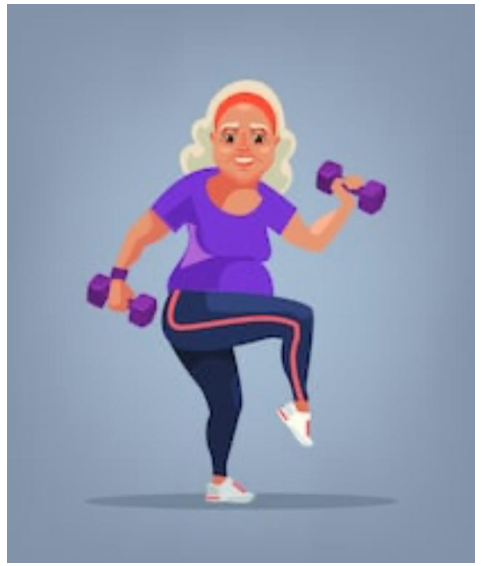
Poor symptom control

Depression and reduced activity

Patient isolation/limited communication during staging process







So what can we do to improve early management?

Avoid delays in responding to positive investigations (e.g. USOC on CT)

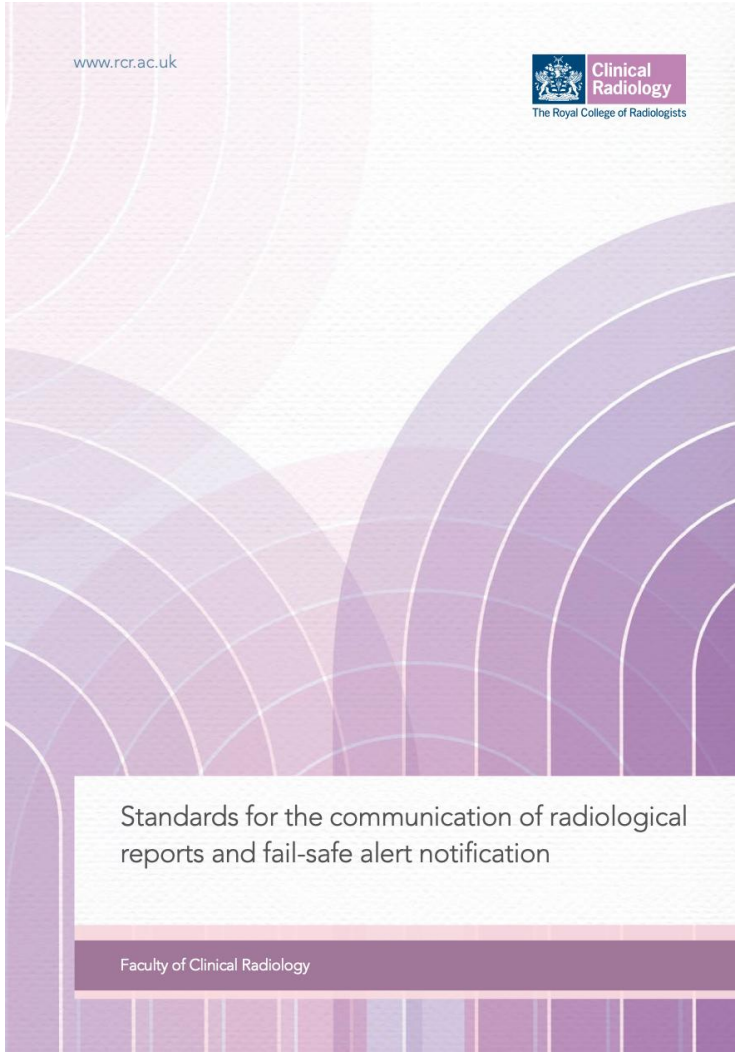
Delays in reacting to positive radiological findings :

Communication. … Flagging up suspicious radiology

Standard 2
It is the responsibility of the radiologist to produce reports as quickly and efficiently as possible, and to flag reports when they feel a fail-safe alert is required.

But who / how to flag reports ….

..need a mechanism to facilitate alert notification



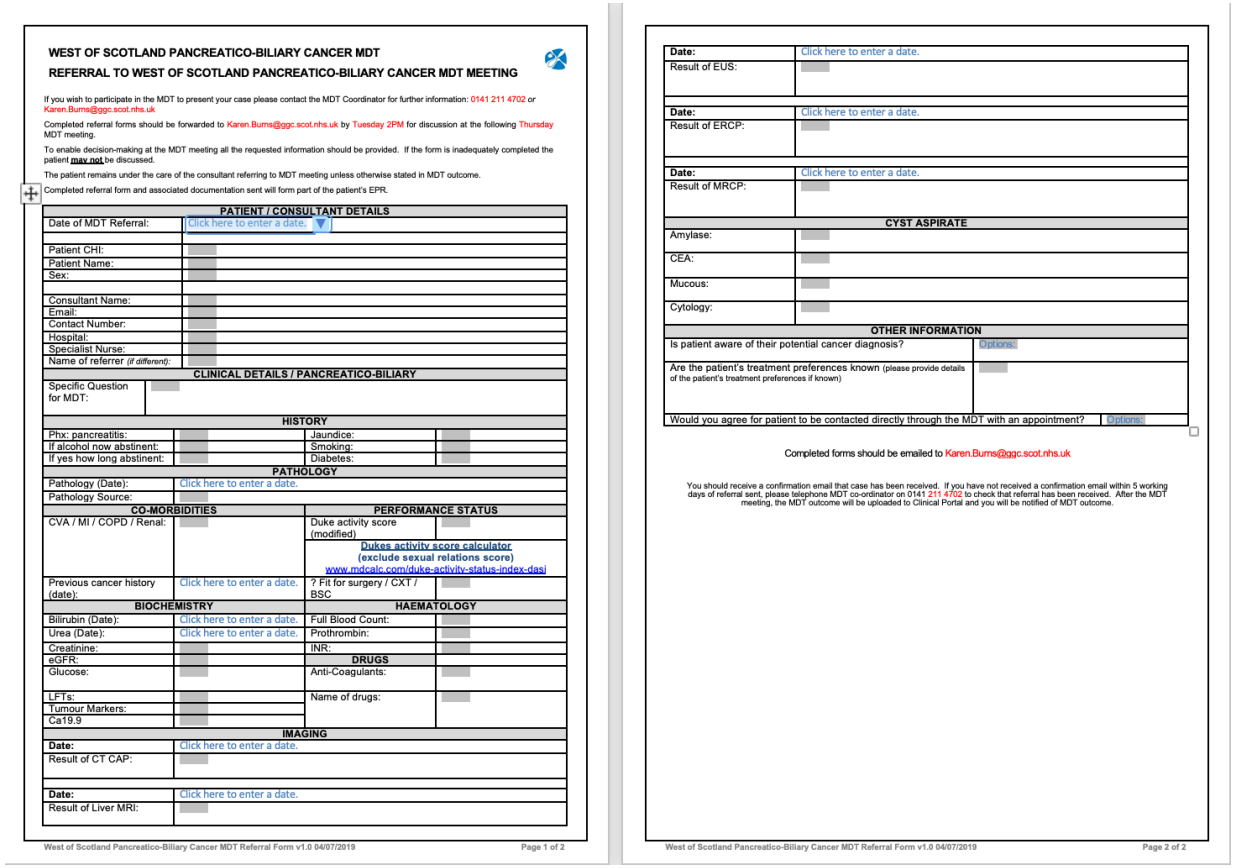
So what can we do to improve early management?

Avoid delays in responding to positive investigations (e.g. USOC on CT)

Streamline the referral process

Streamline the referral process:

Communication. … Consistent referral process and pathway



WEST OF SCOTLAND PANCREATICO-BILIARY CANCER MDT

REFERRAL TO WEST OF SCOTLAND PANCREATICO-BILIARY CANCER MDT MEETING

If you wish to participate in the MDT to present your case please contact the MDT Coordinator for further information: 0141 211 4702 *or* Karen.Burns@ggc.scot.nhs.uk

Completed referral forms should be forwarded to Karen.Burns@ggc.scot.nhs.uk by Tuesday 2PM for discussion at the following Thursday MDT meeting.

To enable decision-making at the MDT meeting all the requested information should be provided. If the form is inadequately completed the patient may not be discussed.

The patient remains under the care of the consultant referring to MDT meeting unless otherwise stated in MDT outcome.

Completed referral form and associated documentation sent will form part of the patient's EPR.

PATIENT / CONSULTANT DETAILS	
Date of MDT Referral:	Click here to enter a date.
Patient CHI:	
Patient Name:	
Sex:	
Consultant Name:	
Email:	
Contact Number:	
Hospital:	
Specialist Nurse:	
Name of referrer *(if different)*:	

CLINICAL DETAILS / PANCREATICO-BILIARY	
Specific Question for MDT:	

HISTORY			
Phx: pancreatitis:		Jaundice:	
If alcohol now abstinent:		Smoking:	
If yes how long abstinent:		Diabetes:	

PATHOLOGY	
Pathology (Date):	Click here to enter a date.
Pathology Source:	

CO-MORBIDITIES		PERFORMANCE STATUS	
CVA / MI / COPD / Renal:		Duke activity score (modified)	
		Dukes activity score calculator (exclude sexual relations score) www.mdcalc.com/duke-activity-status-index-dasi	
Previous cancer history (date):	Click here to enter a date.	? Fit for surgery / CXT / BSC	

BIOCHEMISTRY		HAEMATOLOGY	
Bilirubin (Date):	Click here to enter a date.	Full Blood Count:	
Urea (Date):	Click here to enter a date.	Prothrombin:	
Creatinine:		INR:	
eGFR:		DRUGS	
Glucose:		Anti-Coagulants:	
LFTs:		Name of drugs:	
Tumour Markers:			
Ca19.9			

IMAGING	
Date:	Click here to enter a date.
Result of CT CAP:	
Date:	Click here to enter a date.
Result of Liver MRI:	

West of Scotland Pancreatico-Biliary Cancer MDT Referral Form v1.0 04/07/2019 Page 1 of 2

Date:	Click here to enter a date.
Result of EUS:	
Date:	Click here to enter a date.
Result of ERCP:	
Date:	Click here to enter a date.
Result of MRCP:	

CYST ASPIRATE	
Amylase:	
CEA:	
Mucous:	
Cytology:	

OTHER INFORMATION	
Is patient aware of their potential cancer diagnosis?	Options
Are the patient's treatment preferences known (please provide details of the patient's treatment preferences if known)	
Would you agree for patient to be contacted directly through the MDT with an appointment?	Options

Completed forms should be emailed to Karen.Burns@ggc.scot.nhs.uk

You should receive a confirmation email that case has been received. If you have not received a confirmation email within 5 working days of referral sent, please telephone MDT co-ordinator on 0141 211 4702 to check that referral has been received. After the MDT meeting, the MDT outcome will be uploaded to Clinical Portal and you will be notified of MDT outcome.

West of Scotland Pancreatico-Biliary Cancer MDT Referral Form v1.0 04/07/2019 Page 2 of 2

Standardised referral forms with automated email alerts

Rationalise referral pathways

Pathway variability disassociates patients from the CNS network

NHS Forth Valley 30 diagnosed (9.3%)

Tuesday/Friday HPB MDTs (ERI)

Initial Clinic
FVRH

Diagnostics
FVRH

Outpatient Clinics
FVRH

Staging
FVRH and referred to ERI

Surgery
Referred to ERI

Adjuvant SACT
Referred to EWGH or BWoSCC

Palliative Treatment
FVRH or referred to EWGH or BWoSCC

Follow-up
ERI/EWGH or GRI/BWoSCC

So what can we do to improve early management?

Avoid delays in responding to positive investigations (e.g. USOC on CT)

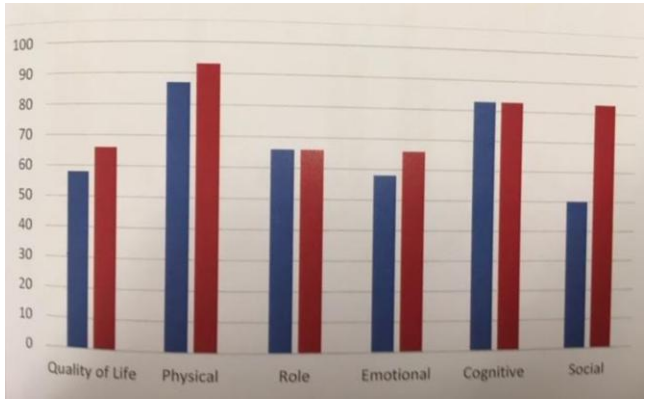
Streamline the referral process

Prevent deterioration of performance status during assessment prior to initiation of treatment

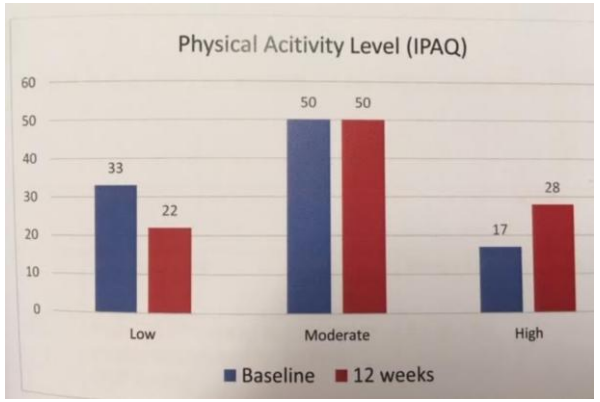
FEED study: (Fish-oil ONS, enzymes (PERT), Exercise and Diet)

Ms Oonagh Griffin, Professor Kevin Conlon and Professor Justin Geoghegan, Dublin

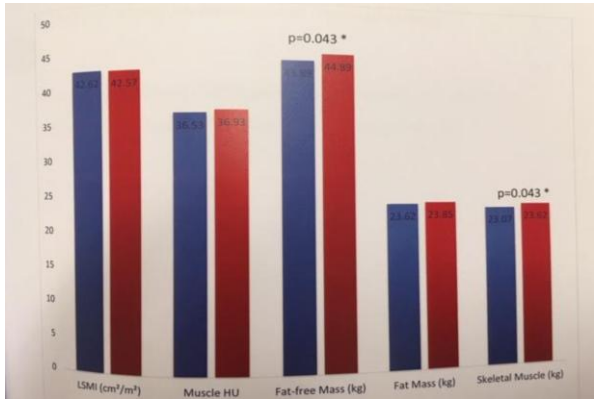
- Study of Intensive nutrition and exercise supportive care during neoadjuvant CXT



Body composition



Physical activity



Health related
Quality of life

Conclusion:

Maintenance of performance status, weight and quality of life is possible during staging and treatment through early holistic education and intervention

So what can we do to improve early management?

Avoid delays in responding to positive investigations (e.g. USOC on CT)

Streamline the referral process

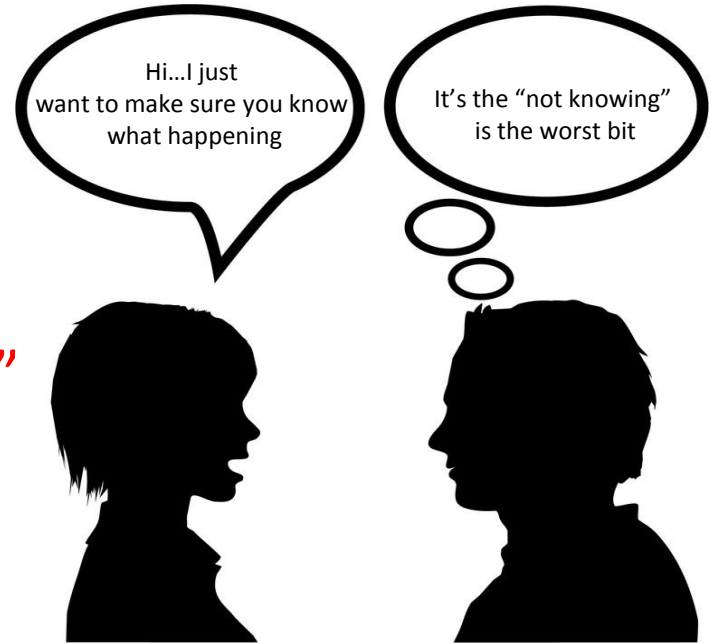
Prevent deterioration of performance status during assessment prior to initiation of treatment

Improve communication between all stakeholders from the point of initial referral

The Key Worker :

Nominated local (likely CNS) individual to act as a fulcrum and point of contact to:

(1) Explain investigations and staging process (and that it may NOT be cancer)
(2) Initiate early holistic BSC, symptom control, nutritional and exercise plan
(3) Liaise with the local DGH re interventions
(4) Introduce concepts of trials if appropriate
(5) Liaise with primary care
(6) Liaise with palliative care
(7) Feed back to Network as patients advocate re “wishes”



So what can we do to improve early management?

Avoid delays in responding to positive investigations (e.g. USOC on CT)

Streamline the referral process

Prevent deterioration of performance status during assessment prior to initiation of treatment

Improve communication between all stakeholders from initial referral

Increase numbers receiving active treatment and trial recruitment through all of above

Proposals: things to stop….

Discontinue discussion of pancreatic cancer patients in local MDTs with direct regional referral, saving time and potentially resource.

Agree consistency of Health Board referral pathways regardless of stage of disease (e.g. Forth and Lanarkshire)

Identify where CNS time is taken up by administration tasks

What do we need?

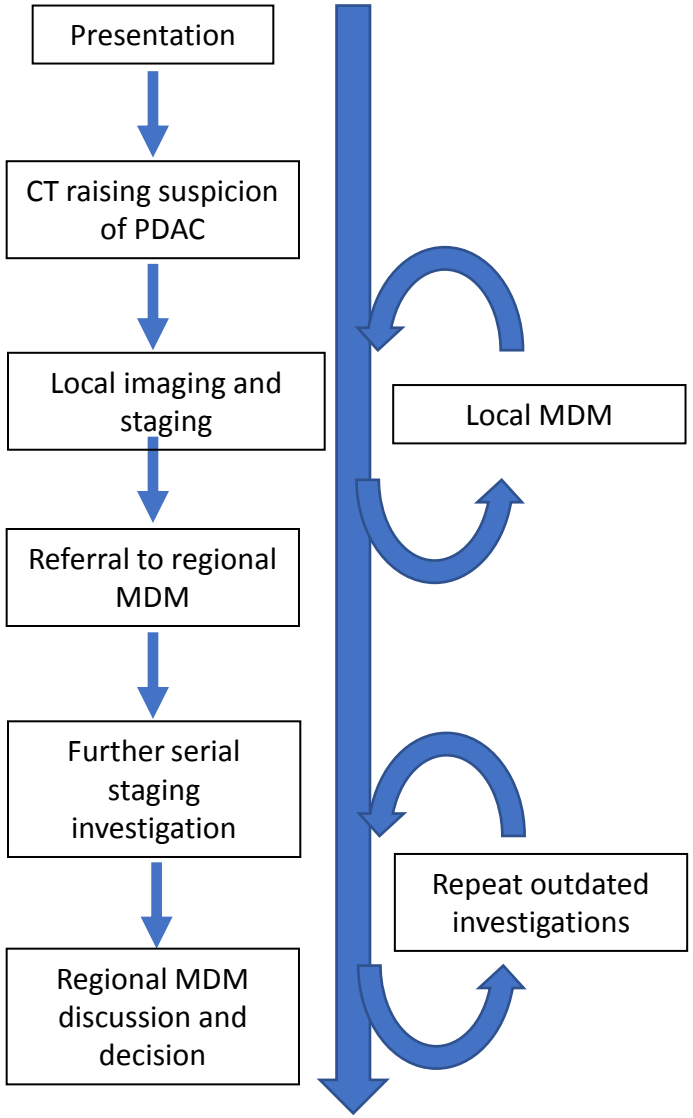
Willingness to change…

What do we need?

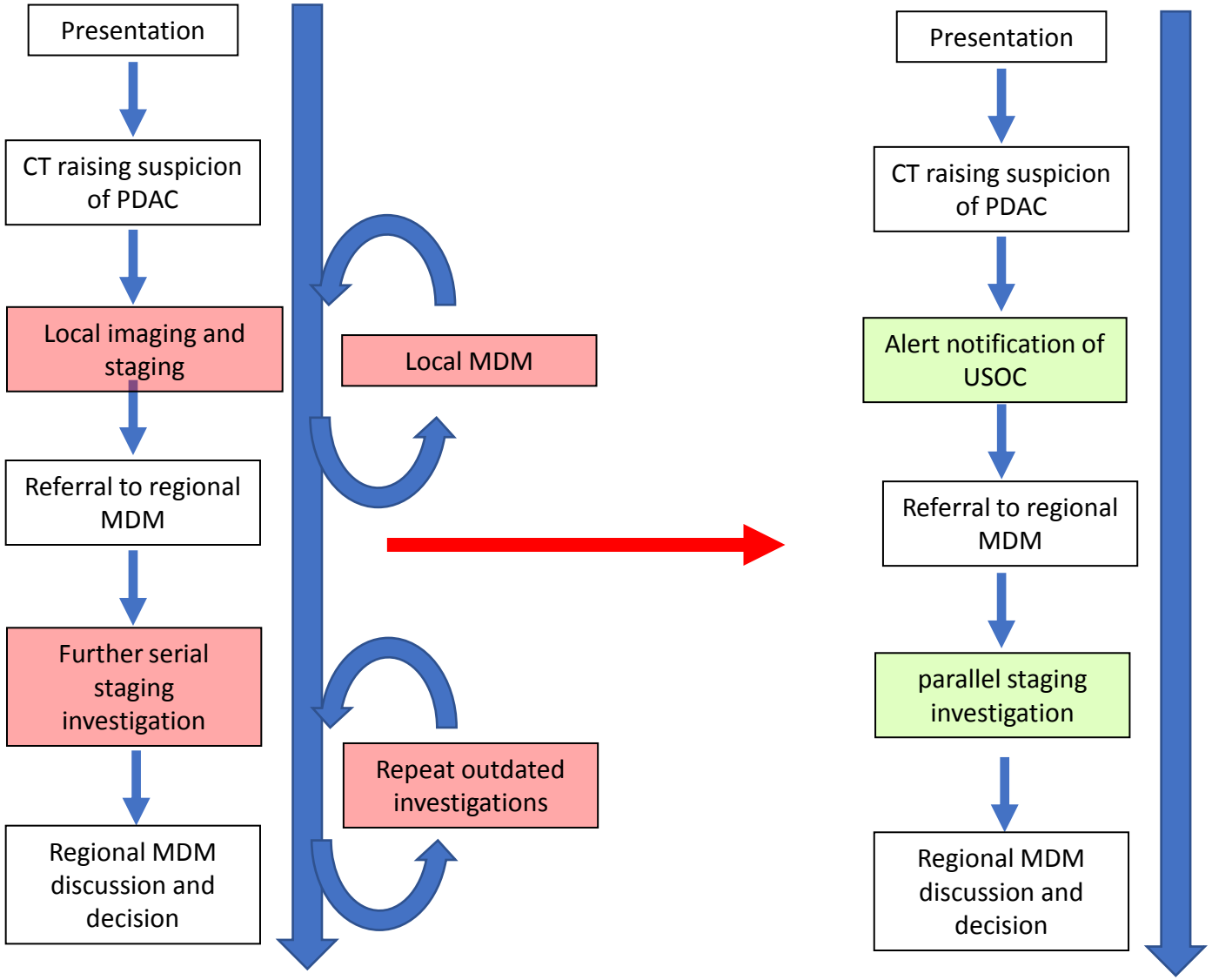
Willingness to change…

Streamline pathways

Streamline pathways



Streamline pathways



What do we need?

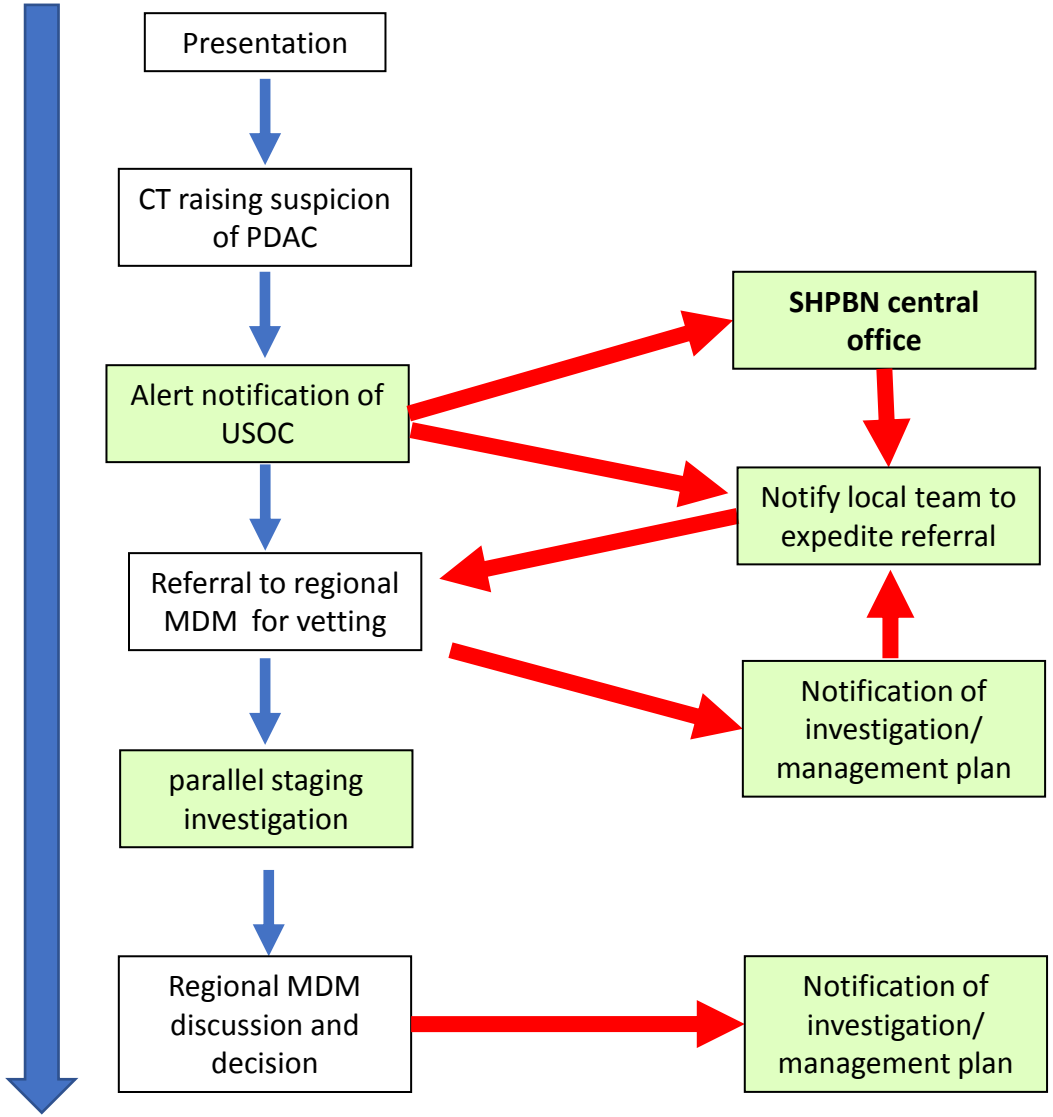
Willingness to change…

Streamline pathways

Establish a “Managed Care Network” focused on addressing care delivery

Central registration (SHPBN) of USOCs and referrals to act as a hub for communication

Central registration of USOCs and referrals …



Single email address for USOCs to initiate alert

Communication with
(a) requesting team
(b) encourage urgent MDM referral

Identify possible local “key worker”

Establish a patient specific communication network

Facilitate accurate QPI data

What do we need?

Willingness to change…

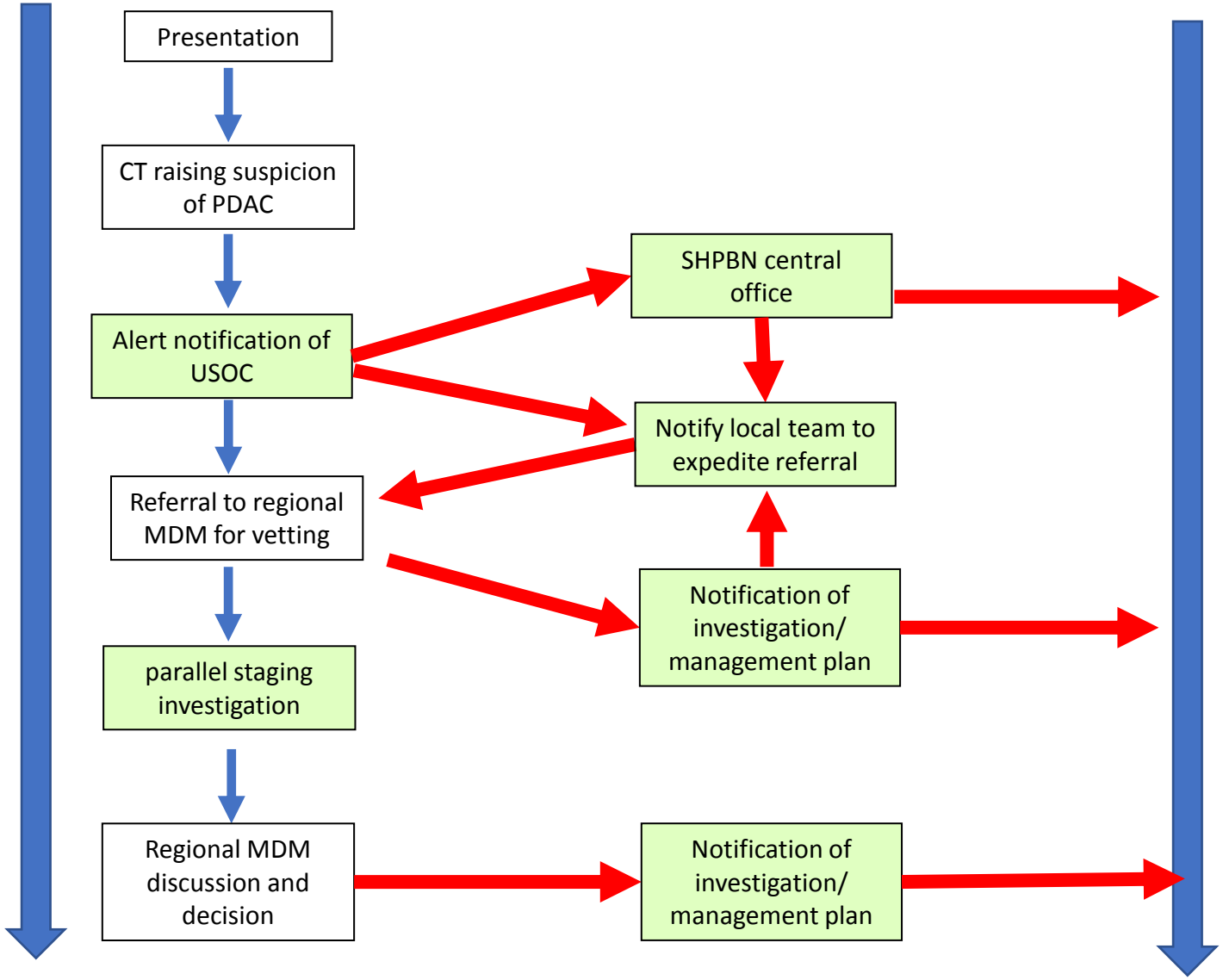
Streamline pathways

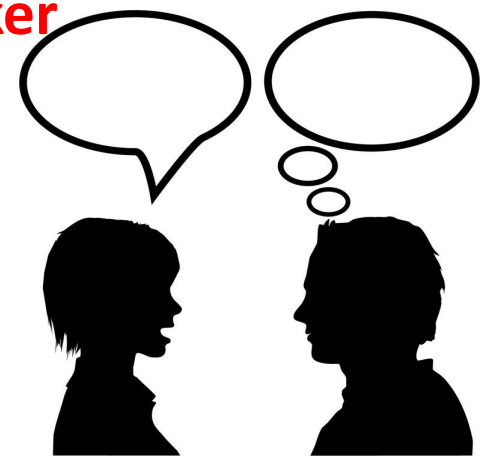
Establish a “Managed Care Network” focused on addressing care delivery

Central registration (SHPBN) of USOCs and referrals to act as a hub for communication

Formalisation of CNS network

Communication , communication, communication… the key worker





Identify a key individual to accompany
And assist the patient/family through the
Investigation / staging and treatment process

Initiate holistic BSC

Discuss the investigation plan

Answer questions

Explain MDM treatment options

Communicate with local teams / primary care

What do we need?

Willingness to change…

…are you ?

2020 QPI's

QPI 6 – Radiological Diagnosis of Pancreatic, Duodenal or Biliary Tract Cancer

QPI 7 – Pathological Diagnosis of Pancreatic, Duodenal or Biliary Tract Cancer

QPI 10 – Lymph Node Yield

QPI 11 – 30 and 90 Day Mortality After Surgical Resection for Pancreatic, Duodenal or Distal Biliary Tract Cancer

QPI 12 – Volume of Cases per Centre/Surgeon

QPI 13 – Clinical Trial and Research Study Access

QPI 14 - 30 Day Mortality following Systemic Anti-Cancer Therapy (SACT)

QPI 15 – Access to Palliative Systemic Therapy for Pancreatic Cancer