Pancreatic Cancer UK

#SummitPanc20

Virtual
ANNUAL SUMMIT 2020
IMPROVING OUTCOMES NOW

Improving the Pathway from Diagnosis to Treatment, 29th Sept 2020, 9 – 11am

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Early engagement of local Clinical Nurse Specialists

Ms Anya Adair, Transplant/HPB Consultant Surgeon,
Royal Infirmary Edinburgh

Early Engagement of Local Clinical Nurse Specialists

Ms Anya Adair

Clinical Lead Scottish HPB Cancer Network

Consultant HPB/Transplant Surgeon

Royal Infirmary Edinburgh

Scottish HepatoPancreatoBiliary Network (SHPBN)

Pancreatic Collaborative established 2018

Name	specialty	Region	Name	specialty	Region
Stephen McNally	Surgeon	Nonce	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)
National Educational meeting Jan 2019

Pancreatic Collaborative review 2019

Co chairs: Ross Carter & Lucy Wall

Questionnaire completed by secondary and tertiary care units across all 14 health boards in Scotland

Scottish HepatoPancreatoBiliary Network (SHPBN)

Pancreatic Collaborative review 2019

Section 1: Diagnosis to Regional MDM Referral pathway

Section 2 - Regional MDM to initiation of treatment

Section 3 - Delivery of MDT proposed Treatment

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

Executive summary findings:

Phase 1: Diagnosis to regional MDM referral

(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

Executive summary findings:

Phase 2: Regional MDM to initiation of treatment :

(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.

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 out-dated imaging prior to treatment

Executive summary findings: (cont.)

Phase 3: Delivery of MDT proposed Treatment

(11) Access to a full range of treatments or research trials are inconsistent across Scotland

(12) Only ~ 50% of patients receive active treatment / < 5% get into trials

Phase 4: Follow up, holistic care and anticipatory care provision

(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

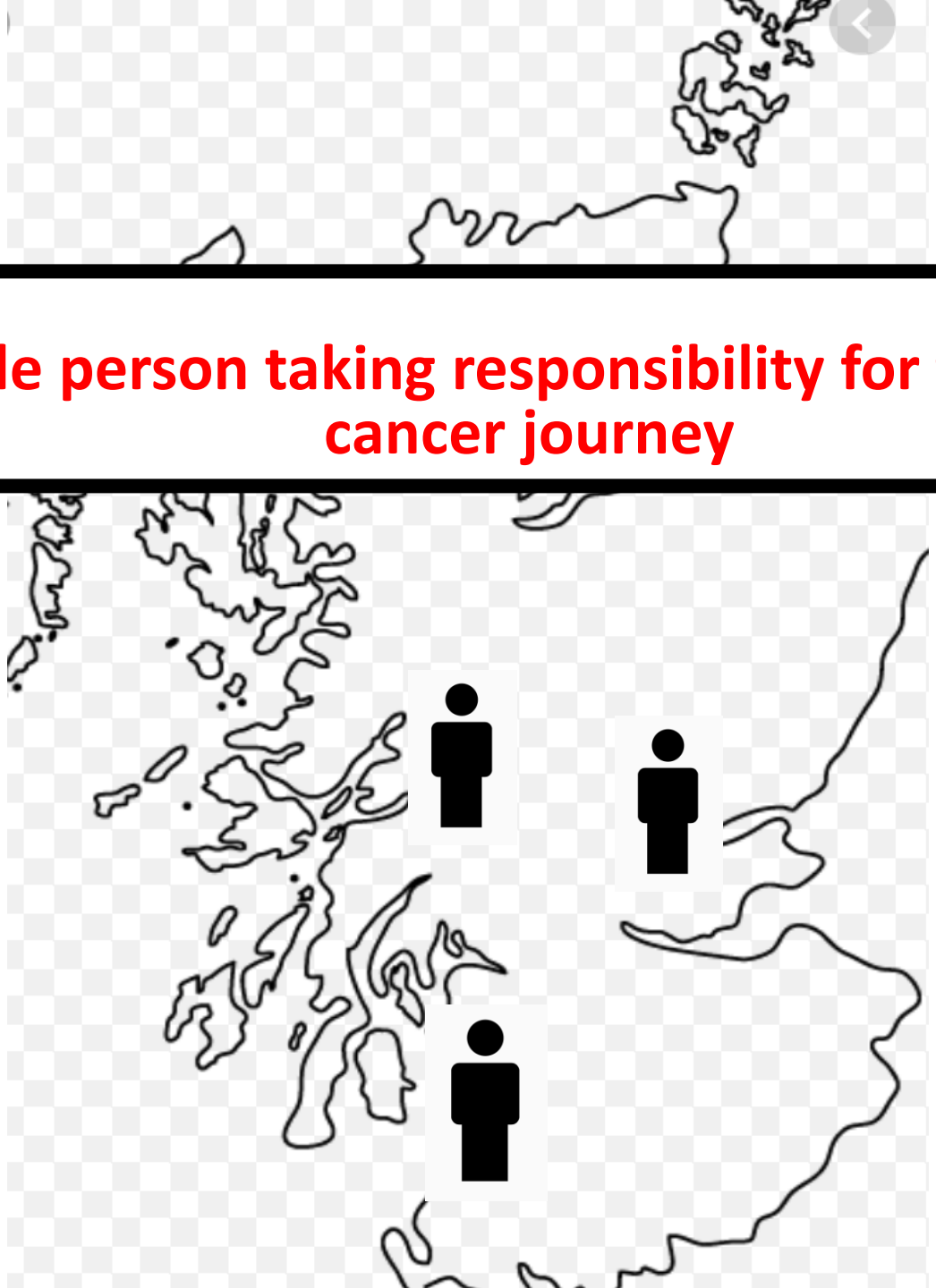
So what can we do to improve early management?

Avoid delays in responding to positive investigations

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

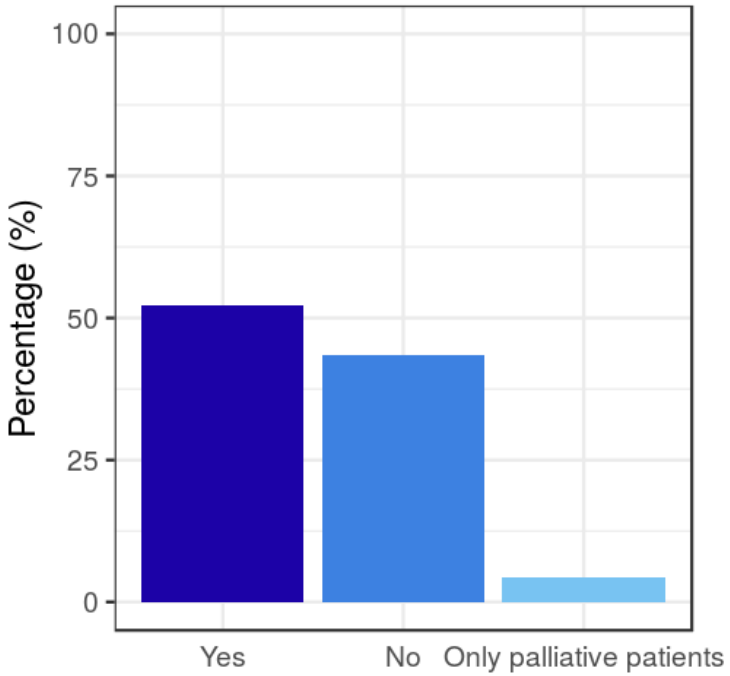


No single person taking responsibility for the patients cancer journey

Hepatocellular Carcinoma
SHPBN National Questionnaire:

- 33 item questionnaire delivered
- 23 hospitals responded
- across 14 health boards

Do your patients have access to a Clinical Nurse Specialist



q18	n	percentage
Yes	12 / 23	52.17%
No	10 / 23	43.48%
Only palliative patients	1 / 23	4.35%

Strong themes in free-text:

- Key to coordinate patient journey (particularly given that patients often have long journeys)
- Help with continuity of care
- Some centres have liver nurses, but these are already busy!

Key Worker/CNS

- Ensures communication with patient and family
- Ensures communication between departments and between hospitals
- Ensures the patient pathway is as smooth and efficient as possible

Quality Performance Indicators (QPIs)

- Scottish Cancer Taskforce
- Provide quality improvement in cancer care across NHS Scotland
- National Quality performance Indicators
- Indicators for the management of HCC

New Quality Performance Indicators (QPI) 2020

- Patients with Hepatocellular Carcinoma (HCC) should have an identified keyworker to coordinate care across the patient pathway

New Quality Performance Indicators (QPI) 2020

Access to Palliative Systemic Therapy for Pancreatic Cancer

Title: Patients with inoperable pancreatic cancer should be seen by an oncologist to assess suitability for systemic treatment.

Description: Proportion of patients with pancreatic cancer not undergoing surgery who are seen in an oncology clinic within 6 weeks of initial diagnostic CT scan.

Target: 50% The tolerance within this target is designed to account for those patients with comorbidities for whom systemic therapy would not be appropriate, and for factors of patient choice.

Scottish HepatoPancreatoBiliary Network (SHPBN)
Best Supportive Care Collaborative

- British Liver Trust, Pancreatic Cancer Scotland, Pancreatic Cancer UK, Ayrshire Hospice.

- Surgeons, Palliative Care Consultants, Clinical Nurse Specialists and Dietician

- Support from Debbie Provan (WoSCAN Lead for Living With and Beyond Cancer)

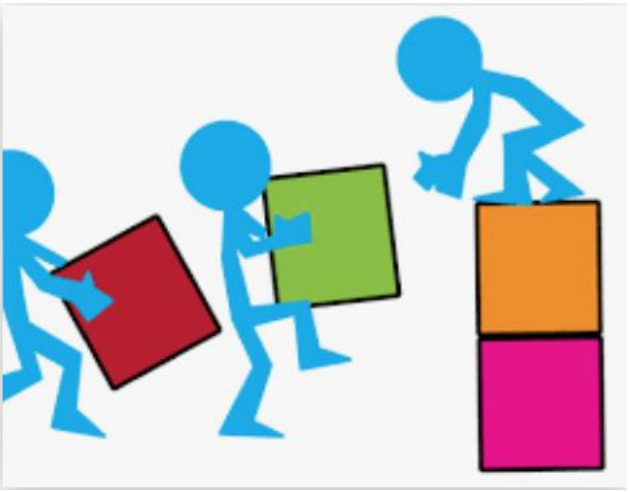
Better cancer care (Scottish Government 2008) states:

- **“**Care systems, protocols or pathways should be developed to ensure that psychological needs are actively considered as a part of planning care.”

- “A broad approach to quality…. ensures that every patient receives the same standard of care regardless of … **geographical location**.”

Realising Realistic medicine

- The Scottish Government proposes that *"**Scotland's NHS will become more patient centred and innovative with the aim that by 2025 anyone providing healthcare in Scotland will take a realistic medicine approach and in this way….***
- Effective patient information and Education about treatment options so informed decisions can be made.



Together is always better: we need to collaborate

- *Same issues with other cancer groups*

- **Less survivable cancer task force:**

  Expert roundtable meetings with Scottish Government Cancer Policy team: 2020

- *Set up a CNS Scottish network for HPB cancers?*
- *Navigator for the patient along their journey?*

thanks

- Ross Carter
- Lucy Wall
- Tom Drake
- Adrian Stanley
- Lindsay Campbell