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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Improving the MDT Function

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Improving MDT Function

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September 2020

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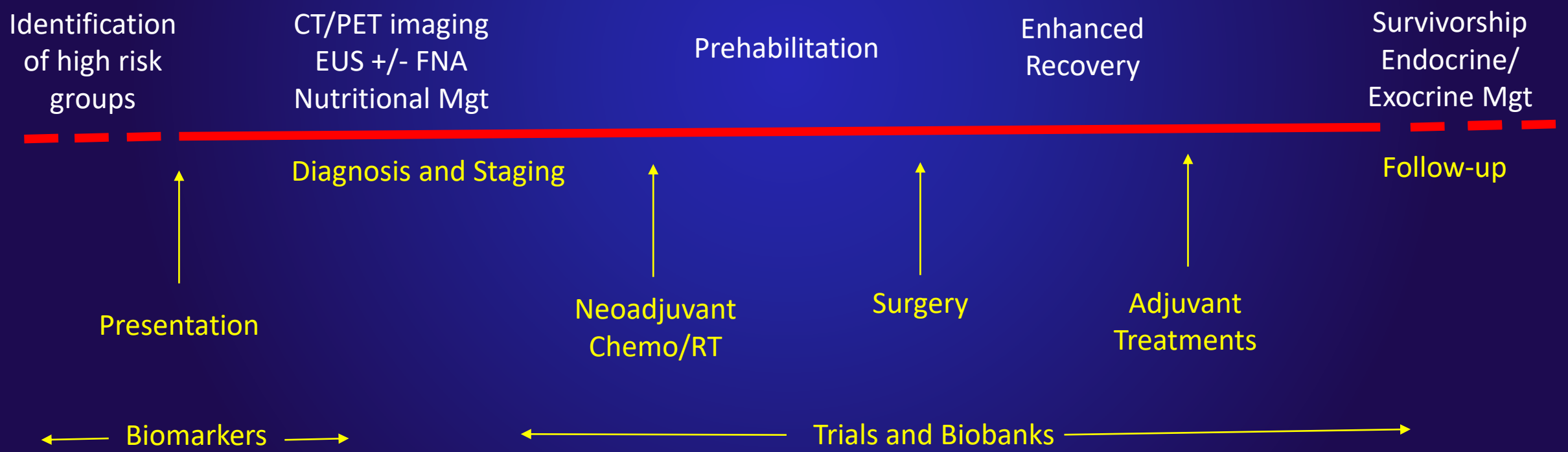
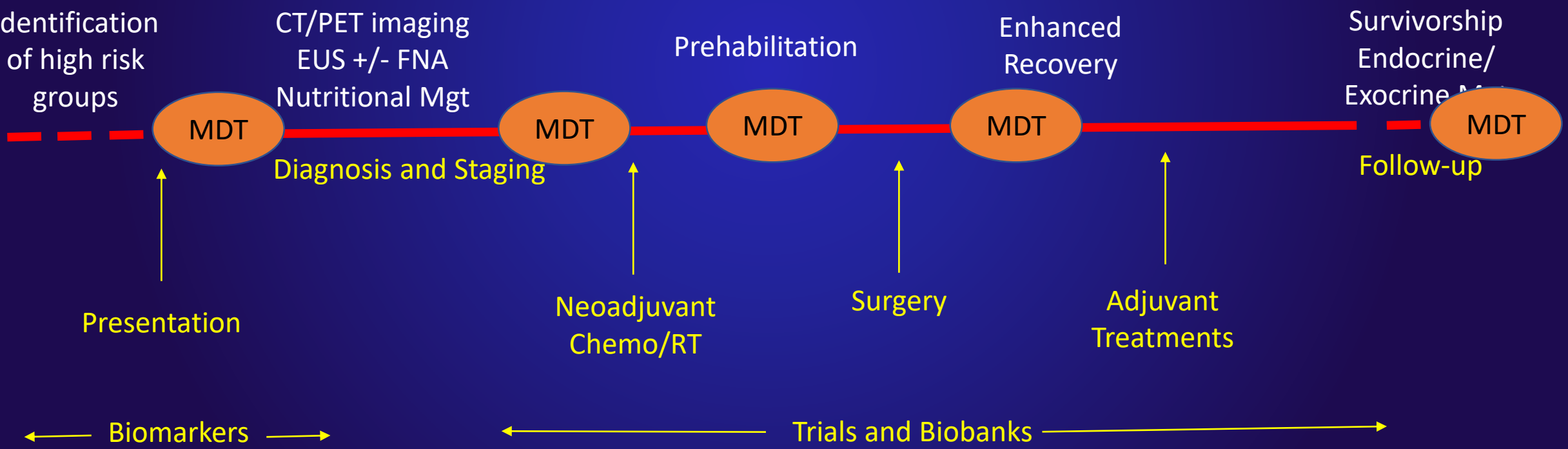
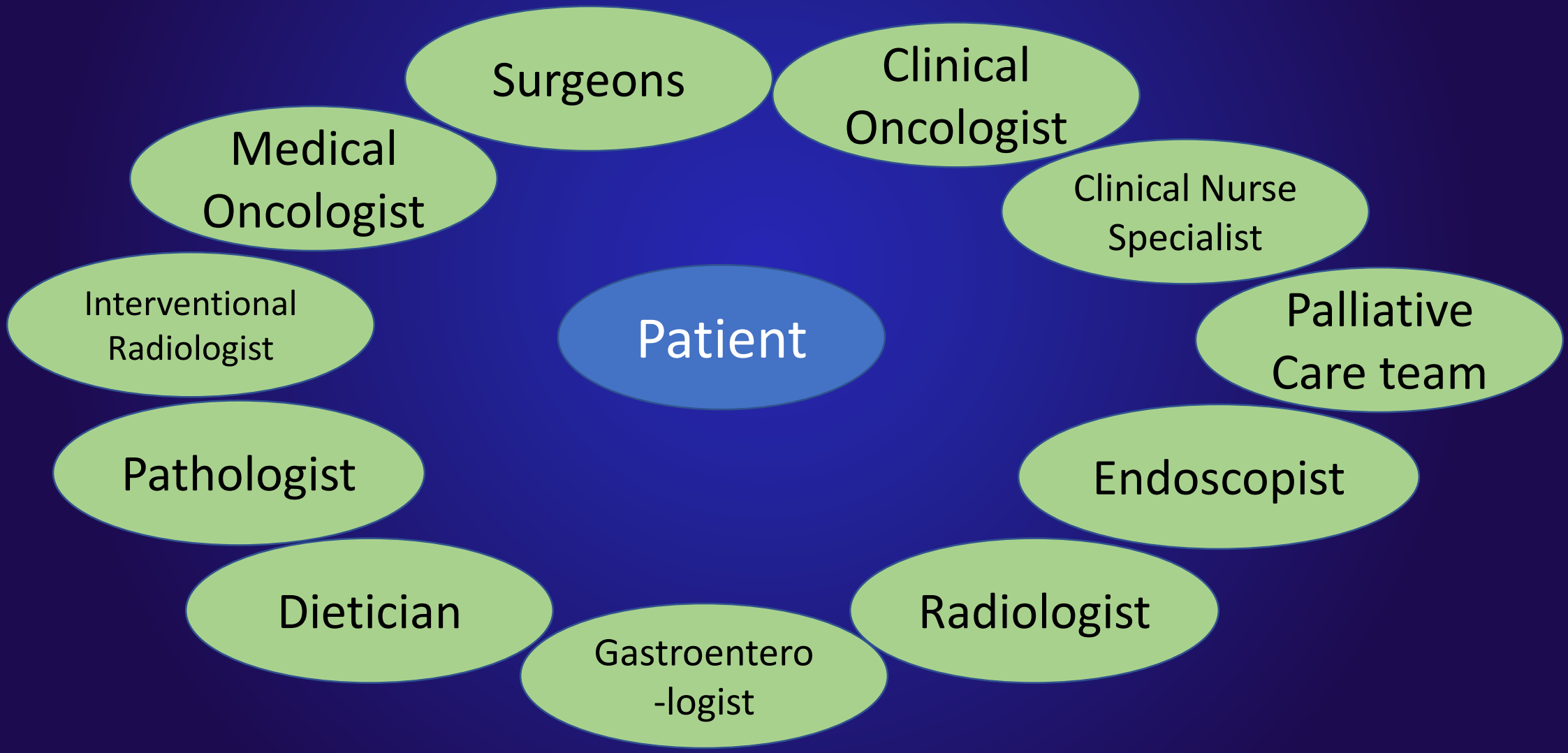
Patient Pathway – Pancreatic Cancer



Patient Pathway – Pancreatic Cancer



Pancreatic Multidisciplinary Team

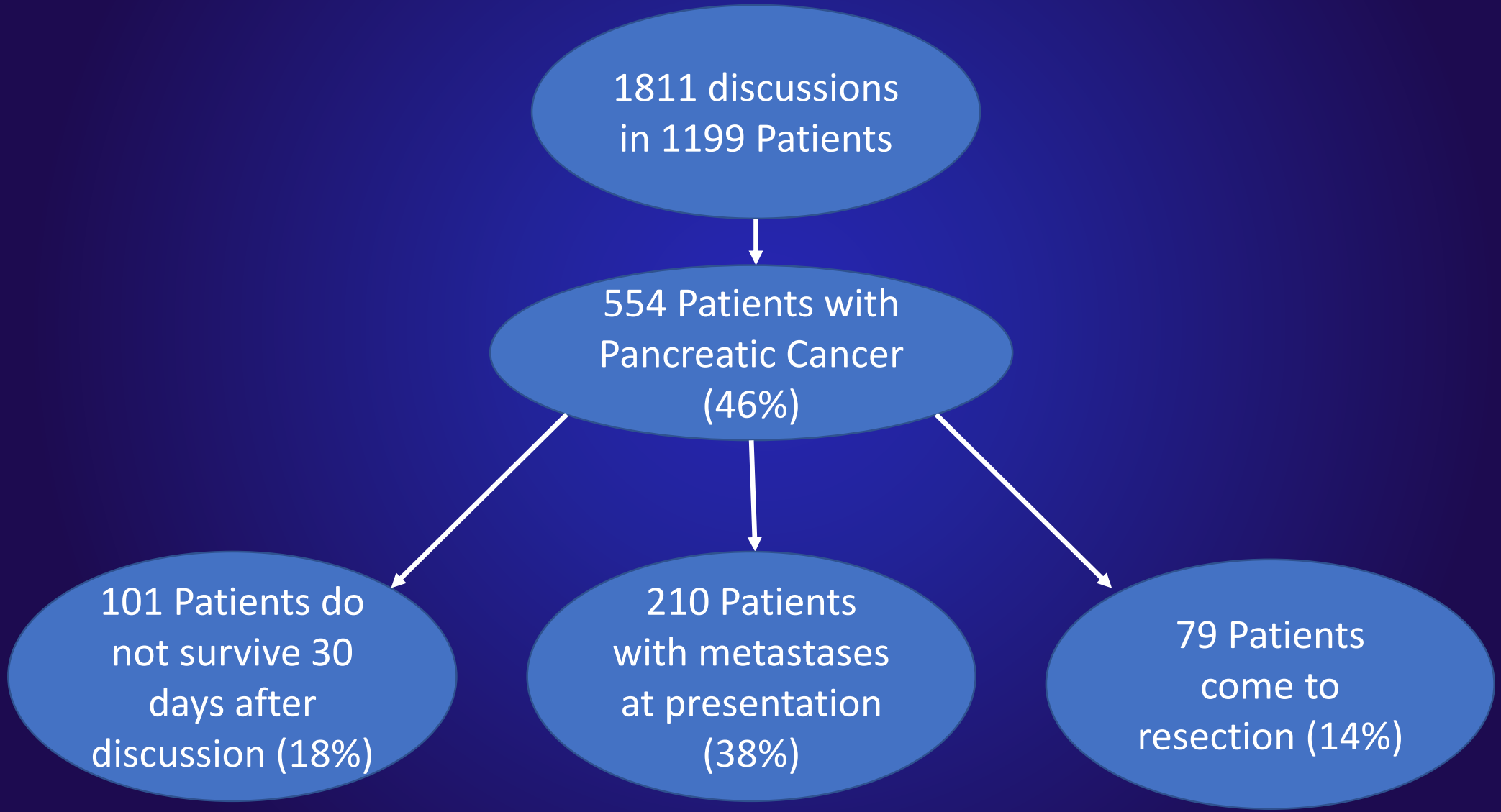


- MDT function data
- Kaizen improvement process
- Experience from MGH observorship
- An ideal MDT

MDT Structure

- Leeds - Pancreatic and Duodenal Cancer MDT
  - 1 meeting per week - 35-50 patients over 3 hours
  - Separate Surgery, Oncology clinics - times/locations
- Teleconference
  - 5 peripheral hospitals teleconference
  - Imaging from 8 NHS trusts (+ 2nd opinions)
  - Oncology delivered in 5 sites
  - EUS delivered in 2 sites
- Coordination
  - 1 x Pathway manager, 2.5 Cancer Nurse Specialists, 2 MDT co'ordinators

Leeds Pancreatic MDT 2017-18



MDT Analysis

- 69% of patients discussed had not been met by anyone at the MDT
- 65% of patients had incomplete referral information available
- 13% of patient discussions could not reach a conclusion because of missing pathology/radiology/other information
- 43% of patients received no interactive discussion, their case was presented then outcome was dictated
- Mean discussion time 217 seconds
  - 47% MDT was spent dictating outcomes

Kaizen Improvement Process

- Data
- A large team
  - Managers, MDT coordinators, clinicians, juniors, techs, IT experts
- Identifying and tackling problems at every stage of MDT process
- Test solutions
- More data

Improvements so far

- Pancreatic Cyst Protocolisation – Focus discussions on cancer patients
- Electronic referral forms – Improve flow of information
  - Make it easier to refer with the right information
- Auto-populating the outputs – Reduce repetition in the meeting
- Standards of care – Increase efficiency

- Future
  - More standards of care
  - Infrastructure improvements

Impact of COVID

- Increased use of virtual MDTs
  - 40% of MDTs stopped face to face meetings
- 80% of respondents felt communication was disadvantaged by virtual MDTs
- 57% of respondents felt decision-making was impacted negatively by COVID
- 64% of respondents felt IT equipment was inadequate

Variation in MDT Decision-making

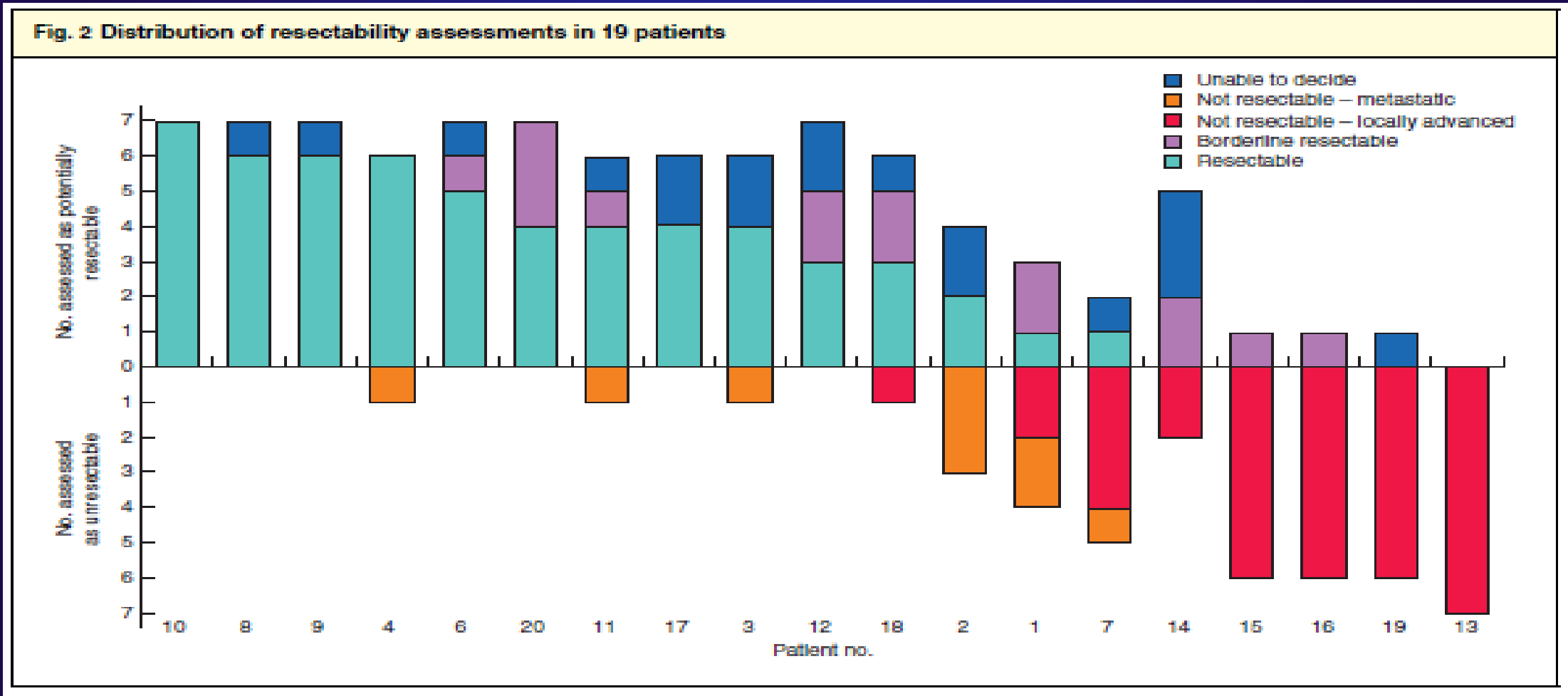
Multicentre study of multidisciplinary team assessment of pancreatic cancer resectability and treatment allocation

J. Kirkegård[1], E. K. Aahlin[3], M. Al-Saiddi[5], S. O. Bratlie[8], M. Coolsen[9], R. J. de Haas[10], M. den Dulk[9,13], C. Fristrup[2], E. M. Harrison[12], M. B. Mortensen[2], M. W. Nijkamp[11], J. Persson[8], J. A. Søreide[6,7], S. J. Wigmore[12], T. Wik[4] and F. V. Mortensen[1]

- A study of 7 pancreatic centres UK and Scandinavia
- 19 patients
- Each MDT asked to assign TNM status, definition of resectability and treatment allocation

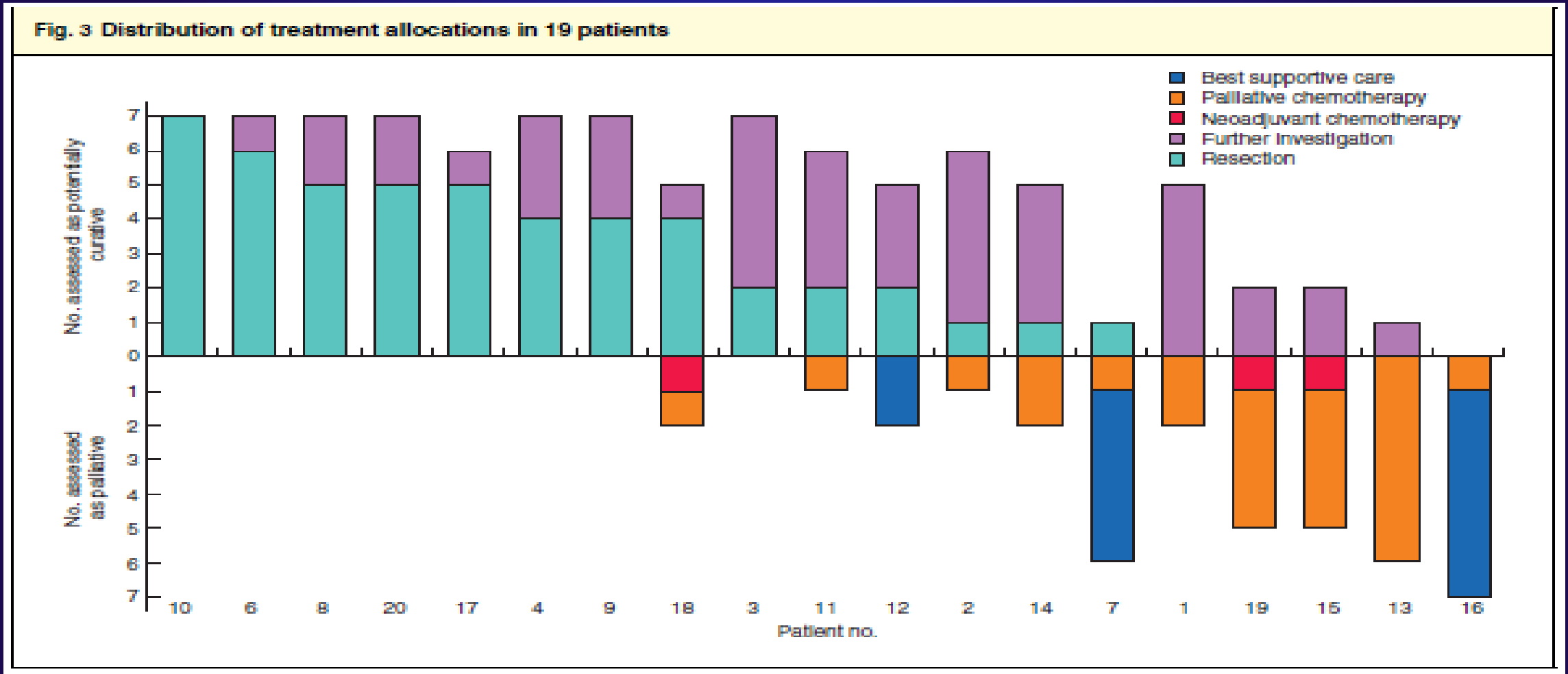
BJS 2019; 106: 756-64

Variation in assessment of resectabiiity



BJS 2019; 106: 756-64

Variation in treatment allocation



BJS 2019; 106: 756-64

Leeds	Mass General - Boston
3 Surgeons + 1 locum	4 Surgeons
80-120 major cases	>200 Major cases
Largest acute pancreatitis case numbers in England	Separate team manages acute pancreatitis
Largest acute general surgery workload (30-40% DCC)	No acute surgery involvement
Large O/P load of cysts, chronic pancreatitis and pancreatitis ?cause	Outpatient workload focussed on patients requiring surgery

MDT Structure

- Leeds
  - 1 meeting per week - 35-50 patients over 3 hours
  - Separate Surgery, Oncology clinic times/locations
  - Oncology delivered at many different hospitals
- Mass Gen. Boston
  - 1 x Radiology meeting
  - 1 x Pre-clinic meeting
  - 1 x Pre-op planning meeting
  - Combined Cancer Clinics
    - Neoadjuvant patients seen by Surgeon, Med Oncologist, Clin Oncologist at same time
    - Cases discussed in central clinic room
- Verona
  - Cancer MDT 90 mins
  - PNET MDT 90 mins
  - Surgical meeting
  - Cystic MDT 60 mins

Combined Cancer Clinic

- Patients with borderline operable or locally advanced PDAC
- Discussed in Clinic
  - Medical Oncologist
  - Pancreatic Surgeon
  - Clinical Oncologist
  - Cancer Nurse Specialist

- Advantages – Many
  - SDM, MDT working, consistent information, improved communication, quicker
- My concern - ?Overwhelming/railroaded
- Feedback – Universally positive

An ideal Pancreatic Cancer MDT – what to avoid

- Systems that negatively impact the patient pathway

- Slowing the patient diagnostic/therapeutic pathway without adding value
- Overly long/arduous
  - Impair decision-making
  - Waste time
- Inconsistent

An ideal Pancreatic Cancer MDT – what to aim for

- Works for Patients
  - Consistent, high quality decisions that don't delay treatment
- Works for Clinicians
  - All information readily available
  - Discussions add value
- Recognise the hidden benefits of MDTs
  - Cognitive diversity of team

Improving outcomes now

- Continuous improvement of MDT processes
  - Driven by data
- Teamwork
- Focus pancreatic clinicians time on looking after patients with pancreatic cancer
- Focus the design of services for the benefit of patients