

Manchester Cancer



## HPB Cancer Pathway Board Constitution 2015



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## 1. INTRODUCTION

Cancer services in Greater Manchester and East Cheshire changed in 2013/14. The Greater Manchester and Cheshire Cancer Network ceased to exist in March 2013 when cancer networks nationally were amalgamated into strategic clinical networks as part of the NHS reorganisation. In Greater Manchester this coincided with the creation of Manchester Cancer, an integrated cancer system for Greater Manchester and East Cheshire.

Twenty Manchester Cancer Pathway Clinical Directors were appointed in late 2013 and took up their roles on 1st January 2014.

These clinical leaders have formed Pathway Boards, multi-professional clinical groups from across the region. Most Pathway Boards began meeting in spring 2014. For the purposes of the National Cancer Peer Review Programme, Manchester Cancer Pathway Boards are taken to be the network group for the relevant tumour type or cancer area.

## 2. CONFIGURATION (13-1C-101n)

### 2.1. Local upper gastrointestinal cancer teams

Primary care practitioners refer all patients defined by the “urgent, suspicious of cancer” guidelines for HPB to the contact point of a single named diagnostic or diagnostic/local team as named below:

Local upper GI cancer teams/specialist OG cancer teams	MDT Lead Clinician	CCGs in catchment	Catchment population
Bolton Hospitals NHS Trust	Mr Joseph Varghese	Bolton	288,341
Central Manchester University Hospital NHS Foundation Trust	Prof Ajith Siriwardena	Manchester (Central) Trafford	206,690 232,619
East Cheshire NHS Trust	Dr Konrad Koss	Eastern Cheshire	267,273
Pennine Acute Hospitals NHS Trust	Mr Siba Senapati	Bury HMR Manchester (North) Oldham	194,675 213,229 173,272 238,544
Salford Royal Foundation Trust	Miss Laura Formela	Salford	233,966
Stockport NHS Foundation Trust	Mr Bart Decadt	Stockport	298,505

Tameside Hospital NHS Foundation Trust	Dr Greg Whatley	Tameside and Glossop	240,079
University Hospital of South Manchester NHS Foundation Trust	Mr Ian Welch	Manchester (South)	162,603
Wrightington, Wigan and Leigh NHS Foundation Trust	Dr Gurvinder Banait	Ashton, Leigh and Wigan	315,766
<b>TOTAL</b>			<b>3,065,562</b>

Referral guidelines for primary care are included in the network guidelines.

Local HPB teams provide local care for their own catchment area and collaborate on clinical decisions with the single specialist HPB MDT hosted by CMFT, with a full core complement of specialists. Patients will be treated in their own locality or at a specialist treatment centre, according to the decision of the MDT and by the appropriate specialist member of the MDT.

The procedures and treatments classed as local are in accordance with the principles of the NHS Peer Review Manual for Cancer Services Hepato-Pancreato-Biliary Cancer Measures (appendix 1):

- Staging investigations – ultrasound, CT, MR
- Palliative treatment options:
  - Relief of symptoms
  - Prolong good quality of life
  - PTC (see appendix 1)
  - Endoscopic stenting
  - Nutritional assessment
  - Pain control
  - Macmillan specialist palliative care referral
    - Hospital
    - Community
    - Hospice

## 2.3. Local colorectal teams

Local Diagnostic Teams/MDTs	Diagnostic Lead Clinician	Referring CCGs	Catchment population
Bolton NHS Foundation Trust	Mr Paul Harris	Bolton	288,341
Central Manchester University Hospitals NHS Foundation Trust	Mr David Donnelly	Manchester (Central) Trafford	206,690 232,619
East Cheshire NHS Trust	Mr Usman Khan	East Cheshire	267,273
Pennine Acute NHS Trust	Mr Saad Salman	Bury HMR Manchester (North) Oldham	194,675 213,229 173,272 238,544
Salford Royal Foundation Trust	Mr Dominic Slade	Salford	233,966
Stockport NHS Foundation Trust	Mr Edwin Clark	Stockport	298,505
Tameside Hospital NHS Foundation Trust	Mr Kamran Siddiqui	Tameside and Glossop	240,079
University Hospital of South Manchester NHS Foundation Trust	Mr Aswatha Ramesh	Manchester (South)	162,603
Wrightington, Wigan and Leigh NHS Foundation Trust	Mr Marius Paraoan	Wigan Borough	315,766
<b>TOTAL</b>			<b>3,065,562</b>

## 2.4. Specialist HPB team

Specialist HPB Cancer Team	SMDT Lead Clinician	Referring MDTs	Catchment Population
Central Manchester University Hospitals NHS Foundation Trust	Prof Ajith Siriwardena	Bolton Central Manchester East Cheshire Pennine Salford South Manchester Stockport Tameside Wigan	<b>3,065,562</b>
<b>TOTAL</b>			<b>3,065,562</b>

## 2.5. Manchester Cancer

Manchester Cancer covers a population of over 3 million served by the following organisations:

- Bolton NHS Foundation Trust
- Central Manchester University Hospitals NHS Foundation Trust
- East Cheshire NHS Trust
- Pennine Acute Hospitals NHS Trust (Bury, North Manchester, Oldham, Rochdale)
- 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
- Wroughtington, Wigan and Leigh NHS Foundation Trust

The Christie Hospital is the tertiary referral centre for the region. Radiotherapy is delivered at Christie Hospital and the satellite radiotherapy units based at Royal Oldham Hospital and Salford Royal.

Some chemotherapy and clinical trials will continue to be delivered from Christie Hospital, although local chemotherapy is currently available at:

- Wigan
- Bolton
- Oldham
- East Cheshire
- Mid Cheshire

2.6. Pathway Board membership (13-1C-102n)

NAME	TRUST	ROLE	REP OR DEPUTY
Derek O'Reilly	-	Pathway Director	-
Dr Mahesh Bhalme	Bolton	Consultant Gastroenterologist/ Hepatologist	Rep
Amanda Corfield-Halliwell		CNS	Deputy
Professor Juan Valle	Christie	Consultant in Medical Oncology / Research Lead	Rep
Dr Mairead Macnamara		Consultant in Medical Oncology	Deputy
Professor Ajith Siriwardena	CMFT	Consultant HPB Surgeon	Rep
Dr Jo Puleston		Consultant Gastroenterologist	Deputy
Dr Konrad Koss	East Cheshire	Consultant Gastroenterologist	Rep
Dr Adrian Tang		Consultant Radiologist	Deputy
Dr Emma Donaldson	SRFT	Consultant Gastroenterologist	Rep
Dr Mong-Yang Loh	Stockport	Consultant Radiologist	Rep
Kirsty Williams		CNS	Deputy
Dr Harry Kaltsidis	UHSM	Consultant Gastroenterologist	Rep
Dr Guvinder Banait	WWL	Consultant Gastroenterologist	Rep
Vicki Stevenson-Hornby		HPB Cancer Nurse Specialist	Deputy
Dr Rafik Filobbos	Pennine	Consultant Radiologist / Radiology Lead	Rep
Dr Vinod Patel	Tameside	Consultant Hepatologist	Rep
Melanie Dakha-Taeidy		CNS	Deputy
Dr Kevin Finn*	-	GP Representative	-
Dr Martin Prince	CMFT	Consultant Hepatologist Co-opted member	-
Debbie Clark	CMFT	Hepato-Biliary Nurse Specialist Co-opted member	-
Caroline McCall*	Manchester Cancer	Pathway Manager	-

\*until 31/03/15

## **2.7. Pathway Board Terms of Reference (13-1C-103n)**

The Hepato-pancreato-biliary Cancer Pathway Board is a multi-professional group chaired by Mr Derek O'Reilly, a Consultant Hepatobiliary & Pancreatic Surgeon from Central Manchester University Hospitals NHS Foundation Trust. These are the Board's Terms of Reference.

These terms of reference were agreed on 14<sup>th</sup> April 2014 by Derek O'Reilly, Pathway Clinical Director for Manchester Cancer, and Mr David Shackley, Medical Director of Manchester Cancer, on behalf of the Manchester Cancer Provider Board. The terms of reference will be subject to future review.

### **2.7.1. The 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.

The Pathway Board is led by a Pathway Clinical Director 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.

The HPB Cancer Pathway Board reports into and is ultimately governed and held to account by the Manchester Cancer Provider Board.

### **2.7.2. Manchester Cancer Provider Board**

The Manchester Cancer 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 (see appendix for the structure of Manchester Cancer).

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 Provider Board regularly invites representatives of commissioners, the Strategic Clinical Network, and Manchester Cancer to its meetings.

### **2.7.3. Purpose of the 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.

### **2.7.4. Role of the Pathway Board**

The role of the HPB Cancer Pathway Board is to:

Represent the Manchester Cancer professional and patient community for HPB cancer.

Identify specific opportunities for improving outcomes and patient experience and convert these into agreed objectives and a prioritised programme of work.

Gain approval from Greater Manchester's cancer commissioners and the Greater Manchester Cancer Services Provider Board for the programme of work and provide regular reporting on progress.

Design and implement new services for patients where these progress the objectives of commissioners and Manchester Cancer, can be resourced, and have been shown to provide improvements in outcomes that matter to patients.

Ensure that diagnosis and treatment guidelines are agreed and followed by all teams in provider trusts, and are annually reviewed.

Ensure that all providers working within the pathway collect the pathway dataset measures to a high standard of data quality and that this data is shared transparently amongst the Pathway Board and beyond.

Promote and develop research and innovation in the pathway, and have agreed objectives in this area.

Monitor performance and improvements in outcomes and patient experience via a pathway scorecard, understanding variation to identify areas for action.

Escalate any clinical concerns through provider trusts.

Highlight any key issues that cannot be resolved within the Pathway Board itself to the Medical Director of Manchester Cancer for assistance.

Ensure that decisions, work programmes, and scorecards involve clearly demonstrable patient participation.

Share best practices with other Pathway Boards within Manchester Cancer.

Contribute to cross-cutting initiatives (e.g. work streams in living with and beyond cancer and early diagnosis).

Discuss opportunities for improved education and training related to the pathway and implement new educational initiatives.

Develop an annual report of outcomes and patient experience, including an overview of progress, difficulties, peer review data and all relevant key documentation. This report will be published in July of each year and will be the key document for circulation to the Provider Board. A template for this report is available so that all Pathway Boards complete the report in a similar manner.

### **2.7.5. Membership principles**

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

Provider trusts not part of Manchester Cancer 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 Board will have at least one patient or carer representative within its membership

One professional member of the Pathway Board will act as a Patient Advocate, offering support to the patient and carer representative(s).

The Board will have named leads for:

- Early diagnosis
- Pathology
- Radiology
- Surgery
- Oncology
- Specialist nursing
- Living with and beyond cancer ('survivorship')
- Research
- Data collection (clinical outcomes/experience and research input).

It is possible for an individual to hold more than one of these posts. The Pathway Clinical Director is responsible for their fair appointment and holding them to account.

These named leads will link with wider Manchester Cancer Boards for these areas where they exist.

All members will be expected to attend regular meetings of the Pathway Board to ensure consistency of discussions and decision-making (meeting dates for the whole year will be set annually to allow members to make arrangements for their attendance).

A register of attendance will be kept: members should aim to attend at least 5 of the 6 meetings annually and an individual's membership of the Pathway Board will be reviewed in the event of frequent non-attendance.

Each member will have a named deputy who will attend on the rare occasions that the member of the Board cannot.

### **2.7.6. Frequency of meetings**

The HPB Cancer Pathway Board will meet every **two** months.

### **2.7.7. Quorum**

Quorum will be the Pathway Clinical Director plus five members of the Pathway Board or their named deputies.

### **2.7.8. Voting**

Decisions will be made by consensus as far as possible. In the event that this is not achieved, a vote will be taken. Each of the ten trust representatives has an equal vote. The patient and

primary care representatives are also voting members. The Pathway Director will not normally vote, except in the event of a tied vote. Deputies may vote in place of the Trust representative if they the latter are absent. A vote is binding if the meeting is quorate.

## **2.7.9. Communication and engagement**

Accurate representative minutes will be taken at all meetings and these will be circulated and then validated at the next meeting of the Board.

All minutes, circulated papers and associated data outputs will be archived and stored by the Pathway Clinical Director and relevant Pathway Manager.

The Pathway Board will design, organise and host at least one open meeting per year for the wider clinical community and local people. This meeting or meetings will include:

- An annual engagement event to account for its progress against its work programme objectives and to obtain input and feedback from the local professional community
- An annual educational event for wider pathway professionals and interested others to allow new developments and learning to be disseminated across the system

Representatives from all sections of the Manchester Cancer professional body will be invited to these events, as well as patient and public representatives and voluntary sector partners.

An annual report will be created and circulated to the Medical Director of the Manchester Cancer Provider Board by 31<sup>st</sup> July of each calendar year.

The agendas, minutes and work programmes of the Pathway Board, as well as copies of papers from educational and engagement events, will be made available to all in an open and transparent manner through the Manchester Cancer website.

## **2.7.10. Administrative support**

Administrative support will be provided by the relevant Pathway Manager with the support of the Manchester Cancer core team. Over the course of a year, an average of one day per week administrative support will be provided.

## 3. PATHWAYS AND GUIDELINES

### 3.1. Clinical guidelines (13-1C-105n)

The comprehensive clinical guidelines for hepato-pancreato-biliary cancer in Manchester Cancer can found at <http://manchestercancer.org/services/hepato-pancreato-biliary/>.

These comprise:

#### **Guidelines for the Assessment & Management of Hepatobiliary and Pancreatic Disease**

1. [Preface, table of contents and introduction](#)
2. [The Greater Manchester and Cheshire HPB sMDT](#)
3. [HPB cancer service in Greater Manchester and Cheshire – model of care](#)
4. [Manchester cancer pathways](#)
5. [Assessment & management of liver metastases](#)
6. [Hepatocellular carcinoma](#)
7. [Benign liver conditions](#)
8. [Perihilar and intrahepatic cholangiocarcinoma](#)
9. [Management of gallbladder disease](#)
10. [Acute pancreatitis](#)
11. [Chronic pancreatitis](#)
12. [Pancreatic cystic lesions](#)
13. [Pancreatic cancer](#)
14. [Neuroendocrine tumours](#)
15. [General perioperative management](#)
16. [HPB trauma](#)
17. [Selected references](#)

The legacy documents from the cancer network, where they exist, have also been posted to the relevant pages of the Manchester Cancer website [www.manchestercancer.org](http://www.manchestercancer.org).

**3.2. Chemotherapy algorithms (13-1C-106n)**

**Standard (off-study) systemic therapy options if clinical trial is not an option (always consider clinical trial if available)**

	Adjuvant	1 <sup>st</sup> -line advanced	2 <sup>nd</sup> -line advanced
Pancreas, adenocarcinoma	<b>Gemcitabine</b> <b>5-FU/LV (MdG)</b>	<b>Nab-paclitaxel-Gem</b> <b>GemCap</b> (PS 0-1) <b>Gem</b> (PS 2) <b>FOLFIRINOX</b> (PS 0-1) <b>CisGem</b> (PS 0-1) - (Likely more favourable if suspected BRCA mutation)	<b>OxMdG</b> <b>CisGem</b> - (Likely more favourable if suspected BRCA mutation)
Biliary Tract adenocarcinoma	Awaiting outcome of BILCAP adjuvant clinical trial – no standard therapy [Capecitabine or Gemcitabine offered in some institutions – no randomised evidence]	<b>CisGem</b> (PS 0-1) <b>Gem</b> (PS 2, but Valle et al. NEJM paper included PS 2 patients so should discuss with Consultant)	No standard treatment (consider clinical trial – ABC-06) <b>SIRT</b> a possibility if liver predominant disease
HCC	None	<b>Sorafenib</b> (CDF) or trial	Consider clinical trial
Pancreatic NET (G1/G2)	None	<b>Somatostatin analogue</b> <b>Everolimus</b> (CDF) <b>Sunitinib</b> (CDF) <b>Strep/Cap</b> <b>Tem/Cap</b>	<b>Everolimus</b> (CDF) <b>Sunitinib</b> (CDF) <b>Strep/Cap</b> <b>Tem/Cap</b>
GI NET (non-pancreatic) (G1/G2)	None	<b>Somatostatin analogue</b> <b>Strep/Cap</b> <b>Interferon-α</b>	
G3 NET	Consider <b>Cis/Etop</b>	<b>Carbo/Etop</b>	<b>Strep/Cap</b> <b>Tem/Cap</b> <b>Irinotecan/5-FU combination</b>

**Details of some more frequently used chemotherapy regimens**

<b>5-FU MdG</b>	<p>Folinic acid 350mg IV day 1; Fluorouracil 400mg/m<sup>2</sup> IV bolus day 1 followed by 2800mg/m<sup>2</sup> continuous infusion over 46 hours; 14-day cycle; 6-12 cycles</p> <p><i>Neoptolemos JP, Stocken DD, Bassi C. et al. Adjuvant chemotherapy with fluorouracil plus folinic acid vs gemcitabine following pancreatic cancer resection: A randomized controlled trial. JAMA 2010;304:1073-1081</i></p>
<b>Cis/Gem</b>	<p>Gemcitabine 1000mg/m<sup>2</sup> IV day 1, 8; and cisplatin 25mg/m<sup>2</sup> day 1, 8; 21-day cycle; 4-8 cycles</p> <p><i>Valle J, Wasan H, Palmer DH. et al. Cisplatin plus gemcitabine versus gemcitabine for biliary tract cancer. N Engl J Med;362:1273-81)</i></p>
<b>FOLFIRINOX</b>	<p>Oxaliplatin 85 mg/m<sup>2</sup> IV day 1; Leucovorin 400mg/m<sup>2</sup> IV day 1; Irinotecan 180mg/m<sup>2</sup> day 1; Fluorouracil 400mg/m<sup>2</sup> IV bolus day 1 followed by 2400mg/m<sup>2</sup> continuous infusion over 46 hours; 14-day cycle; 6-12 cycles</p> <p><i>Conroy T, Desseigne F, Ychou M. et al. FOLFIRINOX versus gemcitabine for metastatic pancreatic cancer. N Engl J Med 2011;364:1817-25</i></p>
<b>Gem/Nab-paclitaxel</b>	<p>Nab-paclitaxel 125mg/m<sup>2</sup> IV followed by Gemcitabine 1000mg/m<sup>2</sup> IV, days 1, 8, 15, 28 day schedule; 6 cycles as tolerated</p> <p><i>Von Hoff DD, Ervin T, Arena FP. et al. Increased survival in pancreatic cancer with nab-paclitaxel plus gemcitabine. N Engl J Med 2013;369:1691-703</i></p>
<b>Gemcitabine</b>	<p>Gemcitabine 1000mg/m<sup>2</sup> IV day 1, 8, 15; 28-day cycle; 3-6 cycles</p> <p><i>Burriss HA, Moore MJ, Andersen J et al. Improvements in Survival and Clinical Benefit With Gemcitabine as First-Line Therapy for Patients With Advanced Pancreas Cancer: A Randomized Trial. J Clin Oncol, Vol 15, No 6 (June), 1997: pp 2403-2413 2403</i></p>
<b>GemCap</b>	<p>Gemcitabine 1000mg/m<sup>2</sup> IV day 1, 8, 15; and Capecitabine 830mg/m<sup>2</sup> bd po days 1-21; 28-day cycle; 3-6 cycles</p> <p><i>Cunningham D, Chau I, Stocken DD. et al. Phase III randomized comparison of gemcitabine versus gemcitabine plus capecitabine in patients with advanced pancreatic cancer. J Clin Oncol 2009;27:5513-8</i></p>
<b>OxMdG</b>	<p>Oxaliplatin 85mg/m<sup>2</sup> IV day 1; Folinic acid 350mg IV day 1; Fluorouracil 400mg/m<sup>2</sup> IV bolus day 1 followed by 2400mg/m<sup>2</sup> continuous infusion over 46 hours; 14-day cycle; 6-12 cycles</p> <p><i>Oettle H, Reiss H, Stieler JM. et al. Second-line oxaliplatin, folinic acid and fluorouracil versus folinic acid and fluorouracil alone for gemcitabine-refractory pancreatic cancer: outcomes from the CONKO-003 trial. J Clin Oncol 2014;32:2423-9</i></p>
<b>Tem/Cap</b>	<p>Capecitabine 1500mg/m<sup>2</sup>/day (orally, divided twice daily, maximum 2500mg/m<sup>2</sup>) on day 1-14, and Temozolomide 150-200mg/m<sup>2</sup>/day (orally divided twice daily) on days 10-14, with the next</p>

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two weeks off, in a 28 day cycle: 6 cycles

*Fine RL, Gulati AP, Tsushima D. et al. Prospective phase II study of capecitabine and temozolomide (CAPTEM) for progressive moderately, and well-differentiated metastatic neuroendocrine tumors. J Clin Oncol 2014;32 (suppl 3:abstr 179)*

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All chemotherapy algorithms can be accessed via the intranet of The Christie NHS Foundation Trust. These are live documents:

<http://nww.christie.nhs.uk/documents/default.aspx?Category=Y&Category1=1>

Search for:  
Policies & Guidelines

Sub-category 1:  
Chemotherapy protocols

### **3.3. Patient pathways (13-1C-107n)**

See appendix 2 for the Manchester Cancer HPB cancer 62-day pathway and jaundice pathway.

For the teenage and young adult cancer pathways developed under the old Greater Manchester and Cheshire Cancer Network see <http://manchestercancer.org/services/teenagers-and-young-adults/>.



## Appendix 1 – Manual for Cancer Services HPB measures

### NHS Peer Review Manual for Cancer Services Hepato-Pancreato-Biliary Cancer Measures

- **Level one care consists of:**
  - Tumour surgical resection
  - Tumour ablative procedures
  - Palliative, biliary, surgical bypass procedures.
  - Nuclear medicine treatment.
  - Percutaneous interventional procedures including SIRT and PVE, except for percutaneous biliary drainage.
- **Level one care needs:**
  - Discussion
  - ...treatment plan decided by...
  - delivery by and..
  - in the specialist HPB MDT's named single site for that treatment.

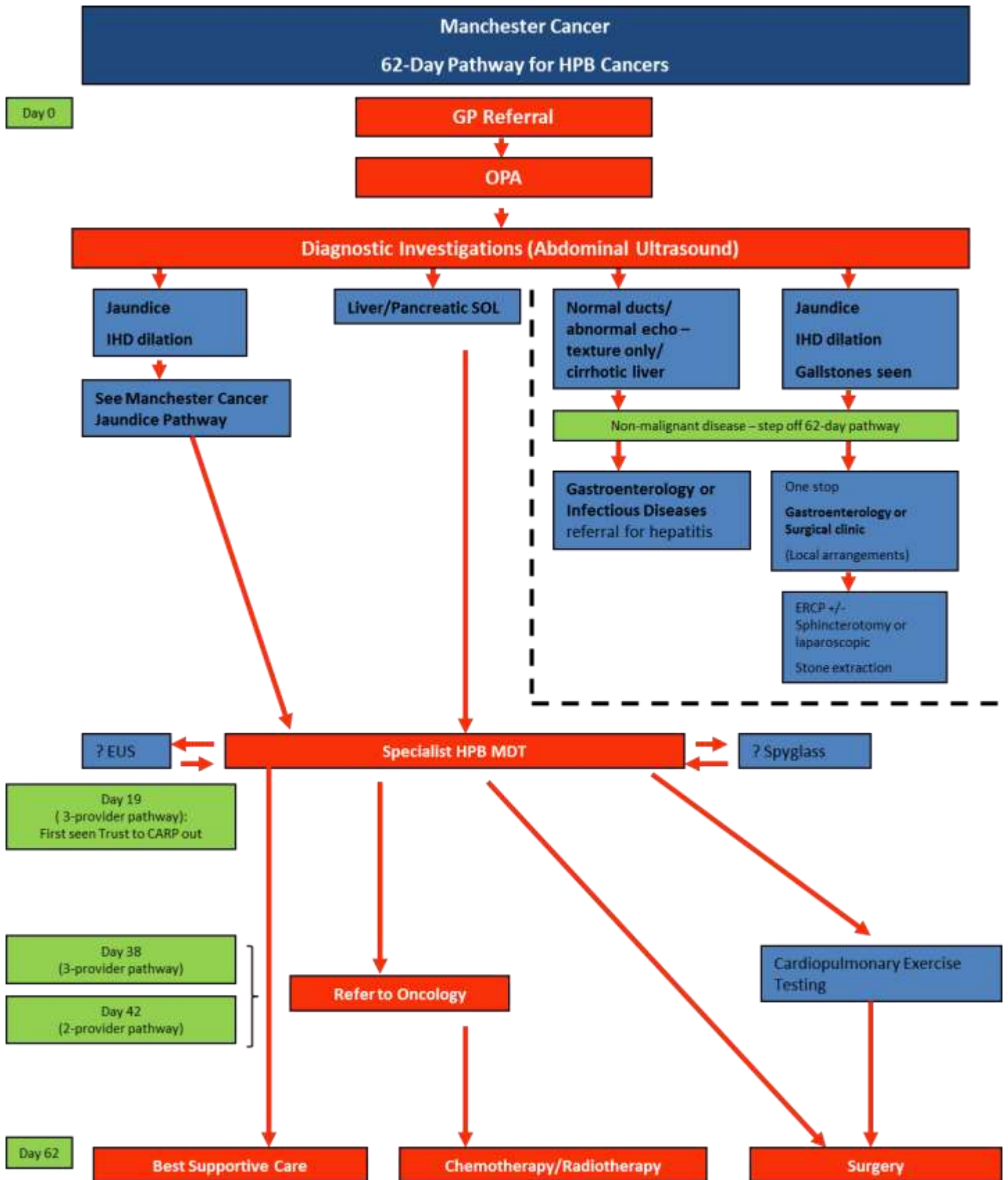
### NHS Peer Review Manual for Cancer Services Hepato-Pancreato-Biliary Cancer Measures

- **Level two care consists of:**
  - Elective percutaneous biliary drainage.
  - All systemic anticancer therapy.
  - Non-palliative radiotherapy.
- **Level two care needs:**
  - Discussion...
  - Treatment plan decided by the specialist HPB MDT.
  - The personnel and the allowed sites ...restricted to ones ***agreed in the network patient pathways.***

NHS Peer Review Manual for Cancer Services  
Hepato-Pancreato-Biliary Cancer Measures

- **Level three care consists of:**
  - Emergency percutaneous biliary drainage.
  - Endoscopic, palliative, biliary and/or duodenal stenting.
  - Palliative radiotherapy.
  - Palliative and supportive care
- **Level three care needs:**
  - Discussion of the case with a core member of the specialist MDT with agreement that only level three care is needed.

Appendix 2 – 62-day pathway



Appendix 3 – Manchester Cancer jaundice pathway

