Urology Tumour Site Specific Group meeting
Tuesday 27th April 2021
Microsoft Teams
13:30 – 16:30

Final Meeting Notes

Present	Initials	Title	Organisation
Sanjeev Madaan (Chair)	**SM**	Consultant Urological Surgeon	DVH
Alan Cossons	**ACos**	Uro-oncology CNS	DVH
Marie Payne	**MP**	Macmillan Lead Cancer Nurse / Clinical Services Manager	DVH
Elaine Ritchie	**ER**	Uro-oncology CNS	DVH
Jayasimha Abbouraju	**JA**	Associate Specialist - Urology	DVH
Amanda Clarke	**ACl**	Clinical Oncologist	DVH
Vincent Gnanapragasam	**VG**	Consultant Urological Surgeon	Cambridge University Hospitals NHS Foundation Trust
John Kyle	**JK**	Implementation Consultant	CIVICA (InfoFlex)
Thomas Cowin	**TC**	Deputy GM for Urology and Vascular	EKHUFT
Chris Hopkins	**CH**	Cancer Compliance Manager	EKHUFT
David Stafford	**DS**	Prostate CNS / Charge Nurse - Critical Care	EKHUFT
Ben Eddy	**BE**	Consultant Urologist	EKHUFT
Carys Thomas	**CT**	Consultant Clinical Oncologist	EKHUFT
Claire Mallett	**CMal**	Programme Lead – LWBC & PC&S	KMCA
Serena Gilbert	**SGi**	Cancer Performance Manager	KMCA
Karen Glass (Notes)	**KG**	Administration & Support Officer	KMCC & KMCA
Colin Chamberlain	**CC**	Administration & Support Officer	KMCC
Annette Wiltshire	**AW**	Service Improvement Facilitator	KMCC
Tracey Ryan	**TR**	Macmillan User Involvement Manager	KMCC
Sue Green	**SGr**	Macmillan Recovery Package Facilitator	MFT
Roberto Laza-Cagigas	**RLC**	Senior Exercise Physiologist	MFT
James Shaw	**JS**	Deputy General Manager	MFT
Tahir Bhat	**TB**	Consultant Urologist	MFT
Cynthia Matarutse	**CMat**	Macmillan Lead Cancer Nurse	MFT
Heather Pagden	**HP**	Uro-oncology CNS	MTW

Sarah Aylett	**SA**	Uro-oncology CNS	MTW
Diletta Bianchini	**DB**	Medical Oncologist	MTW & MFT
Alastair Henderson	**AH**	Consultant Urological Surgeon	MTW
Kathryn Lees	**KL**	Consultant Clinical Oncologist	MTW
Amit Goel	**AG**	Consultant Histopathologist	MTW
Hide Yamamoto	**HY**	Consultant Urological Surgeon	MTW
Branimir Penev	**BP**	Consultant Urologist	MTW
Emily Moore	**EM**	Macmillan Uro-oncology CNS	MTW
Jennifer Pang	**JP**	Clinical Oncologist	MTW
Ann Courtness	**ACou**	Macmillan Primary Care Nurse	NHS Kent & Medway CCG
Chris Singleton	**CS**	Senior Programme Manager - KMCA	NHS Kent & Medway CCG
Bana Haddad	**BH**	Macmillan GP & Cancer Lead / Clinical Lead – LWBC & PC&S	NHS Kent & Medway CCG
Annie Davis	**AD**	Guest – no further details	
Brian Murphy	**BM**	Patient Representative	
Apologies			
Fay Fawke	**FF**	Lead Uro-oncology CNS	DVH
Milan Thomas	**MT**	Consultant Urologist	EKHUFT
Pippa Miles	**PM**	Senior Service Manager	EKHUFT
Patryk Brulinski	**PB**	Consultant Clinical Oncologist	MTW
Mark Cynk	**MC**	Consultant Urologist	MTW
Rakesh Koria	**RK**	Macmillan GP Associate Advisor & NHSE GP Appraiser	NHS Kent & Medway CCG
Helen Graham	**HG**	Research Delivery Manager	NIHR
		CNS's	MFT

Item		Discussion	Agreed	Action
1.	**TSSG Meeting**	**<u>Apologies</u>** • The apologies are listed above.		

		Introductions • SM welcomed the members to the meeting and asked them to introduce themselves. **Action log Review** • The action log was reviewed, updated and will be circulated along with today's minutes. **Review previous minutes** • The previous minutes were reviewed and agreed as a true and accurate record of the meeting.		
2.	**Prehabilitation patients**	**Update provided by Roberto Laza-Cagigas** • RLC introduced himself as the Senior Exercise Physiologist at the K&M Prehabilitation service. This service is community-based in Medway for people newly diagnosed living with and beyond cancer across the county. The service has been funded for 2 years by the K&M Cancer Alliance. • RLC referred to a case study of a man diagnosed with prostate cancer and was given the opportunity to join the prehabilitation service. Over a 4-month period the patient turned his life around, he had lost weight, halved his medication and was no longer classified as a Type 2 diabetic. • RLC promoted the prehabilitation service which helps the patients both physically and mentally to prepare for their surgery and subsequent recovery. • RLC explained the four main principles used are: - i) Functional – exercise prescription, medical optimization ii) Nutrition – dietary modifications iii) Lifestyle Choices – smoking & alcohol cessation, sleep hygiene		

		iv) Stress Management – relaxation strategies • RLC highlighted that 93% of patients that used the service regarded it as excellent, a powerful motivator to achieve healthy lifestyle changes and a beneficial part of their cancer treatment. RLC stated the great improvement particularly for diabetic patients and improving their HBA1c levels. • The fundamental principles for the service include: - i) Personalisation ii) Holistic needs Assessment iii) Supervision and Adaptation iv) Follow up support and links with pre-existing infrastructure • RLC confirmed the team consist of Public Health representation, Dr Tara Rampal – a Clinical Lead, physiotherapists and a counsellor. • RLC highlighted the website contact details are - www.kentandmedwayprehab.org and this provides further details including making a referral or for the patient to do a self-referral. • RLC referred to the Patient and Public Involvement Focus Group which provides direct feedback from the patients and includes the pros and cons of the service. • RLC invited the group to the Prehabilitation Study Day: Empowering patients and improving outcomes which is taking place on the 7th June 2021 – and can be accessed online via Facebook, Instagram and Twitter. • RLC confirmed there is no limited timescale to see a patient and 1 - 2 weeks prior to surgery would still be considered enough time to improve the patient's journey. • KL would be keen to sign up some additional MTW patients to the service as it is running virtually.		

		• TB confirmed there are 2 prehab centres, one for K&M patients and also one located at MFT. • CS explained the funding from the Cancer Alliance will be in place until December 2021. A paper is in the process of being to extend the funding beyond December. CS added this is a valuable service for K&M patients for the future. • SM thanked RCL for the amazing service they are providing for their K&M patients.		
3.	**Performance**	**<u>DVH – update provided by Marie Payne</u>** • MP highlighted some issues DVH have regarding the 2ww referrals for December and January. This has improved overall in February. There were some issues with registrars and accessing the 2ww rapid access clinic. They are now doing a triage service before the clinic. • 31-day service – DVH have consistently met this standard. • 62-day – 3 patient breaches in December. They have experienced issues with TRUS biopsies and staff available to do them. • 104-day – 1 patient in February has had a cancer diagnosis and been referred to GSTT. There have been delays in outpatients and MRI following a bone scan. • 28-day FDS they met this standard in December 2020 but not in January or February. Data completeness at the end of March was 72.34% with 135 records incomplete. They are addressing this issue by providing additional training for the MDT Co-ordinators. • Key risks include there being no face to face rapid access appointments and the difficulty of assessing the patient over the phone.		**Performance presentations to be circulated by KG**

		• Mitigating actions include triaging the patients to ensure they are put on the correct pathway and investigations are booked prior to seeing the patient. • Their lead CNS has developed a rapid access clinic proforma so they do not have to wait for letters to be typed and this can be sent to the GP and patient straight away. • Theatre capacity for surgery was outsourced to KIMS during the pandemic but has now returned to DVH and MFT. Outpatient demand capacity has outweighed their clinic capacity but this has been addressed with providing extra clinics. **EKHUFT – update provided by Chris Hopkins** • CH confirmed they have consistently met the 2ww referral standard for 2 years and is due to having daily calls with the teams to manage capacity and ensure compliance. • 31-day standard was not met in January with 6 patients that breached but this was addressed in February. • 62-day targets have been more challenging for EKHUFT with big treatment numbers. The main reasons for the patient breaches are due to delay with LATP biopsies, patient illness / DNA investigations, delays with TURBT's and Oncology outpatient capacity. • TB questioned the reason behind the TURBT delays. TC was not aware of any issues and there being a reduction in capacity. TC added they are not currently having any issues with dating TURBT's and he is keeping a close eye on it. • 28-day FDS EKHUFT are below target with an average of 52% and data completeness is at 80%. The front end of the pathway is the area they need to improve. • Key risks and barriers to delivery of the service due to Covid is clinic capacity, the switch to telemedicine / phone calls and having significantly reduced		

		theatre capacity. • Mitigating actions taken to improve performance include face to face clinics which will resume in May, increase theatre capacity, extra clinics scheduled and regular clinical reviews. **MFT – update provided by James Shaw** • JS confirmed their 2ww performance is consistently compliant. 31-day performance for January and February has not been met as they are in the recovery phase. 62-day performance for February and March, MFT are not compliant. They are checking to see if the data is accurate as the treatment numbers appear low. • 28-day FDS they are working on this standard. Unfortunately, they are also not able to capture the Data Completeness accurately and are working on this. • Key risks are due to not having HDU facilities during the second wave of Covid which prevented being able to perform Cystectomies. **MTW – update provided by Hide Yamamoto** • HY confirmed MTW have been consistently compliant for 2ww and 31-day performance standards. 62-day performance there is generally no issue. 104-day patient numbers and backlogs are extremely low. • 28-day FDS they are below target at 53% which is mainly due to Haematuria pathways which they are working on. HY has no update for the data completeness. • HY concluded they have no theatre capacity issues but do have continuous outpatient capacity issues.		
4.	**Clinical Pathway Discussion**	**HOP**		

		• SM has updated this policy. AW to ensure the links are accurate, before this can be finalised and circulated to the group. **Bladder** • TB has agreed to update this document to include all the additional further comments. SM suggested TB deleted some of the precise detail and replace with reference to NICE/EU Guidelines and to add in the hyperlink. They could then finalise this document together. **Prostate** • SM agreed to speak to Ben Eddy as this is the most complex pathway to update and there are lots of amendments. BE will be leaving the trust in September so it may mean SM will update this pathway if not completed in time. **Testicular** • DB agreed to update this pathway and send to SM to finalise.		
5.	**Staging for prostate cancer patients**	**Update provided by Amanda Clarke** • ACl referred to the baseline staging of cancer patients particularly those having radical treatment. She explained this has come to a head at DVH as they often refer patients from the Sidcup area to the Clinical Oncologist at GSTT. The staging criteria primarily for radiotherapy is different to that of K&M. • ACl mentioned this has been discussed at the Urology NOG meeting on how to stage these prostate patients but suggested this should be discussed further at this meeting. • ACl explained the GSTT criteria require PSMA PET scans before the patient starting the hormone treatment. ACl added they have limited access to the PSMA PET and only have 6 slots allocated per week across K&M.		

		• ACl asked the group what do they feel is the minimum data set for staging investigations for prostate cancer patients. Should they align to GSTT as they are part of their cancer network and what are the implications of this for the PET capacity. ACl added this will affect their first line definitive treatments for hormone treatment which could add another step into the pathway. • SM was keen that the guidelines were formalised and updated once a decision had been agreed as this would form part of the Prostate Clinical Pathway. • SM confirmed GSTT have significantly more capacity to do the PET scans which K&M do not have. SM added they would be going against the Guidelines and all the management protocols are against PET scans. SM stated he would be seriously against having the PET scan. • KL and CT agreed they will end up under treating and this should not be done as standard staging. GSTT are going against the guidelines and they should stick with what they are currently doing. HY added there is a risk of an over treatment of these patients. • AH suggested if they do not use the same policy as GSTT there should be a written consensus of what staging investigations the patient should have. • HY mentioned he has been advised that short-term hormone treatment before a PET scan will not affect imaging. • SM concluded a mixed response from the group with no routine consensus for using PSMA PET, but to continue to use for pre-surgery, high risk disease or relapsed patients but to not do as a routine investigation. **Action** - ACl agreed to summarise the points raised today, making it broad and inclusive and will circulate to the group for comment. AH agreed to send his comments to ACl from an MTW perspective.		**AC / AH**
6.	**Research**	**Update provided by Kathryn Lees**		

		• KL mentioned there has been some maternity leave from the radiotherapy research radiographers which has had an impact on capacity and the ability to open new trials at MTW. • KL confirmed their open trials are all up and running including PACE C which is an exciting trial. KL added PIVOTAL boost is still running. • CT confirmed they have re-opened all their trials at EKHUFT. • KL referred to the systemic trials and it would be beneficial to have more prostate cancer trials open. • KL mentioned there a few bladder trials but they are not recruiting very well. • DB suggested compiling a Research newsletter detailing the actively recruiting trials across K&M which would enable the cross referral of patients. DB asked for the information to be sent to her. SM and KL thought this was an excellent idea and would help promote the trials across the trusts. SM was pleased and encouraged DB to take over from him as the KSS Research Lead. • SM mentioned DVH are still struggling with the research team workforce capacity. They are not recruiting for the trials at the same rate as they were pre-COVID. • SM mentioned the trials in the pipeline which are more of a surgical interest include the PACIFIC trial from Imperial College. The ATLANTA trial also from Imperial, is the local treatment for metastatic prostate cancer patients. • HY mentioned MTW have the TRANSLATE study which will open later this year – an Oxford trial. Therefore, MTW will not be recruiting to other trials.		
7.	**RMS & Portal demo**	**<u>Update provided by John Kyle</u>** • JK introduced himself as the Project Manager and Implementation Consultant		**Presentation to be circulated to the group.**

		from CIVICA and has been leading on a number of K&M for CIVICA (previously called InfoFlex) over the last 2 years. • JK mentioned he had been asked by CMal to do a presentation today on the InfoFlex prostate stratified follow up and prostate patient portal. • JK confirmed there are three elements to the Prostate SFU design which include the patient portal for patients to have access to their PSA results, to be able to complete PROMS and have access to their CNS. Lastly, they have the treatment summaries design. • JK demonstrated the fully integrated database system for K&M from referral – diagnosis – treatment – Prostate Stratified follow-up and Prostate Portal. JK added the Prostate SFU system is now live and the Cancer Information System (CIS) have started to provide some training. • HY mentioned the most common result they have for PSA's is the less than value and is recorded as 0.01 depending on the centre. HY suggested the PSA value of 0 is recorded under the PSA Review tab. JK confirmed this would not be an issue and asked the group to collate any concerns which can be addressed at the local testing. • JK was pleased to announce the Prostate patient portal is their first cancer patient portal for a large tumour group. They enrolled some patient volunteers to provide feedback on the content and the layout of the portal. The design has now been agreed and are now going through the end stages of installation at the EK data centre.This should then be given back for full testing prior to roll-out. Patients will be expected to complete their PROMS via varying devices before being able to view their PSA results. • JK mentioned the Cancer Care map will be embedded into the patient portal for the patient to view any local resources available to them. • JK confirmed patients would update the data in the same database as the clinicians would be using for their day to day cancer care and be reviewed instantly.		

		• JK mentioned the treatment summaries should be available at the same time as the patient portal. JK added there is some technical testing by the CIS team and should be ready for final validation soon. The patient will also be able to view their treatment summary. • SM agreed it all looks good and asks when it could all be used. JK confirmed the Prostate SFU is now live and training has started. The patient portal is in the process of being installed and they are awaiting the security / IG to be in place. JK asked for feedback from some representatives from this group to test the processes before committing to going live. JK referred to integration of the Kent & Medway Care Record (KMCR) to view the PSA results. The KMCR is used for sharing data, including pathology and radiology results for Health and Social Care. • SM would be very happy to support this and thanked JK for the excellent presentation. JK hoped that within the next 6 weeks the portal excluding PSA results would be ready to go onto the testing phase. CMal mentioned the pathways and processes would also need to be aligned internally for each Trust.		
8.	**Clinical Audit**	**<u>National Prostate cancer audit – update provided by Kathryn Lees</u>** • KL provided an update on the NPCA which was reviewed and published in 2020. It is an audit for prostate cancer patients diagnosed from 1st April 2018 to 31st March 2019. • The aim of the NPCA is to assess the process of care and outcomes for men diagnosed with prostate cancer in England, Wales but does not include Scotland. • The basis of the audit is to look at the routine data sources including the 14 core performance indicators. These include data collection, performance of MDT's and checking appropriate treatment is given to patients. KL mentioned a second part to the audit is the PROMS data collection. This is prostate cancer		

		data and is audited 18 months after treatment. • KL mentioned the national headline results state there has been a 23% surge in prostate cancer cases diagnosed as a consequence of the "Fry-Turnbull" coverage. The number of TP biopsies performed have increased from 17% to 21%. KL explained they are not very good at documenting the data completeness and have only recorded 52% of cases. 5% of low risk patients were over treated which is not too bad and is probably due to patients who want treatment. 29% of locally advanced patients were not given radical treatment and this is a cohort of patients undertreated nationally. • KL highlighted the local data completeness scores from across K&M taken from InfoFlex. KL mentioned they have an issue collating accurate data from InfoFlex which can be improved. • KL confirmed they are good at not over treating their low risk patients. They are treating men with locally advanced disease better than the national average and giving plenty of radiotherapy. The percentage of men who rated their overall care as 8 or above was 92% at MFT SMDT and 96% at EKHUFT. • KL compared K&M surgical and radiotherapy outcomes against the national targets. • KL highlighted that overall Kent NPCA results are in line with national data. Late toxicity from radical treatments are well within acceptable ranges across all sites. • KL stated levels for improvement: - i) Data collection / recording could be better and to get the MDM Co-ordinators to put the data in the correct boxes ii) Use of early Docetaxel in West Kent iii) Local Brachytherapy boost service delivery – working on this and looking to develop an HDR service iv) Late GI toxicity service		

9.	**CNS Updates – all Trusts**	**<u>EKHUFT – update provided by David Stafford</u>** • DS mentioned he has written a SOP for the supported self-management follow up pathway. FF has agreed to review the SOP alongside TrueNorth. This will then be shared with the CNS's, Oncology and TSSG group. **<u>Action</u>** – DS agreed to share the SOP with the TSSG group to feedback. **<u>DVH</u>** • There was no update provided at the meeting today. **<u>MFT</u>** • There was no update provided at the meeting today. The CNS's sent their apologies via SGr who confirmed they had extra clinics to attend. **<u>MTW</u>** • There was no update provided at the meeting today.		**DS**
10.	**Guest Speaker Consultant Urologist**	**<u>Personalising prostate cancer management: risk groups, individualised prognostics and beyond – presentation provided by Vincent Gnanapragasam</u>** • VG was invited to talk about the work they have been doing regarding risk management and diagnostic modelling. • VG explained he is a reader in Urology at the University of Cambridge and a Consultant Urologist and his work is mainly diagnostics and risk-based management. • VG would like to talk about the tools they have developed which is crucial to the stage of management in assessing the risks for patients and the subsequent appropriate treatments.		

		• VG highlighted the average age of prostate cancer death is actually 90 and that most prostate cancer is not lethal. • VG referred to various risk tools which have been used in prostate cancer over the years including the CAPRA score which is used primarily in America. • VG highlighted a study conducted in 2016 on how good the NICE recommended Guidelines were in predicting prostate cancer death in UK. The Cambridge Prognostic Groups saw very different outcomes and this was tested on over 86,000 men. • VG confirmed they were particularly keen to look at active surveillance, comparing men in the CPG1, CPG2 and CPG3 groups. There was not much difference in mortality between the men in CPG2 without treatment. However, they saw clear differences in CPG3 and if not treated there was double the risk of prostate cancer mortality. They adopted a policy that CPG3 men do not go onto active surveillance whereas CPG2 men do. • VG mentioned the CPG system is free for anyone to use and includes a calculator. NPCA have agreed from 2021 to use the CPG system for classifying their cancers. • Predict Prostate has been endorsed by NICE and this has over 20,000 users worldwide. Patients are also able to access and use it. VG mentioned most men would opt for active surveillance as a first treatment option. • SM thanked VG for an excellent, informative presentation and for VG's great ongoing work. • SM mentioned they use the Predict Prostate tool and found it is better when the CNS is with the patient. They stopped using the tool during the pandemic but have now restarted again. SM added it shows the patient they have chosen the right treatment for them. • KL confirmed she uses Prostate Predict and finds it is a very useful tool. KL		

		mentioned her only concern was that it does not provide the numbers of patients on long term hormone therapy.		
11.	**Cancer Alliance update**	**<u>Update by Claire Mallett</u>** • CMal provided an update on the cancer recovery phase and the overall aims of the Kent & Medway Cancer Alliance are to: i) Restore urgent cancer referrals back to at least pre-pandemic levels ii) Reduce the backlog at least to pre-pandemic levels for 62-day (urgent referral and referral from screening) and 31-day pathways iii) Ensure sufficient capacity to manage increased demand moving forward, including follow up care • CMal reflected on the national priorities for Long-Term Plan include: - i) Rapid Diagnostic pilots – VISS pilot at DVH and Rapid Lymphadenopathy pilot at EKHUFT. ii) 28-day FDS – currently in shadow form. iii) Supporting PCN colleagues iv) Targeted Lung Health Check Programme. v) Personalised Care • CMal mentioned the NHS Planning Guidance has now been published and they will be looking over the next year at 3 other tumour stratified pathways with a view to implement at least 1. The work done within prostate has been an invaluable model and has been shared with other tumour groups. • CMal confirmed an increased national focus to reduce health inequalities across the population. There are a number of pilots including the “Smear Project,” for patients with learning disabilities and the Cancer Champions project in Thanet.		**Presentation to be circulated by KG**

		• SG confirmed in January and February 2021 alone there had been two-thirds (62%) of the normal expected level of Urology 2ww referrals. Calculating from March to January there are in the region of 2 - 4000 patients who have missed out on appointments. The national team have estimated this is approximately 409 treatments short of what would normally be expected and they need to be prepared for this shortfall.		
12.	**CCG update**	**<u>Update by Chris Singleton</u>** • Chris Singleton and Laura Alton are the newly appointed Senior Programme Managers for cancer commissioning and have replaced Rosie (Baur) and Sally (Allen). They are working as part of an integrated CCG and Cancer Alliance team. This is a positive change from the locality-based commissioning approach, and is in line with the development of the Integrated Care System. It will support delivery of local and national cancer priorities, and bring together the expertise of the Cancer Alliance. • Cancer is a clear priority in the recently published NHS Planning Guidance, and we will be working with all relevant colleagues to help deliver the priorities, particularly in terms of returning to pre-pandemic levels of cancer treatment • CS mentioned they have split the TSSGs and CS will be the commissioning link for Urology. We are very keen to help support development of clinical pathways that improve access to cancer services for the K&M population, navigating through the new CCG governance processes. As a new organisation the CCG will have to ensure that they work at scale across the county, but also ensuring that all voices are heard. • They are working closely with their planned care commissioning colleagues in each of the 4 Kent and Medway Integrated Care Partnerships, given the overlap between cancer and planned care pathways. • We are currently focusing on a number of commissioning priorities for cancer, including pilots of a number of rapid diagnostic services including the Vague		

		and Indeterminate Symptoms pilot at DVH, rapid lymphadenopathy and low dose CT at EKHUFT. For the VISS we are looking to make the DVH service a substantive commissioned service due to the success of the pilot, and discussions are also underway to extend this model more widely across the county. • We have also been working with the provider of the K&M Prehab programme, which has been presented at a number of TSSGs, to extend the pilot of this service for our patients, to help patients prepare for surgery. • Please do feel free to contact us if you require commissioning support with any cancer pathway developments. Chris Singleton – chris.singleton@nhs.net Laura Alton – l.alton@nhs.net • SM asked about the delay of the PSA follow up document for Primary Care which had been discussed previously with RB and was due to be implemented last year. SM highlighted that a minority of GP's have refused to take on the PSA follow up. CS confirmed they are actively looking at implementing it and agreed to keep SM updated on the progress.		
13.	**AOB**	• BM asked as a patient representative for the group in relation to the previous discussion about the PSMA PET. He added this information could be worrying for a patient if it did not alter the course of their treatment. SM agreed it is a very important point which Clinicians should address. • AH mentioned he has sent an update to TB as an appendix to the Bladder Cancer POC document. • AH would like TSSG approval regarding 10 - 50% of all 2ww Hematuria pathway referrals being inappropriate for a variety of reasons. SM fully supported AH request. AW confirmed this has been added as an appendix to the document.		

		• CS explained it is important that a triage is taking place through the STT nurses or Consultants and the patient is not a 2ww referral. CS asked if the patient is referred through an urgent pathway or an 18-week pathway. • AH mentioned an audit conducted of 120 patients on a 2ww referral and removed 25% of these patients of which no cancer was found. AH proposed these patients had an outpatient appointment with more appropriate tests conducted. SM agreed that these patients would not meet the NICE criteria. AH confirmed they will still notify the GP but the risk of cancer from this particular group of patients is nil. • There were no other issues raised under any other business. • SM thanked the group for their attendance and support at the meeting today, it has been a very interesting mix of presentations. He hoped the next meeting could take place face to face.		
	Next Meeting Date	• **Thursday 14th October 2021 (13:30 – 16:30) – via Microsoft Teams**		**KG has sent the meeting invites out**