Urology Tumour Site Specific Group meeting
Thursday 14th October 2021
Microsoft Teams
13:30 - 16:30

Final Meeting Notes

Present	Initials	Title	Organisation
Sanjeev Madaan (Chair)	**SM**	Consultant Urological Surgeon	DVH
Elaine Ritchie	**ER**	Uro-oncology CNS	DVH
Alan Cossons	**AC**	Uro-oncology CNS	DVH
Fay Fawke	**FF**	Macmillan Lead Uro-oncology CNS / Deputy Lead Cancer Nurse	DVH
Olumide Olufuwa	**OO**	Lead Research Nurse	DVH
Bikram Bhattacharjee	**BB**	Consultant Radiologist	DVH
Ed Streeter	**ES**	Consultant Urological Surgeon	EKHUFT
Georgios Papadopolous	**GP**	Consultant Urological Surgeon and Endoscopic Lead of Non-Muscle Invasive Bladder Cancer	EKHUFT
Morna Jones	**MJ**	Uro-oncology CNS	EKHUFT
Thomas Cowin	**TC**	Deputy General Manager for Urology and Vascular	EKHUFT
Ben Eddy	**BE**	Consultant Urological Surgeon	EKHUFT
Sashi Kommu	**SK**	Consultant Urological Surgeon	EKHUFT
Albert Edwards	**AE**	Consultant Clinical Oncologist	EKHUFT
David Osborne	**DO**	Data Analyst	KMCA
Claire Mallett	**CM**	Programme Lead – LWBC / PC&S	KMCA
Serena Gilbert	**SG**	Cancer Performance Manager	KMCA
Tracey Ryan	**TR**	Macmillan User Involvement Manager	KMCA
Karen Glass (Minutes)	**KG**	Administration & Support Officer	KMCC & KMCA
Colin Chamberlain	**CC**	Administration & Support Officer	KMCC
Annette Wiltshire	**AW**	Service Improvement Facilitator	KMCC
Jennifer Priaulx	**JP**	Macmillan Cancer Transformation Project Manager	MFT
Claire Blackman	**CB**	Macmillan Urology CNS	MFT
Tahir Bhat	**TB**	Consultant Urologist	MFT
Cathy Samuel	**CS**	Macmillan Uro-oncology CNS	MTW
Rakesh Raman	**RR**	Consultant Clinical Oncologist	MTW
Kathryn Lees	**KL**	Consultant Clinical Oncologist	MTW
Amit Goel	**AG**	Consultant Histopathologist	MTW
Amanda Clarke	**AC**	Consultant Clinical Oncologist	MTW
Sugeeta Sukumar	**SS**	Clinical Oncology Registrar	MTW
Jennifer Pang	**JP**	Core Medical Trainee	MTW

Alastair Henderson	**AH**	Consultant Urological Surgeon	MTW
Heather Pagden	**HP**	Uro-oncology Nurse Specialist	MTW
Patryk Brulinski	**PB**	Consultant Clinical Oncologist	MTW
Sukanya Ghosh	**SG**	Consultant Radiologist	MTW
John Donohue	**JD**	Consultant Urological Surgeon	MTW
Naomi Butcher	**NB**	General Manager Cancer Services	MTW
Chris Singleton	**CS**	Senior Programme Manager - KMCA	NHS Kent & Medway CCG
Kate Regan	**KR**	Macmillan Primary Care Nurse Facilitator Lead	NHS Kent & Medway CCG
Brian Murphy	**BM**	Member of the Prostate Cancer Support Association & Patient Representative	
Apologies			
Ben Hearnden	**BH**	Macmillan Prostate Cancer CNS	EKHUFT
David Stafford	**DS**	Macmillan Lead Nurse in Urology Cancer Services	EKHUFT
Henry Taylor	**HT**	Consultant Clinical Oncologist	MTW
Mathilda Cominos	**MC**	Consultant Clinical Oncologist	MTW
Hide Yamamoto	**HY**	Consultant Urological Surgeon	MTW

Item		**Discussion**	**Agreed**	**Action**
1.	**TSSG Meeting**	**Apologies** • The apologies are listed above. **Introductions** • SM welcomed the members to the meeting and asked them to introduce themselves. **Review Action log** • The action log was reviewed, updated and will be circulated along with the minutes from today's meeting. **Review previous minutes** • The previous minutes were reviewed and agreed as a true and accurate record.		
2.	**EKHUFT & MFT Cystectomy data**	**EKHUFT Robotic Cystectomy Service – update provided by Ed Streeter** • ES explained the Robotic Cystectomy Service started in 2012. ES has performed 149 cases		**Unable to circulate this presentation**

		to date on patients ranging in age from 46 – 88. Transition to fully intra-corporeal cases in January 2019 of which there were 70 cases. • ES highlighted the structure of the team and inpatient protocols which are in place. • A breakdown of the 70 patients seen: i) No cancer – 3 ii) Non-muscle invasive bladder cancer – 31 iii) Muscle invasive bladder cancer – 36 With neoadjuvant chemo – 1 Pre-op hydronesphorosis – 20 Sarcomatoid – 5 Melanoma – 1 Combined with nephroureterectomy en bloc – 2 • ES explained the average number of cases he sees each year is 25. The average length of stay for robotic cystectomy is down to 4 days compared to previously being 17 days for an open cystectomy. • ES mentioned 2 patients died early within the first year (2019) following the operation and the second patient due to progression of disease within the first 3 months. He has since had no other patients die after their operation. • ES summarised the robotic surgery at EKHUFT: i) Significant improvement on open cystectomy ii) Engagement of Multidisciplinary team (to include CNS team, pre-assessment, Theatres / Anaesthetics, Stomatherapy, Ward, colleagues) iii) Experienced dedicated surgeons – to do 25 procedures per year • SM thanked ES and commented on the excellent results. TB agreed these are excellent results that they should all aspire too and congratulated ES. TB mentioned they are hoping to restart their robotic cystectomy service soon at MFT which was paused during Covid. **Action – TB hoped to be able to present MFT's Cystectomy data at the next TSSG meeting.**		**TB**
3.	**Performance**	**<u>DVH – update provided by Fay Fawke</u>** • FF confirmed they met the 2ww standard in July but not in August or September primarily due		**Performance presentations to be**

		to GP's referring into the wrong clinics and patients waiting for investigations to be completed. They had 1 breach in July so did not meet the 31-day standard. • FF mentioned they did not meet the 62-day target in July due to patients with complex needs. August and September (predicted) to achieve and they are actively clearing the backlog. There are 17 patients waiting over 62-days as of the 8th October and 3 patients waiting over 104-days. • FF highlighted 28-days to diagnosis is improving and they have additional resources in place to meet the standard by October 2021. • Key risks and barriers were due to LATP biopsy slots but these have now increased so they should see improvement moving forwards. They have developed a proforma for Rapid Access clinics and have increased the LATP biopsy slots to 4 per week. • SM explained the front end of the pathway and 28-day FDS can only be met properly if they have a timed pathway and anticipates this improving. **EKHUFT – update provided by Thomas Cowin** • TC confirmed they consistently meet the 2ww standard, due to daily calls with the team to ensure capacity and compliance. With regards to the 31-day standard they had a slight dip in August but were compliant in July and September. • They are continuing to work on their compliance for the 62-day standard which they met in July but not in August or September. They are looking at next key events and if brought forward would stop patients breaching at 104-days. • With regards to 28-days FDS their average compliance is 41% and they are working closely with pathway navigators to conduct additional training and education in order to improve the front end of the pathway. • Mitigating actions include planning for robotic surgery at least 2 months in advance. They have a newly appointed cancer navigator in post who is escalating pathway issues to the lead CNS on a daily basis. Additional, LATP slots are being put on weekly, together with additional 2ww outpatient clinics. There are daily huddles with the waiting list team to ensure patients have surgery dates within breach dates. Finally, the urology team are reviewing their pathways and processes.		**circulated**

		MFT – update provided by Jennifer Priaulx • JP explained with regards to the 2ww standard they have no issues and are working towards a 7-day target within urology. Additionally, they have no specific issues in regards to the 31-day or 62-day standards. • Main breach reasons are due to the patient being unwell, patient choice, diagnostic delays, outpatient delays, outpatient capacity or complex cases. • 28-days FDS compliance was 60.53% in July and 66.67% in August with the national target being 75%. • Since the change in Cancer Services Management team they have implemented daily support PTL's, weekly PTL's and PTL's with the diagnostic team. • They have employed more MDT co-ordinators and pathway navigators with a training pack in place for them. The pathway manager is planning to hold workshops for the co-ordinators and navigators to look at the PTL's and keep the patients moving through the pathway. • They have a 14-point plan in place to improve the diagnostic turnaround times across all the diagnostics. CB mentioned from next week she will be joining the PTL, from a CNS perspective and to help improve the pathway. SM agreed it is a very good idea for CNS's to join the PTL in order to provide additional clinical input. **MTW – update provided by Naomi Butcher** • NB explained for the last 3 months they have not been able to achieve the 93% standard for 2ww, due to MRI delays which they are looking into. • They have consistently achieved the 31-day and 62-day targets to a high level. This is due to clinical leadership team engagement and the team streamlining some of the processes. • In relation to the 28-day FDS there has been a lot of ongoing work in terms of compliance and data completeness. They have just appointed a haematuria and prostate STT nurse. They are working on the data completeness in terms of collecting and recording the data accurately on the system. • Key risks to delivery are due to site and bed pressures for surgery, patient choice delays / isolation and staff shortages.		

		• Mitigating actions include setting up a new joint urology / oncology clinic post MDM which takes place on a Friday afternoon which has been in place for 3 weeks. NB added there has been really good engagement across the board. NB mentioned the prostate specialist nurse – Soni (Xavier) has continued to improve the prostate pathway coordination. • SM was pleased to announce how well all 4 trusts have performed and were previously top nationally. They are now the 2nd best performing CA with regards to Urology. This clearly demonstrates the engagement of consultants and CNS's at all 4 sites and thanked them for this.		
4.	**Clinical Pathway Discussion**	**HOP** • This document has been finalised. **Bladder PoC** **Previous action updated - SM asked if TB and ES could work together to update the Bladder pathway of care document and send to SM for him to finalise. TB agreed.** **Prostate PoC** **Action - SM mentioned BE has made some edits to this document but it is not complete. SM agreed to look at this in the absence of any volunteers to finalise this PoC.** **Testicular PoC** • SM stated the final document was circulated and there were no comments made.		**TB / ES** **SM**
5.	**Management of bone health with ADT in prostate cancer**	**Presentation provided by Albert Edwards** • AE provided an update on the guidance given for the management of bone health for patients with prostate cancer treated with androgen deprivation therapy (ADT). • AE referred to a prospective US study - 'Osteoporotic Fractures in Men Study.' There were 5994 men aged over 65 recruited into the study from 2000 – 2002. 97% of these men were followed up for approximately 9 years. 178 patients experienced incident hip fractures which is quite a large number. There were various risk factors associated with the osteoporotic fractures detailed. • AE referred to NICE Guidance and recommendations:		**Presentation to be circulated**

		i) NG131 – Prostate Cancer: diagnosis and management (2019) ii) CG146 – Osteoporosis: assessing the risk of fragility fracture (2012; 2017) • SM asked if AE had any guidance he could offer for his patients in clinic with regards to their bone health. AE referred to NICE guidelines which recommends FRAX or QFracture and input the patient data to assess the risk of fragility fractures. AE mentioned there is nothing to stop SM advising his patients to take a calcium supplement and Vitamin D as long as there is no contraindication. AE recalled the minutes from a previous TSSG meeting stating there was no funding available for assessing all prostate patients going onto ADT for their bone mineral density. AE thought this was just for symptomatic patients but may well not be the case. AE is unsure if they are able to screen these patients. AE added if he is able to confirm the detail he will feedback. KL confirmed the patients will get a baseline bone density scan at UCLH but she would advise them to take over the counter calcium and vitamin D supplements. She would then check the patients' bone density after 2 years. • SM would be keen for there to be some structured local guidance for urologists and junior doctors as to what they should be doing for these patients. AC confirmed they are still working on the guidelines and there is some capacity for DEXA's for the appropriate patients. They should all be FRAX scoring new patients if they are going to be on hormones for more than 6 months to then be able to prescribe bisphosphonates appropriately. AC concluded they are working on having helpful guidelines at DVH and will disseminate to the group in due course. • SM and AC agreed it would be good to keep track and monitor these patients and have a regional strategy in place for a couple of years which they could then publish.		
6.	**MDT Streamlining update**	• SM mentioned MDT's are becoming over-burdened and he is not sure if any progress has been made to streamline MDT's. SM asked for some ideas from the group on how to streamline MDT's. • SM suggested the pathologist could decide if the patient should go to a pre-MDM or the main MDM. The MDM Co-ordinator could put these patients together in a separate list. AG thinks this is a good idea. **Action - SM asked for a volunteer to do some baseline work on a formalised standard of care for the Cancer Alliance. There were no offers, SM agreed to assign this to someone. He hoped to progress this and discuss further at the next meeting.**		**SM**

7.	**Research**	• SM stated there has not been much Research activity over the last year or so due to Covid and asks for a summary from each site as to how they are recovering. **<u>MTW – update by Ali Henderson</u>** • There are 2 trials due to open in urology - TRANSLATE – prostate biopsy study and HY is heavily involved with this trial which should open in the next couple of months. Additionally, STAMINA – a trial to encourage patients to engage in some physical activity after starting hormonal therapy. This trial has been paused temporarily due to the Nuffield gyms being closed due to Covid. • KL provided an update on MTW Oncology trials. They have the following trials open including PACE-C, PIVOTOL Boost and are in the process of opening PEARLS initially at MTW and then at EKHUFT. KL added they have a nice spread of prostate radiotherapy trials. • KL mentioned there are no radiotherapy bladder trials open at the moment but have ATLANTIS open for metastatic bladder patients. • PB mentioned there is a site initiation visit at KCH in 2 weeks' time and they hope the PACE-C trial will be open by the beginning of November. Additionally, they hope STAMPEDE will open early in 2022. • KL added UK GPS is open across all sites for young men aged under 65 for prostate cancer, with + family history – genetics trial.		
8.	**Clinical Audit**	**<u>PSMA and Choline PET - CT in Kent Oncology Centre audit - provided by Patryk Brulinski</u>** • PB highlighted the audit background details which include: i) Increased use of next generation imaging in prostate cancer across the UK ii) Better sensitivity for metastasis but not yet adopted as standard in the UK iii) PSMA PET-CT vs Choline PET-CT – superior diagnostic accuracy in trial setting iv) Heterogeneous availability in different centre's v) Figures within KOC • PB explained the audit was conducted for just 99 patients with an age ranging from 47 – 90. 74 of the patients had a Choline PET-CT scan with 25 who had the PSMA PET-CT scan.		**Awaiting copy of the presentation**

		• The metastatic PSA level pick up rate for the PSMA scan had a better pick up rate at 72% compared to the Choline scan at 39%. • PB thanked the Nuclear Medicine teams at EKHUFT, MTW and the Oncology team at KOC for their support with this audit.		
9.	**CNS Updates**	**<u>DVH – update provided by Fay Fawke</u>** • FF highlighted they are still waiting for the InfoFlex supported self-management portal system to go live. CM explained the reason behind the delay is the CCG have introduced a new process for clinical safety governance. This needs to be looked at and also to verify patient registration for the portal. CM confirmed the good news is the treatment summaries are available now to be tested. There is further ongoing work being done by Natalie Williams which will be circulated detailing what the portal clinical view will look like. There will be components that a selected group can test and feedback on. CM agreed to keep the group updated on the time frames. • FF concluded an advert has gone out for a full-time Band 7 STT Urology nurse. **<u>EKHUFT – update provided by Morna Jones</u>** • MJ agreed they were also waiting for the supported self-management portal. Their 2 support workers are now doing HNA's and hope they will also be able to support the future portal. **<u>MTW – update provided by Heather Pagden</u>** • HP agreed they were also in the same position as DVH and EKHUFT waiting for the portal. • They have now appointed a hematuria STT nurse to help with the bladder pathway. KL confirmed they have also appointed a new metastatic STT nurse (Jeanette) within oncology which will be a great help. SM agreed this is a very good development for the trusts and they will also be able to work on the bone health pathway. **<u>MFT – update provided by Claire Blackman</u>** • CB explained they are also in the same situation as the other trusts regarding the portal. • STT nurse has written the policy for commencing the rapid access nurse led clinic which will speed up the pathway. CB has also enquired about getting a metastatic nurse in place to		

		support oncology. • CM explained even though the portal has been delayed this does not stop the group continuing with the remote monitoring, the tracking system is live and to move the patients across. CM does not have a timeframe yet for the delayed portal but will update when she has more details. • CM mentioned the SOP pathway self-management document which was drafted by the EKHUFT team. CM is sure the document has been circulated to the group but is now keen for this to be signed off.		
10.	**mpMRI vs bpMRI**	**<u>Multiparametric MRI of the Prostate – to use contrast or not - presentation provided by Sukanya Ghosh</u>** • SG explained she likes the Likert scoring as it considers PSA density, DRE and all the relevant clinical history before interpreting the image. PI-RADS on the other hands only considers the MRI findings and not what to biopsy. • SG mentioned she looked at 37 identified PI-RADS patients at MTW from January – September 2021 and all had a biopsy. 56% of these patients were negative with 43% positive and 8% of these with clinically significant prostate cancer. SG alluded to an MRI prostate scan audit which she conducted in 2016. Consequently, contrast was stopped at MTW which saved £20,900 per year and 280 hours of scanning time which allowed an additional 558 MRI prostates to be completed in a year. • SG concluded they should be using mpMRI contrast for patients who have hip replacements or anything that degrades T2 or DWI, strong family history, prostate interventions or have previously undergone a bpMRI.		**Awaiting a copy of the presentation**
11.	**How to empower practice nurses to complete cancer care pathways**	**<u>Presentation provided by Kate Regan</u>** • KR explained she is now the Macmillan Primary Care Nurse Facilitator Lead for K&M and has been in post for approximately 4 years. KR works for the CCG but her role is financed by the Cancer Alliance and Macmillan. Her main aim is to empower practice nurses working in PC to complete cancer care reviews at 12 months. They have been delivery training modules consecutively to support the nurses. • Face to face training commenced in 2017 - 2020 initially within EKHUFT and has been delivered by both KR and Ann Courtness. Due to Covid the training has been delivered		**Presentation to be circulated**

		virtually. KR mentioned both Ben Hearnden and Dave Stafford – EKHUFT CNS's came to their prostate cancer training with the practice nurses. In 2021 they offered a virtual course for the whole of K&M. • The nurses will attend a 6-month training course which is facilitated by Macmillan and supported by the CNS teams. The objective is to empower practice nurses to support people living with cancer as a long-term condition and to complete a holistic cancer care review to help address and support unmet needs. • KR explained during Covid the nurses have been unable to shadow the CNS's in the trusts due to social distancing. KR has been attending some monthly CNS meetings to highlight the training and to develop a community of practice / collaborative working. Additionally, KR is planning to attend all of the TSSG meetings to make the CNS's aware of this training. • KR provided her email address - kateregan@nhs.net and asked if there are any further questions or they would like to be involved in helping with the training next year to contact KR directly. • SM encouraged all the CNS's on the call to get involved as it will benefit them all in the long run.		
12.	**Prostagram & update on the current surgical trials in Imperial**	• SM explained Hashim Ahmed is unable to attend and present at the meeting today due to last-minute clinical commitments. **Action – SM would like HA to be invited to the next TSSG meeting to present or alternatively suggested setting up a separate 1 – 2-hour meeting with Clinicians only prior to the next meeting.**		**SM / AW**
13.	**Cancer Alliance and CCG update**	**<u>Update provided by Chris Singleton</u>** • CS agreed to provide an update on the CA priorities in CM's absence and a CCG update. He added they aim to make these updates tumour site specific although there is not too much to update from a urology perspective. • CS highlighted some of the work they have been doing from a K&M perspective. The Rapid Diagnostic Services are being developed and are working really well. The VISS pilot at DVH has shown some very positive results over the last 2 years and is being extended for a further year. They are looking to roll this service out to MFT and EXHUFT by March 2022 and will		**Presentation to be circulated**

		share best practice from the DVH pilot. From 2024 all patients across all CA's will be able to access the vague symptoms clinics which have shown a higher yield for a cancer diagnosis than the standard 2ww clinics. • The Rapid Lymphadenopathy pilot has been running in EKHUFT since September 2020 and has also shown some hugely successful and positive results, with a 15% conversion rate to cancer. They are looking to expand this service to MTW in the coming months. • CS mentioned as part of the early cancer diagnosis work, K&M have been selected as one of eight CA's to be part of the NHS Gallery Grail programme which is due to commence on the 25th October 2021. This will offer selected patients, a blood test to pick up DNA markers and will identify 50 of the harder to diagnose cancers before the patient has symptoms. CS added there is an indication that only 1 - 2% of patients tested may require a 2ww referral so should not inundate already busy cancer pathways. • There has been national confirmation that K&M have been selected for the Targeted Lung Health Check (TLHC) programme which will focus on areas of high smoking prevalence. • An update from a CCG perspective is that the CCG is transitioning into an Integrated Care System (ICS) and is subject to parliamentary approval. This will mean the CCG will cease to exist formally from 31st March 2022. The ICS will benefit due to working collaboratively and have more of a K&M system approach.		
14.	**AOB**	• BM referred to the previous discussions about the MDT. A plea from the patients' perspective is to not lose sight of the importance of those discussions for the patient who maybe struggling with a treatment decision. The fact that their case is being discussed seriously by a range of experts is very reassuring for them and their future treatment options. • BM is also reassured to see how open the discussions are now at the TSSG meeting and thanked SM and the group for this. • SM reassured BM that the MDT discussions should be tailored to discuss just the complex patients and the other cases would still be thoroughly discussed but away from the main MDT. • No further AOB raised at the meeting. • SM thanked the group for their attendance and contribution at the meeting today.		

	Next Meeting Dates	• **Tuesday 26th April 2022 & Thursday 13th October 2022 via MS Teams (times to be agreed)**		**KG to circulate the meeting dates and times**