Kent and Medway Cancer Collaborative

Urology Tumour Site Specific Group meeting
Tuesday 26th April 2022
Microsoft Teams
13:30-16:30

Final Meeting Notes

Present	Initials	Title	Organisation
Sanjeev Madaan (Chair)	**SMa**	Consultant Urological Surgeon	DVH
Anca Gherman	**AGh**	Clinical Trials Research Nurse	DVH
Srijit Banerjee	**SB**	Consultant Urologist	DVH
Elaine Ritchie	**ER**	Uro-oncology CNS	DVH
Angela Elliott	**AEl**	Nurse Specialist in Urology	DVH
Svetla Mureva	**SMu**	Consultant Radiologist	DVH
Fay Fawke	**FF**	Macmillan Lead Uro-oncology CNS / Deputy Lead Cancer Nurse	DVH
John Kyle	**JK**	Implementation Consultant	Civica
Sashi Kommu	**SK**	Consultant Urological Surgeon & Cancer Lead	EKHUFT
Milan Thomas	**MT**	Consultant Urological Surgeon	EKHUFT
Naomi Webb	**NW**	General Manager for Urology	EKHUFT
Thom Cowin	**TC**	Deputy General Manager for Urology	EKHUFT
Matthias Koslowski	**MK**	Consultant Cellular Pathologist / Consultant Histopathologist	EKHUFT
Morna Jones	**MJ**	Lead Uro-oncology CNS	EKHUFT
Ed Streeter	**ES**	Consultant Urological Surgeon	EKHUFT
David Stafford	**DS**	Macmillan Lead Nurse in Urology Cancer Services	EKHUFT
Hashim Ahmed	**HA**	Consultant Urological Surgeon	Imperial College Healthcare NHS Trust
David Osborne	**DO**	Data Analyst	KMCA
Claire Mallett	**CMal**	Programme Lead – Personalised Care & Support	KMCA
Karen Glass (Minutes)	**KG**	Administration & Support Officer	KMCC & KMCA
Annette Wiltshire	**AWilt**	Service Improvement Facilitator	KMCC
Tracey Ryan	**TR**	Macmillan User Involvement Manager	KMCC
Colin Chamberlain	**CC**	Administration & Support Officer	KMCC
Jennifer Priaulx	**JPr**	Macmillan Cancer Transformation Project Manager	MFT
Clarissa Madla	**CMad**	Research Nurse	MFT
Angela Williams	**AWill**	Urology CNS	MFT
Sian Wilson	**SW**	Research Nurse	MFT
Claire Blackman	**CB**	Macmillan Urology CNS	MFT
Tahir Bhat	**TB**	Consultant Urologist	MFT

Diletta Bianchini	**DB**	Consultant Medical Oncologist	MTW
Annaselvi Nadar	**AN**	Team Leader – FDS	MTW
Branimir Penev	**BP**	Consultant Urological Surgeon	MTW
Albert Edwards	**AEd**	Consultant Clinical Oncologist & Joint radiotherapy lead	MTW
Amanda Clarke	**ACl**	Consultant Clinical Oncologist	MTW
Amit Goel	**AGo**	Consultant Histopathologist	MTW
Chris Harker	**CH**	Cancer Performance Data Analyst	MTW
Alastair Henderson	**AH**	Consultant Urological Surgeon & Lead Clinician	MTW
Niki Poulson	**NP**	2ww Haematuria pathway Nurse	MTW
Kathryn Lees	**KL**	Consultant Clinical Oncologist	MTW
Henry Taylor	**HT**	Consultant Clinical Oncologist	MTW
Hidekazu Yamamoto	**HY**	Consultant Urological Surgeon & MDT / Cancer Lead	MTW
Jennifer Pablo	**JPab**	Straight To Test Assessment Nurse	MTW
Carys Thomas	**CT**	Consultant Clinical Oncologist	MTW
Jennifer Pang	**JPan**	Consultant Clinical Oncologist	MTW
Laura Alton	**LA**	Senior Programme Manager – KMCA	NHS Kent & Medway CCG
Jack Jacobs	**JJ**	Macmillan GP & Cancer Lead	NHS Kent & Medway CCG
Bana Haddad	**BH**	Macmillan GP & Cancer Lead / Clinical Lead – Personalised Care & Support	NHS Kent & Medway CCG / KMCA
Brian Murphy	**BM**	Patient Representative	
Apologies			
Bikram Bhattacharjee	**BB**	Consultant Radiologist	DVH
Iain Morrison	**IM**	Lead Consultant Radiologist	EKHUFT
Matin Sheriff	**MS**	Consultant Urological Surgeon	MFT
Steph McKinley	**SMK**	Matron- Faster Diagnosis	MTW
Patryk Brulinski	**PB**	Consultant Clinical Oncologist	MTW
Steph McKinley	**SMc**	Matron – Faster Diagnosis	MTW
Adele Cooper	**ACo**	Uro-oncology CNS	MTW
Mark Cynk	**MC**	Consultant Urological Surgeon / Lead Clinician in Urology	MTW
Maria Blanco- Criado	**MBC**	Lead Oncology Pharmacist	MTW
Ann Courtness	**AC**	Macmillan Primary Care Nurse Facilitator	NHS Kent & Medway CCG
Kate Regan	**KR**	Macmillan Primary Care Nurse Facilitator	NHS Kent & Medway CCG

Item		**Discussion**	**Agreed**	**Action**
1.	**TSSG Meeting**	**Apologies**		

		• The apologies are listed above. **Introductions** • SMa 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 to the members with the final minutes from today's meeting. **Review previous minutes** • The minutes from the previous meeting, which took place on Thursday 14th October 2021 were reviewed and accepted as a true and accurate record.		
2.	**Clinical Audit**	**East Kent Renal Cancer data – presentation provided by Milan Thomas** • MT provided an overview of his professional background to date. • MT explained EKHUFT have provided kidney cancer surgery since 2015 and robotic surgery was introduced in 2011. • MT's total caseload since 2016 is 459 but he thinks this is probably closer to 500 cases. The type of surgery undertaken includes nephroureterectomy, radical nephrectomy and robotic partial nephrectomy. • Since moving to EKHUFT, MT was keen to reduce the length of stay for all types of renal surgery. There has been a significant reduction in the length of patient stay to 2 days for open, laparoscopic and robotic renal cancer. This has resulted in a massive cost saving for the trust. • Their focus was on enhanced recovery, the CNS team using pre-habilitation to achieve a 1-day length of stay in hospital for 40% of all kidney cancer patients. This was presented to BAUS in 2021. • MT mentioned the volume of work has been increasing for partial nephrectomies. Increased BMI is a risk factor for kidney cancer. There can be significant bleeding associated with partial nephrectomies ranging from 10 – 1200 ml with the median blood loss being generally 160ml.		**Presentation circulated to the group on the 6th May**

		• MT emphasised that in 459 renal surgery cases he has only had 1 mortality. This particular patient was quite hypoxic at the time of induction and she struggled post operatively for 3 weeks in respiratory distress. • MT looked at HDU and ITU admissions post operatively, the trend is downwards which is unlikely to change as the only option for kidney cancer patients is surgery. • MT highlighted some coding issues at EKHUFT with some patients that are re-admitted but these numbers are still fairly respectable. • SMa thanked MT for his excellent presentation and for developing such a fantastic service. • SB asked if patients are discharged with any tubes etc after their kidney surgery. MT confirmed all patients are discharged without drains, catheters and there are no stents in any of the partial nephrectomy cases.		
3.	**Performance**	• SMa highlighted that the trusts are still struggling with the 28-day FDS performance targets and he would like the trusts to include this within their update. K&M CA are below the England average at 50.6% compared to 56.2%. SMa also referenced the FDS data completeness which is also an issue. SMa understood that EKHUFT still has a high backlog of patients and he hoped to be able to provide some support from West Kent. **<u>DVH – update provided by Fay Fawke</u>** • **Please refer to the circulated performance slide pack for an overview of the Trust's data.** • With regards to the 28-day FDS – they are still below the standard but they are improving. Their delays are due to capacity issues for their haematuria patients and they have now set up a 2ww haematuria rapid access clinic. They have had a lot of staff sickness within the Urology CNS's due to Covid and they are also using up annual leave. **<u>EKHUFT – update provided by Thom Cowin</u>** • **Please refer to the circulated performance slide pack for an overview of the Trust's data.** • TC highlighted that they also had 2ww haematuria capacity issues in February. Within the 31-day pathway they had robotic capacity issues in February. There are a number of risks and		**Performance slides were circulated to the group on the 6th May**

		issues within 62-days which still exist due to diagnostic capacity, pathology reporting, theatre capacity, limited capacity for surgical out-patient appointments prior to surgery, limited cystoscopy capacity and a high demand for TP biopsies. • They are working on the 28-day FDS and will have an additional cancer navigator joining the team in the next few weeks. • NW explained the main backlogs / delays are within diagnostics for the prostate pathway. NW highlighted issues at EKHUFT with regards to MRI capacity which has an impact on the 28-day FDS pathway. MJ mentioned they will be recruiting a STT urology CNS which they hope will help. • HT referred to the Community Diagnostic Centres which will be able to provide more capacity and a workstream has been set up to look into sharing resources. HT acknowledged the difficulty of some patients being able to travel for tests. HT agreed if you can nail the 28-day standard the 62-standard will take care of itself. HT stated the importance of clinical assessments and performance status for their patients. **MFT – update provided by Jennifer Priaulx** • **Please refer to the circulated performance slide pack for an overview of the Trust's data.** • JP explained they have struggled to meet the 28-day FDS particularly for prostate cancer with MRI turnaround times, equipment issues and biopsy turnaround times. 6 days is their target for diagnostics. In terms of the data completeness they have taken on additional admin staff and improved their training which has helped. **MTW – update provided by Chris Harker** • **Please refer to the circulated performance slide pack for an overview of the Trust's data.** • 28-day FDS – their performance status is fluctuating and there is ongoing work to record the data accurately. A prostate discharge clinic has been set up. • SB referenced an increase in inappropriate 2ww referrals. HY explained they have had stringent processes in place for a while at MTW with CNS's triaging the inappropriate referrals from PC. MJ mentioned their new STT nurse will be charged with sorting out the inappropriate referrals. NP explained she has been triaging the haematuria pathway referrals at MTW and has been able to weed out inappropriate referrals and patients that are not available for tests within 2		

		weeks. It is still early days but this has been quite positive for MTW. • AH stated they do see a growth year on year of referrals but this does not convert to a proportional growth of new cancers. The advantage of the STT nurses is they are doing the right thing for the patient as well as managing the waiting list. • HT defended PC stating they are under enormous pressure to refer patients in and there is some work they can do together with PC regarding referrals. AH stated there has been a lower level of patients being referred in from PC. There are some patients who are not fit enough for treatment and are being screened out. • JJ asked if the group could be mindful of the language used towards their PC colleagues regarding inappropriate referrals and added there are limitations in the service for them. A STT nurse at the beginning of the pathway will help hugely. Many referrals coming in from PC may also come from inexperienced clinicians and locums who are not familiar with the pathways. Most GP's will adhere to the guidelines in place.		
4.	**Clinical Pathway Discussion**	**<u>Bladder</u>** • Ongoing updates to this POC document. **<u>Prostate</u>** • Ongoing updates to this POC document.		
5.	**Prostagram - update on the current surgical trials in Imperial**	**<u>Presentation provided by Hashim Ahmed</u>** • SMa introduced HA and thanked him for his time today. SMa explained HA is a Professor of Urology at Imperial College Hospital and has been involved in a lot of practice changing research in urology. • HA explained they have an extensive portfolio of prostate trials at Imperial. SMa was a key partner for these trials prior to 2017 when HA took up his role. He hopes to continue the partnership with K&M with ongoing trials. • HA provided an overview of the IP1-PROSTAGRAM pilot feasibility study looking at the role which imaging might play as a mammogram equivalent type of screening test for prostate		**Presentation circulated to the group on the 6th May**

		cancers. In this study they recruited 411 men aged 50-69 years old within 7 Primary Care practices. • HA provided the group with an overview of Imperial's prostate trials, including: STAMPEDE, ATLANTA and PACIFIC. • HA highlighted the Imperial Prostate Masterclass – 9 – 10 September 2022 – www.ipmasterclass.co.uk to register. • HA is keen that MFT (HY) complete and deliver on the TRANSLATE study. They plan to recruit into PACIFIC for the next 3 years. There will be a pilot of 10 Centre's initially. HY and HA agreed to discuss further in due course.		
6.	**Update on Prostate cancer NICE guidance**	**<u>Presentation provided by Sanjeev Madaan</u>** • SMa outlined the changes made to the Prostate Cancer NICE guidelines in December 2021, which included: **i) Age-specific PSA thresholds for people with possible symptoms of prostate cancer.** **ii) Risk stratification for people with localised or locally advanced prostate cancer.** • Previously the PSA value for men aged 50 - 69 was a threshold of 3 but there was no clear clinical evidence based on this. Recently, NICE has evaluated the clinical evidence for the PSA levels: i) Below 40 years – use clinical judgement ii) 40 – 49 years – more than 2.5 iii) 50 – 59 years – more than 3.5 iv) 60 – 69 years – more than 4.5 v) 70 – 79 years – more than 6.5 vi) Above 79 years – use clinical judgement • The TSSG agreed to use a cut off of PSA level 10 for men aged above 79. SMa highlighted the risk stratification changes (low, intermediate and high risk) for people with localised prostate cancer. The latest risk stratification is based on the Cambridge Prognostic Group – 5 levels. • SMa asked if they should start recording their MDT meetings using the 5 criteria levels as recommended by NICE. HY thought it might be worthwhile for audit purposes. They agree it is		**Presentation circulated to the group on the 6th May**

		not urgent. • CH explained the risk stratification is recorded on InfoFlex. For a low risk prostate cancer patient, they would go straight onto active monitoring in terms of national CWT data. The details SMa has shown is different to what is in the guidance and wondered when this data would come into effect. SMa explained the detail was published in December and he would be keen for InfoFlex to be updated by the next TSSG meeting.		
7.	**PSA monitoring in Primary Care and update to prostate referral form from NICE criteria changes**	**<u>Update provided by Laura Alton</u>** • LA explained on the 6th April the PC commissioning team agreed funding for the transfer of stable PSA patients to PC. This is good news and 90% of PC practices across K&M have agreed to this transfer. There is a small cohort of practices across the county who are either unwilling or unable to undertake the transfer of these patients. • LA stated next steps, can they clarify the arrangement for the safe discharge of patients to PC – via a letter outlining the frequency of monitoring required. Additionally, to firm up a rapid access route back into SC should this be required via email or ERS. The GP's have also asked for a point of contact from each trust. • They are continuing to work with those GP practices that are currently unable to take on this work. • LA confirmed her colleague Chris Singleton chris.singleton@nhs.net is leading on this work, she is updating the group on his behalf today. • HY stated he fully supports shared PC and SC. When discharging patients back to PC it should be a swift route for them via an email with no added bureaucracy to navigate through. SMa stated this is for patients that have been treated by SC, to be discharged and followed up in PC. SMa agreed it is also important to hand back to PC the non-prostate cancer patients – who have a raised PSA but no cancer. • LA asked if there were any comments / feedback on the newly updated 2ww referral form which has been shared with the group and includes the new PSA threshold levels before these forms are uploaded. • The TSSG agreed the PSA level for men aged 79 should stay at 10 as discussed previously. SMa confirmed that is already within the 2ww referral form so that will stay the same.		

8.	**Prostate discussion on protocol & update on PSFU**	**<u>Update provided by Claire Mallett and John Kyle</u>** • CMal stated there have been some delays with the prostate Patient Portal and they are waiting for imminent NHS login approval from NHSE/NHS Digital. Once this approval has been given they can take the papers to the CCG Clinical Cabinet. • Portal testing has been undertaken by the Trusts and they are now looking to have patients within the portal to go live in August. • CMal highlighted the SOP document and there being some outstanding issues within that document. CMal has met with FF recently. Within the protocol it allows for 3-5 year on the supported self-management programme and asked if this should be standardised across the patch. • CMal explained the pathway of supported self-management care has now started to be embedded. • KL agreed the portal will be excellent and will be a useful PROMS data exercise. KL suggested in order to help GP's they have a clear 5 year follow up on the portal. There were no objections from the group and it was agreed to change this to 5 years. • JK explained they have been making progress on the portal and the login will provide extra security which is a good thing. They will be in a good place in the next couple of months' and hopes to get some good feedback from the group. **Action – CMal agreed to send the SOP to KL to review who is very happy to update from an oncological point of view.**		**Presentation circulated to the group on the 6th May** **CMal / KL**
9.	**MDT Streamlining**	**<u>DVH – presentation provided by Srijit Banerjee</u>** • SMa explained at their last MDM they discussed 52 patients which he felt was too many as those which needed a more detailed discussion were rushed through. • There is a national directive to create SOC's for MDT's at a CA level for all trusts to follow. • SB explained this has been a long time coming as their MDT's are overburdened and they need to be streamlined.		**Presentation circulated to the group on the 6th May**

		• A Standard of Care (SoC) is a point in the pathway of patient management where, there is a recognized intervention (s) that should be made available to a patient. The MDTM will maintain oversight of all patient cases, but where a SoC meets a patient's need, the case would be listed, but need not be discussed at the full MDT meeting. • Discussion on who should be present at the MDT meeting – to include Consultant Urologist, MDT Co-ordinator, Middle grade / specialist doctor / Specialist registrar, CNS, pathologist and radiologist. • SB explained that streamlining is not a one-size fits all approach, they need to use clinical judgement and this may not apply to all patients. • HY referenced that GIRFT are keen to streamline MDT's. AL suggested they have agreed processes in place regarding the specific thresholds for the patients they want to discuss at the MDT. AH agreed there are 3 areas: i) Not needing an MDM discussion ii) Standard cases – get double reporting iii) Complex specialist cases – get discussed • SMa asked SB if could make his presentation more comprehensive. SB agreed to circulate the word document which is free to edit as required. SMa asked if SB could add in Specialist MDT as he does not feel this is running effectively and these are cases mandated by a specialist centre – radical treatment for prostate cancer, specialist treatment for renal cancer and cystectomy. **Action – SB agreed to send the streamlining document to the group for further comments.**		**Actioned after the meeting.**
10.	**Research**	**<u>DVH</u>** • SMa explained that DVH have been struggling with their research and they have not recruited any patients for a long time. **<u>Cancer Research in Region Propelling Collaborations and Engagement – update provided by Sashi Kommu</u>** • SK is keen to share the work taking place from EKHUFT across the patch.		

		• SK explained they want to propel cancer research across the region and referenced the K&M Medical School – they have 2 universities with incredible labs and many of them have been actively engaged. They have looked at Patient Centered Engagement of Students (PaCES) focused on an early career of researchers and engaged with the bio-medical students. • SK mentioned they have launched the East Kent Clinical Trials Unit which they are very proud of. SK highlighted some of the urology research projects taking place at EKHUFT and the CEPER pathway. SK agreed to reach out to all consultants in the region on how to improve research collaborations within the regions. • SMa mentioned that TB is doing cystectomy's at MFT and he would be someone for SK to approach. SMa is very happy to support.		
11.	**CNS Updates**	**DVH** • FF confirmed she has no update for today's meeting. **EKHUFT** • No update provided. **MFT** • No update provided. **MTW** • No update provided.		
12.	**Listening & Learning**	**Presentation provided by Tracey Ryan** • TR presented the listening and learning audit, conducted by EK360 on a cohort of 76 patients attending endoscopy appointments. The audit explored the reasoning behind patient's reluctance to attend appointments with a view to improving future attendance. • TR explained the cohort patients approached included men, BAME community, LGBTQ+,		**Presentation circulated to the group on the 6th May**

		physical and mental disabilities. • The three main areas raised included: i) **Information / Communication** – step by step, reasons, videos ii) **Anxieties** – fear of the unknown, embarrassment, reassurance, helpful hints and patient stories iii) **Hidden factors** – including physical and mental disabilities, abuse. • TR explained with the information collated they have set up a focus group which includes endoscopy managers and screening teams. • They are looking at solutions to help patients attend future appointments: i) Flag for patient with additional needs – referral form ii) FAQ's to be sent out to patients iii) Patient videos – diagnosed and non-diagnosed / for screening and symptomatic patients iv) Information formats v) Admin training – could ask key questions to help patients to help reduce DNA rates • TR referred to a quick win's trial at one K&M trust for a period of three months in order to review outcomes. Additionally, to work on creating videos, further information and training for the admin team. • TR emphasised the importance of remembering to ask the patient "what matters to you" and not just "what is the matter with you." TR referred to the important role of the support network around the patient. • TR explained if patients are aware their opinions / concerns are being acted upon where possible this does have a positive impact and it encourages future engagement with surveys etc. • NP mentioned she does a telephone triage service for cystoscopy's and provides a tailored explanation about the procedure to the patient. They seem receptive to what they are coming in for. She has had feedback from the nurse's which has been really beneficial as the patients are then prepared for their procedure. NP added there is a questionnaire which goes out with the outcome letter to the patient to provide the feedback for those who are able to complete it. • TR agreed to share the final outcome with the group so this can be incorporated into their		

		everyday work of the teams.		
13.	**Prostate cancer awareness project to Higher Risk Men (Black ethnicity and family history)**	• Cathy Finnis and Sarah Barker were unable to attend today's meeting but would be happy to provide an update at the next TSSG. This project is not due to start until Q3. Any feedback from the slide presented please could this go to CF, KG or LA.		**Slide was shared with the group.**
14.	**Cancer Alliance update**	**<u>Update provided by Laura Alton</u>** • LA explained the national cancer programme priorities. There is a key focus on Faster diagnosis and operational performance, early diagnosis, treatments and personalised care and cross cutting themes. • LA highlighted the roll out of the Non-Site-Specific pathway to additional sites across K&M with the aim to have full coverage by 2024. The CA will be supporting trusts to implement best-practice timed pathways for prostate, colorectal, lung and UGI pathways with new timed pathways for gynae and H&N. • LA referenced the Galleri Grail pilot which continues across K&M and moves to Maidstone on the 7th April, returning to Sittingbourne and then onto Ashford finishing in June. Grail have achieved 70% participant recruitment. LA mentioned Targeted Lung Health Check programme will start in East Kent initially with a rapid expansion by 2023/24. The CA continues to support Cystosponge, Colon Capsule Endoscopy, Lynch Syndrome testing and Liver Surveillance. • Treatments and Personalised Care – ongoing personalised and stratified pathway work within prostate is ongoing. There is a new cancer workforce lead (Rebecca Nelhams) starting in April to support workforce development and to take forward themes from the Kent Oncology review.		**Presentation circulated after the meeting**
15.	**AOB**	• KL referred to the National Prostate Cancer Audit, which highlighted that the data completeness was not very good and is most probably due to Covid. MTW have a permanent MDT Coordinator who should hopefully improve the data completeness. There have also been issues with PROMS data collection and recording it, which the Patient Portal should hopefully mitigate against in future. They have recruited a dedicated PROMS data manager to initially cover prostate and gynae and will start in the next 6 months. From a radiotherapy point of view, they will be able to formalise data collection and develop an electronic pathway. Funding is available		

		to support this. • Ongoing CNS support for patients as they develop metastatic disease and pass through treatment. They now have a metastatic CNS prostate nurse at MTW. They need further support for the radical radiotherapy patients. • SMa thanked the group for their attendance at the meeting which he felt was a very good meeting.		
	Next Meeting Date	• **Thursday 6th October 2022 (AM meeting) – F2F meeting - venue - TBC**		**KG circulated meeting invites**