Kent and Medway Cancer Collaborative

Urology Tumour Site Specific Group meeting
Thursday 14th October 2025
Via MS Teams
09:00 – 12:30
Final Meeting Minutes

Present	Initials	Title	Organisation
Sanjeev Madaan **(Chair)**	**SM**	Consultant Urological Surgeon	DVH
Vishakha Tripathi	**VT**	**Guest speaker** - **Consultant Genetic Counsellor / Clinical Lead SELCA Genomics**	GSTT
Toby Richardson-Jones	**TRJ**	**Guest speaker – F2 Doctor**	University of Sussex
Anca Gherman	**AG**	Macmillan Uro-Oncology CNS	DVH
Dawn Stewart	**DS**	Cancer Pathway Lead	DVH
Seshadri Sriprasad	**SS**	Consultant Urological Surgeon & Professor, Deputy Chief Medical Officer	DVH
Ranjit Kaur	**RK**	Urology MDM Co-ordinator	DVH
Michelle McCann	**MMC**	Interim General Manager of Cancer and Haematology	DVH
Philippa Cooper	**PC**	Uro-Oncology Clinical Nurse Specialist	DVH
Nicola Lancaster	**NC**	Macmillan Metastatic Oncology CNS	DVH
Joseph Nariculam	**JN**	Consultant Urologist	DVH
Desmond Owusu	**DO**	Consultant Radiologist	DVH
Carys Thomas	**CT**	Clinical Oncologist	EKHUFT
Milan Thomas	**MT**	Consultant Urological Surgeon	EKHUFT
Melene Locke	**ML**	Senior Cancer Research Nurse	EKHUFT
Thiwanka Karawita	**TK**	Consultant Pathologist	EKHUFT
June Tay	**JT**	Consultant Urologist	EKHUFT
David Stafford	**DS**	Lead Uro-Oncology CNS	EKHUFT
Naomi Webb	**NW**	General Manager Urology Vascular	EKHUFT
Claire Mallett	**CM**	Programme Lead – Living with and Beyond Cancer	KMCA
Jo Jackson	**JJ**	ED Project Manager	KMCA
Chris Singleton	**CS**	Senior Programme Manager	KMCA
Karen Glass **(Minutes)**	**KG**	PA / Business Support Manager	KMCA & KMCC
Bana Haddad	**BH**	Primary Care Clinical Lead / GP	KMCA / NHS Kent & Medway ICB
Jonathan Bryant	**JB**	Primary Care Clinical Lead / GP	KMCA / NHS Kent & Medway ICB

Colin Chamberlain	**CC**	Administration & Support Officer	KMCC
Sam Williams	**SW**	Administration & Support Officer	KMCC
Tahir Bhat	**TB**	Consultant Urologist	MFT
Omar Algurabi	**OA**	Specialty Doctor	MFT
Clarissa Madla	**CM**	Clinical Research Delivery Manager	MFT
Holter Siangko	**HS**	Urology-Oncology research nurse	MFT
Javed Burki	**JB**	Consultant Urologist	MFT
Claire Blackman	**CB**	Macmillan Urology CNS	MFT
Faisal Ghumman	**FG**	Consultant Urological Surgeon / Clinical Director – Cancer Lead	MFT
Suzanne Bodkin	**SB**	Cancer Service Manager	MFT
Muhammad Farooq	**MF**	Macmillan Urology CNS	MFT
Patryk Brulinski	**PB**	Consultant Clinical Oncologist	MTW / KOC
Henry Taylor	**HT**	Consultant Clinical Oncologist	MTW
Erika Wade	**EW**	Lead Uro-Oncology CNS	MTW
Amanda Clarke	**AC**	Consultant Clinical Oncologist	MTW
Jennifer Pang	**JP**	Clinical Oncologist	MTW
Jodie Hotine	**JH**	Lead Radiotherapy Research Radiographer	MTW
Albert Edwards	**AE**	Consultant Clinical Oncologist	MTW
Hide Yamamoto	**HY**	Consultant Urological Surgeon / CRG surgical lead	MTW
Bhavin Kawa	**BK**	Consultant Interventional Radiologist	MTW
Diletta Bianchini	**DB**	Consultant Medical Oncologist	MTW
Alison Richards	**AR**	Lead Uro-oncology Research Nurse	MTW
Debbie Webber	**DW**	Urology Research Practitioner	MTW
Kathryn Lees	**KL**	Consultant Clinical Oncologist	MTW
Amit Goel	**AG**	Consultant Histopathologist	MTW
Rohit Sasidharan	**RS**	Consultant Clinical Oncologist	MTW
Carys Thomas	**CT**	Consultant Clinical Oncologist	MTW
Verity Roberts	**VR**	Research Radiographer	MTW
Jeanette Smith	**JS**	Macmillan Metastatic Prostate Cancer CNS	MTW
Neethu James	**NJ**	Faster Diagnosis CNS	MTW
Pavnish K Rai	**PR**	Research Radiographer	MTW
Claudia Simon	**CS**	Uro-Oncology CNS	MTW
Brian Murphy	**BM**	**Patient Partner**	

Apologies			
Fay Fawke	**FF**	Deputy Lead Cancer Nurse	DVH
Marie Payne	**MP**	Macmillan Lead Cancer Nurse / Clinical Services Manager	DVH
Danielle Mackenzie	**DM**	Macmillan Lead Nurse for Personalised Care	EKHUFT
Ann Courtness	**AC**	Macmillan Primary Care Nurse Facilitator	KMCA
Emma Lloyd	**EL**	Cancer Pathways Improvement Project Manager	KMCA
Matin Sheriff	**MS**	Consultant Urological Surgeon	MFT
Alistair Henderson	**AH**	Consultant Urological Surgeon	MTW

Item		Discussion	Agreed	Action
1.	**TSSG Meeting**	**Apologies** • The formal apologies are listed above. **Introductions** • SM welcomed the members to today's meeting via MS Teams and the group introduced themselves. SM hoped the next meeting would be face to face which he would personally prefer. • If you attended the meeting and have not been captured within the attendance log above please contact **karen.glass3@nhs.net** directly. **Review Action log** • The action log was reviewed, updated and will be circulated to the members together with the final minutes from today's meeting. **Review previous minutes** • The minutes from the previous meeting which took place on Thursday 24th April 2025 were accepted as a true and accurate account of the meeting.		

2.	**Mainstreaming Genomic Testing in the Cancer Pathway: a framework.**	**<u>Mainstreaming in Cancer Genetics: building a framework - update provided by Vishakha Tripathi</u>** • SM welcomed VT to the meeting and introduced her as the Clinical Lead for Genomics at South East London Cancer Alliance and Consultant Genetic Counsellor at GSTT. SM emphasised the importance of genetic testing but is not currently available as it should be for K&M's patients. • VT shared their strategic approach and framework which enabled them to roll out mainstreaming to a couple of their high value pathways. • VT explained the UK Genomics Strategy document sets out four priority areas including: i) Embedding genomics across the NHS – from primary care and community care through to specialist and tertiary care ii) Delivering equitable genomic testing to improve outcomes in cancer, rare, inherited and common diseases iii) Genomics to be at the forefront of the data and digital revolution iv) Evolving the service through cutting-edge science, research and innovation • One of the key enablers of "mainstreaming" genomics was facilitated through a network of 7 Genomic Medicine Service Alliances (GMSA) and 7 Genomic Laboratory Hubs (GLA's). • The 10-year health plan for 2025 is now in place and Genomics features quite predominantly within this document. The focus is to move from genetic testing and diagnostics to prevention. • In 2022 /23 the team were tasked with developing a Urology mainstreaming pilot with their uro-oncology colleagues at GSTT and SELCA. The aim of the pilot was to have a process in place for all eligible prostate cancer patients to have point of care testing within uro-oncology and not be referred to genetics. VT outlined the finer details of the mainstreaming project and stated the importance of it being a multi-professional approach. • They relied on some digital interactive training methods including:		**Presentation circulated to the group on the 16th October 2025**

		i) https://nucleus.medics.academy/ - freely available and with a focus on upskilling cancer genomics knowledge ii) Regular meetings with urology teams iii) Risk assessment tool – Q Genome – https://qgenome.co.uk/ • The following pathway documents were developed: i) 2 x patient information leaflets for germline and somatic testing. ii) Clinician checklist iii) Quick guides • Separate patient and clinician surveys were created to assess their views of the mainstreaming genetic pathway within urology. They also used a tool called ASIGN-E designed to track progress. The overall feedback was wholly positive from both patients and clinicians. • VT acknowledged some of their achievements including: i) 8 x GSTT urology clinicians were upskilled - enabling patients to get point of care testing much earlier. ii) Train the trainer model - more urology specialists have now been trained. iii) Monthly Metastatic Prostate MDM takes place on a Tuesday morning and if anyone would like to join that meeting to email VT directly. • The current offer for clinicians to upskill and provide mainstreaming includes: i) Nucleus – the clinician would need to undertake 2 mainstreaming modules – suggested cancer biology and consent conservation ii) Clinicians to download and access Clinibee iii) Q Genome - there are pathway specific training plans in place for Lynch Syndrome, Colorectal and Endometrial. iv) A competency framework to compliment conversations in clinic v) Patient leaflet and clinical quick guide.		

		• SM thanked VT for the comprehensive overview of the service. VT confirmed the local Genomic Laboratory Hub for K&M was GSTT. SM asked if they could embed this service within K&M. VT explained they have a user-friendly package available which would require some resource from KMCA to get started. VT confirmed she would be able to support if it was for 1/2 clinicians but larger teams would require further resource. • HY stated the importance of implementing this pathway within urology but added it would need to be job planned across the 4 trusts. • VT explained the cost of the Nucleus licence is a tiered fee for all 5 modules at a cost of £80 for CNS trainee students and up to £120 for medical consultants. In terms of the Q Genome licence this is freely available to all within K&M as they come under the regional genetics' catchment area. • VT does not anticipate there being any more staff required than being used for the Lynch Project. • VT mentioned 20-30% of patients offered testing will be referred to clinical genetics. Only those patients with known pathogenic variants and variants of uncertain significance from germline reports would need to be referred to genetics. • VT suggested the next stage would be to approach KMCA as a joint venture with GSTT to discuss resource and funding allocations. • CS would be keen as part of the KMCA to work together with VT to develop this priority service for K&M. CS asked if the costs could be outlined - as the funding window for 25/26 has now closed. However, they have a real opportunity to develop a bid for submission in early 2026 to hopefully be agreed. It was agreed that key members from GSTT, SELCA attend one of the Urology CRG meetings to discuss the detail further. **Action – Chris and Sanjeev proposed inviting Vishakha T and colleagues to a future Urology CRG meeting to develop a funding bid for implementation in K&M. Diletta B to also be included in this discussion. Diletta to forward the details of a previous bid to both Chris S and Sanjeev M (which would need updating to reflect what is needed in 2026).**		**SM / DB**

3.	**Urology Specimens of limited / no clinical value**	**<u>Update provided by Sanjeev Madaan and Amit Goel</u>** • SM referred to the previous TSSG discussion regarding the major issues West Kent have had with histopathology reporting in the last year. In the mean-time they have been working to reduce the workload on histopathology in particular specimens of limited clinical value. • AG proposed at the last meeting some recommendations which have been discussed at the CRG meeting. SM asked if everyone is happy with the final list of recommendations they will implement these across K&M. **i) <u>Prostate TURP audit</u>:** • Known Prostate cancer patients, waiting for radiotherapy and prior to undergo a TURP - these samples do not need to be processed. This does not change the management of these patient and would reduce the burden on histopathology services. • KL explained it would be helpful to know the results but it is not critical. • HY mentioned if they are young patients, have metastatic disease and need genomic testing that may be classed as a special case. Having more tissue would be beneficial for genetics. • BM highlighted from a patient's perspective having the TURP hugely reassured him that he was clear at that time. SM reassured BM that his situation would not have been affected by these potential changes. • AG explained the genetic testing biopsies are the best test compared to a prostate TURP. For those rare cases where there is not sufficient biopsy material in a young patient a TURP would be useful but not necessarily for genetic testing. • SM referred to post-radiotherapy patients and if the TURP specimen shows cancer this would suggest recurrence which would be a different scenario. DA explained a patient with metastatic prostate cancer and providing additional tissue from the TURP procedure does not add anything.		**Details circulated prior to the meeting**

		TSSG AGREEMENT – A pre-radiotherapy TURP in a diagnosed prostate cancer patient for de-obstruction does not need to be re-tested unless there was not enough specimen. **ii) <u>Epididymal cysts audit</u>:** • SM mentioned he has not seen any positive cancer diagnosis within this cohort of patients. **TSSG AGREEMENT – To not send any Epididymal cysts for histopathology examination, unless clinically suspicious of malignancy.** **iii) <u>Foreskin audit</u>:** • In the extensive audit that AG carried out they did not find any cancer under the age of 20. If the foreskin does not show any signs of worrying pathology they do not need to send for further analysis. AG explained most of the time the samples received are due to chronic inflammation with younger patients. BXO (Balanitis Xerotica Obliterans) does not tend to change the management of these patient's long term. There is a risk of recurrence with urethral strictures but will be treated like any other patient with a circumcision. HY mentioned they are doing a local BXP audit to ensure they are not over sending tissue. **TSSG AGREEMENT – To not send any foreskin samples to histopathology for patients under the age of 18 years old unless they are clinically suspicious of cancer. The group agreed to consult the trusts Paediatric Urologists for final approval on the foreskin guideline.** **Action – Amit and Sanjeev decided to defer adding hydrocele sacs to this list until an audit was completed and the topic discussed in a future CRG meeting.**		**SM /AG**
4.	**Pathways / Variation in protocols across K&M** **Prostate**	**<u>Audit of IRADS 3 MRI lesions – does PSA density affect Gleason score and treatment? – update provided by Hide Yamamoto</u>** • HY would like agreement from the TSSG in terms of biopsy PIRADS 3 MRI lesions and what PSA density thresholds should be used.		**Presentations circulated to the group on the 16th October 2025**

	Bladder **Renal Pathway**	• The PIRADS score which has been revised a few times and determines the risk of having prostate cancer. i) PI-RADS 1 and PI-RADS 2 – very low risk of having prostate cancer and unlikely to need a biopsy ii) PI-RADS 4 and PI-RADS 5 – require a biopsy iii) PI-RADS 3 – there is some conflicting guidance within guidelines and whether they would require a biopsy or not. • HY noted at MTW the PI-RADS 3 lesions account for about a ¼ of their total MRI's carried out. Potentially, if they are able to reduce biopsy'ing all of these it would save some resources but how many cancers could be missed. • The PSA density is the ratio of the patient's PSA and gland volume of the prostate. The higher PSA density the more likely that cancer will be diagnosed. Essentially dividing the PSA value by the size of the gland. • HY referred to the EAU, AUA, NICE and GIRFT guidelines for MRI imaging in biopsy indication and strategy with particular reference to PI-RADS 3. • HY highlighted the benefits of not performing a biopsy: i) Avoid overdiagnosis and over treatment ii) Resource management – biopsy, clinics and treatment iii) Many may not need treatment • HY and some of his junior doctors conducted an audit from when they were biopsy'ing all PI-RADS 3 lesions. The aim was to find out the patient's diagnosis and the patient's subsequent treatment which included a 6-month follow up. • HY outlined the methods used and results of the audit of 201 patients identified by the radiologist as having a PI-RADS 3 lesion (aged 45-78). i) 197 patients had a prostate biopsy - ○ 21 TRUS (10.7%) – TRANSLATE Study		

		○ 176 TP biopsy (89.3%) - 7 under GA ii) Breakdown of pathological outcomes – 96 / 197 were benign. iii) Results showed - ○ 55/197 patients (27.9%) diagnosed with prostate cancer Grade Group >2 ○ 38/197 patients (19%) had radical treatment within 6-months of diagnosis ○ Treatments detailed • HY explained if they decide not to biopsy those patients with a PSA density < 0.15 61% of patients would not have a biopsy. If they set a lower PSA density threshold < 0.10 only 28% would not have a biopsy. • HY concluded: i) There is a clear trade-off between biopsy number and diagnosed cancer cases ii) GG3+ (most aggressive cancers) cases are less common in PI-RADS 3 (6%) iii) As a TSSG where do they feel they can safely draw the line to be able to ration resources? • SM confirmed at DVH they use a PSA density threshold of 0.12. • MT suggested following the GIRFT and NICE guidelines and patients should have a well-established follow up process in place. • BM stated most patients would be concerned if the threshold was raised, would they be followed up and not forgotten. BM added would GP's be able to do this? **TSSG AGREEMENT – The alliance agreed to adopt a PSA density threshold of 0.12 for PIRADS 3 lesions, with exceptions for patients with strong family history, Afro-Caribbean background, or concerning clinical features. The importance of robust follow-up protocols, particularly in primary care, was emphasised to ensure patients are not lost to follow-up.** **<u>Bladder Cancer Pathway – update by Omar Algurabi</u>**		

		• OA highlighted that bladder cancer is the tenth most common cancer in the UK and worldwide. There has been a 2% rise in the number of new cases diagnosed in the UK between 2019 – 2021. Bladder cancer is generally categorised into - non-muscle vs muscle invasive cancer. • A patient in the community with Haematuria is referred via the USC pathway. The STT nurse at MFT will triage all cases of visible and non-visible Haematuria. Flexible cystoscopy (Haematuria clinic) is a one-stop clinic carried out within 2-weeks of a community referral. If the result is normal the patient will be discharged. If there is a lesion in the bladder the patient will be booked for an urgent TURBT within 1-2 weeks and referred to the CNS at the same time. • All patients following a TURBT will be discussed in the pre-MDM on a Wednesday morning. Newly diagnosed bladder cancer cases are risk stratified into low – intermediate – high and very high risk according to EAU and NICE guidelines. All new cases will be discussed at the MDT on Friday morning. • Within one week of the MDM the patient will have an urgent clinic appointment and will be informed of the diagnosis together with a proposed plan. • MFT receives on average 2 referrals per week for radical cystectomy's from DVH, EKHUFT and MTW. • Issues were raised regarding incomplete transfer of histopathology reports, blood results, and MDT outcomes from EKHUFT to MFT, leading to delays in patient management. Suggestions included sending complete referral packs and improving administrative processes, with MT and DS agreeing to address these in their local governance meetings. **Action – Hide and Tahir suggested a future meeting discussion on the follow up procedure for both bladder and prostate cancers with improved patient tracking. Sanjeev agreed to discuss further at the CRG meeting prior to the next TSSG.** **<u>Variation in Renal Cancer / Upper urinary malignancy pathways protocols – update provided by Milan Thomas</u>**		**CRG / TSSG**

		• MT referred to the kidney pathway at EKHUFT and a recent surge in renal cancer cases. There has been improvement in their capacity with the recruitment of a WTE independent robotic renal surgeon. • Renal cancer referrals are picked up from a variety of pathways including: i) USC GP referrals – renal mass ii) Haematuria pathway iii) Interdepartmental incidental finding or current inpatient – colorectal / gynae iv) A&E presentation • MT and Morna Jones discuss whether specific patients are suitable for an MDT discussion and will divert to other pathways as required. Their MDT is a joint pelvic and upper tract MDT and they can discuss up to 100 cases per week. • Matt (Crockett) is currently leading on a trust wide Kidney Cancer improvement project which should show improvements once implemented. • MT highlighted the variation in services of East Kent compared to West Kent including: ○ **West Kent** - 3 diagnostic sites – with consultant led clinics (3 x radiology and cystoscopy capacity) - Local and Specialist MDT - Treatment Centre - MFT ○ **East Kent** - 1 diagnostic site + 1 treatment Centre - 2 renal surgeons, 1.5 renal CNS. Trainee SCP covering - Highly sub-specialised - Very little cross cover. • FG offered support from West Kent, and MT noted ongoing improvement projects aimed at optimizing the pathway. The group acknowledged the need for resource investment and closer collaboration to address rising demand and maintain performance.		

5.	**Renal cancer Biopsy Protocol**	• Bhavin Kawa sent his apologies as he was unable to join today's meeting. **Action – Bhavin to be invited to the next TSSG meeting to provide an update.**		
6.	**Can staging CT chest be omitted in patients diagnosed with stage pT1a RCC**	**<u>Audit presentation: Can staging chest CT's be omitted in patients diagnosed with stage T1a Renal Cell Carcinoma (RCC) – update provided by Toby Richardson-Jones</u>** • TRJ presented an audit supervised by MC, on the necessity of CT chest staging in T1a renal cell carcinoma. • The objectives of the audit: i) Evaluate local practice for staging chest CT in patients with stage T1aRCC ii) Determine the rate of RCC-related thoracis metastasis in this cohort iii) Assess the clinical utility of chest CT's performed • They identified 170 patients diagnosed with T1aRCC – inclusion period 01/02/2024 – 31/03/2025. • During this period, they performed 68% CT staging chest and within that cohort 22 patients had notable lung findings (19 benign and 3 malignant – due to pre-existing known lung cancers). • TRJ referred to some recently published literature regarding a retrospective review of data collected from the same cohort of patients from the Royal Free hospital. This covered a 2-year period with a cohort of 383 patients. They performed a CT chest for 69% of patients and 14% had notable lung findings (0 had metastatic disease and 3 cases of synchronous primary lung cancer). The cost of a CT is £147 and this varies across sites. • In conclusion: i) No CT chest scans identified RCC related metastases ii) All malignant thoracic findings were known other primary sites iii) Supports EAU guideline suggestion that chest CT may be safely omitted in		**Presentation circulated to the group on the 16th October 2025**

		incidentally diagnosed cT1aRCC. • SM stated from a patient's overall management he would recommend continuing with a CT chest in that setting. • AC highlighted that potentially finding the incidental lung cancers early would have a significant cost benefit and quality of life should not be discounted. • SM thanked TRJ for the presentation but from an Alliance position they will not be changing their diagnostic work up at this stage.		
7.	**Trust-level urology cancer pathway performance across K&M**	**<u>Trust-level urology cancer pathway performance – update provided by Hide Yamamoto</u>** • HY provided an update on the urology data dashboard which is divided into two groups – prostate pathway performance and non-prostate pathway performance (including bladder, kidney, testes). **<u>Prostate cancer diagnosis</u>** • HY highlighted the significant variation in monthly referrals per trust: i) **DGT** – 28 in Sept 2024 compared to 78 in Dec 2024 ii) **EKHUFT** – 134 in Aug 2024 compared to 246 in March 2025 iii) **MTW** – 154 in Jan 2025 compared to 86 in April 2025 iv) **MFT** – 70 in Jan 2025 compared to 115 in April 2025 • **FDS performance** – from April 2023 – August 2025. There appears to be a coding issue for MFT. TB stated both MFT and DVH had an issue with pathology turnaround times at this time. He is keen to understand why this was not the case for MTW. AG explained there is no bias as to which samples are processed first and is based on those samples that come through first plus there are no transport delays for MTW. SM stated they were waiting 4-weeks for pathology results to come back at DVH which made it impossible for them to meet the FDS performance target. The new processes put into place within pathology has		**Presentation circulated to the group on the 16th October 2025**

		now improved this issue. • **62-day performance** – from diagnosis to first cancer treatment - there is some variation across the trusts. SM explained from DVH's perspective there was a major issue with pathology, plus CNS staffing issues and clinic capacity issues. They have also lost a consultant who has not been replaced. • **Straight to test (first attendance at a telephone nurse-led clinic)** – this is being recorded at MTW and EKHUFT but there seems to be a coding issue at DVH and MFT. DVH and MFT agree to look into this further – they both have STT triage nurses in place. • **Waiting time from referral to telephone triage consultation** – this is very good and are recording the patients on day 1. • **Waiting time from referral to MRI prostate** – varies from 7 – 12 days across trusts. The aim is to get the MRI completed within the first week of referral. • **Waiting time from referral to FDS: cancer ruled out** – multiple step process involved – variation of 9/10 days across trusts. • **Waiting time from referral to LATP biopsy** – SM is concerned that the STT team from DVH are not attending this TSSG meeting and the data performance for this target is not acceptable. MMC confirmed there are ongoing discussions to provide additional surgical capacity. HY confirmed there is regional support for DVH if they would like it. HY referred to an LATP course running in November if anyone is interested in attending. • **Waiting time from referral to FDS: cancer diagnosed** – SM suggested there are some coding issues at DVH as their numbers are much higher. Agreed clinic availability is also an issue. **<u>Non-prostate pathway performance and referrals</u>** • **Urological cancer diagnoses excluding prostate per quarter** – MT confirmed the big spike in referrals at EKHUFT in September 2024 was due to renal referrals. The other trusts appeared to have stable referral patterns since 2019.		

		• **Referrals seen on urology pathway excluding prostate** – generally stable. • **FDS performance** – they seem to be doing well as a region. EKHUFT have made big improvements since 2024. • **62-day performance** – all doing well and above the national target. • **Waiting time from referral to telephone triage consultation** – time to triage is adequate and quite quick. DVH and MFT to check their recording. • **Waiting time from referral to CT (bladder cancer only)** – earlier the better for these patients. • **Waiting time from referral to cystoscopy** – variation across the trusts but largely OK. • **Waiting time from referral to TURBT** – data missing from DVH and MFT – HY asked if the coding team could look into this. • SM acknowledged the significant improvement at EKHUFT over the last year which is really commendable. However, DVH has gone down but they will look into this.		
8.	**Audit – West Kent Prostate cancer management in patients diagnosed over 75 and presenting with high risk or metastatic disease NPCA 2025**	**<u>Update provided by Kathryn Lees</u>** • KL provided an update on the National Cancer Prostate Audit for 2025 – for patients diagnosed from 1st September 2021 – 31st August 2022. The audit looked at outcomes and treatment decision making. Their outcomes both surgically and radiotherapy wise are pretty good which is reassuring. • KL referred to the NCPA data audit priorities and changes made from 2023 – 2025. • KL outlined MFT's data for 2025 – NCPA: i) 7% of patients were diagnosed with metastatic disease ii) 67% high risk patients were given radical treatments		**Presentation circulated to the group on the 16th October 2025**

		iii) Metastatic patients – under 75 – 58% were given systemic additional treatment and 13% over 75. • KL highlighted the data capture for T staging is still quite poor across the trusts. • KL provided an update on the audit of MTW practice from January – June 2022 of 225 patients. i) 54 patients were > 75 years old – treatment decisions outlined ii) 22 patients had locally advanced disease – 91& were seen in oncology iii) 17 patients – metastatic disease – varying ages mostly in their 70's. iv) Systemic treatment escalation by age – 10 < 75 and 7 < 75 • KL explained their levels of metastatic disease is quite low at 7%. This may be due to their patient selection and diagnosing earlier. Systemic treatment escalation for metastatic patients is low at 29% for those that accept it but has been offered to 47% similar to the national rates. There maybe a way as oncologists they can persuade older patients to accept the treatment. • HY confirmed they always discuss the high-risk patients in their MDT and offer treatment to those that need it. He wondered if there was a data issue. • PB thanked KL and agreed it is good to compare the national and local data. He feels they are doing the right thing locally for their patients. PN asked how many of their patients over the age of 75 have a G8 assessment score recommended by EAU guidelines. PB and KL wondered if the InfoFlex data was not being recorded in the correct fields and therefore not being captured accurately. • DB expressed her concern in terms of MFT and EKHUFT being the outliers for treatment escalation for metastatic prostate cancer patients over the age of 75. DB suggested looking more closely at the data for this cohort of patients. • SM did not feel they were ignoring the high-risk / elderly patients in MDM going onto oncology but agreed they should re-look at the figures.		

9.	**Research update**	**<u>Update provided by Diletta Bianchini</u>** • DB thanked the Research Nurses for their hard work and would like to raise awareness of the trials which are open, available for patients and cross-refer across sites. **<u>Clinical Radiotherapy Trials at MTW – update by Jodie Hotine and Patryk Brulinski</u>** ○ **Radiotherapy - Open Trials**– PEARLS and STAMPEDE 2 – 2/6 trials are for Urology ○ **Set-up** – OASIS and STAR-TRAP • PB explained the radiotherapy research trials are working well despite limited radiographer capacity. The clinical trials offered for surgical / oncology and radiotherapy will be one of the measures to provide a better quality of care for their patients. • KL raised the issue of inequality of research trials available across the patch. KL explained they are forced to register for radiotherapy trials as a trust. KL asked if it would be possible to register for trials as the Kent Oncology Centre so sites could recruit patients to the same trials. The aim would be for the radiotherapy research team to be better supported and then able to cover both sites. DB agreed this is a valid point which has been raised previously in other tumour sites. DB believes there has been work done to centralise research for breast cancer patients at MTW. JH explained they have spoken to Hazel Everest previously and the issue lies within the governance of the hospital and so has been an ongoing issue. SM suggested they looked into this further. **<u>Clinical Trials at MTW – update provided by Alison Richards</u>** • AR highlighted the other clinical trials which are currently open at MTW include: ○ **Open** - Transform ○ **Set up** - Mevpro-3 and Wiser P **<u>Clinical trials at DVH – update provided by Sanjeev Madaan</u>**		**Trust updates circulated to the group on the 16th October 2025**

		• SM stated the situation with the research team at DVH is really bad and they do not have the capacity to start any new trials. He added this may be a similar issue for other units.
		
		• Trials currently open include:
		
		  ○ TAPSO-2
		  ○ Orion BC bladder cancer trial
		  ○ ATLAS
		  ○ ELIPSE
		  ○ IP7-PACIFIC
		  ○ EASE trial – renal cancer patients on surveillance. SM open to other trusts if anyone has an eligible patient
		  ○ COBRA – hope to start this trial if the research team agree
		
		<u>Clinical Trials at EKHUFT – update provided by Milan Thomas</u>
		
		• There are very limited trials currently open which includes:
		
		  ○ PARTIAL – surgical trial
		  ○ PART – now stopped
		
		<u>Clinical Trials at MFT – update provided by Clarissa Madla</u>
		
		• Trials open to recruitment include:
		
		  ○ PARADIGM
		  ○ IP7-PACIFIC – in set up
		  ○ BC-RECON
		  ○ ELIPSE
		  ○ MICROBIOME MOLECULAR CHARCTERISATION
		  ○ COBRA
		  ○ TRANSFORM
		  ○ STAMPEDE-2		

10.	**CNS update including Intra vesical BCG Service provision across K&M**	**<u>Intra vesical BCG service provision across K&M – update provided by Erika Wade</u>** • SM explained patients who have a high-risk non-muscle invasive bladder cancer they give inter-cycle BCG and those with intermediate risk have inter-cycle mitomycin. SM asked if this should be carried out by the CNS or Urology Nurse Specialist. i) DVH – Urology Nurse Specialist ii) MTW – Specialist Nurse iii) MFT – Urology Nurse Specialist iv) EKHUFT – no clarification provided • SM concluded there is no hard and fast rule that this procedure should be carried out by a CNS. **<u>CNS update from MTW – provided by Erika Wade</u>** • Erika – new band 8 CNS lead – supporting the team with the aim to improve their service. EW will be focusing on the metastatic kidney patients who have not had a key worker / CNS in post. • New prostate CNS due to start next week – will then have 2 in post. • 2 x bladder CNS in post • Renal CNS – part time • Metastatic prostate CNS – part time – covers both sites • On hold for a further post. • The CNS's do cover each other for AL and sickness. **<u>CNS update from DVH – provided by Sanjeev Madaan</u>** • Metastatic CNS • STT / Diagnostic CNS • 2 x CNS – cover prostate, bladder and kidney – cover everything **<u>CNS update from MFT – provided by Tahir Bhat</u>**		

		• 3 x CNS • 2 x STT nurses • 2 x benign nurses • They cover bladder, prostate and kidney but also cross-cover each other when required. **No CNS update from EKHUFT**		
11.	**AOB**	• PC asked about DVH patients who have been operated on at MFT and what the follow up process should be. • SM has previously spoken to both TB and FG. Any patient who has had surgery at MFT, not by the original consultant then their initial follow up should be at MFT and then referred back to their local team. TB thought that process was already in place. TB asked PC to email him the details of the patients this concerns and he will look into it. • PB mentioned there have been questions asked about the Primary Kidney SABR at the specialist MDT. PB stated this is in development but not currently available. PB would be happy to provide an update at the next TSSG meeting. **Action – Patryk to provide an update on the Primary Kidney SABR for the next TSSG meeting. JJ to take note for the next agenda.** • PB asked for high risk prostate cancer a PET CT scan is carried out from the thighs to the head as metastatic disease is rarely seen below the knees. They do not need to extend the scan. DB raised her concerns regarding using the PSMA PET scan as primary staging. It was agreed they should be doing a CT, bone scan and PET scan. **Action – Sanjeev suggested having a session on PSMA PET at the next TSSG meeting / update at a CRG meeting. Diletta to be invited to the specific CRG meeting.** **Action - Bhavin Kawa to be invited to a CRG meeting to have a preliminary discussion and if appropriate to present on renal biopsies at the next TSSG meeting as he was unable to join today's meeting.**		**PB / JJ** **DB / SM / JJ** **BK / SM / JJ**

		Cancer-related Fatigue Management film animation – update provided by CM post meeting The video, created by a dedicated team of clinical nurse specialists, cancer support workers and allied health professionals, offers practical advice and emotional support to help patients and their families better understand and manage one of cancer's most common and disruptive side effects. It can also be a valuable resource for professionals working with cancer patients. You can watch the video on the Kent and Medway Cancer Alliance website – www.kentandmedwaycanceralliance.nhs.uk/cancer-related-fatigue Listen to Dr Jonathan Bryant, GP and Kent and Medway Cancer Alliance Clinical Lead talk about the film, in an interview with Sophie Sutton, on BBC Radion Kent Make a Difference - Radio Kent - Listen Live - BBC Sounds (around 1:42). **Limbo land - patient experiences of uncertainty and cancer** A series of films of capturing personal cancer experiences, including professional perspectives on roles and support available limbo land - personal cancer experiences | Cancer Alliance		
15.	**Next Meeting Date**	• **Tuesday 28th April 2026 – 09:00 – 12:30 – PLEASE HOLD THIS DATE IN YOUR DIARY** • **Thursday 8th October 2026 – 09:00 – 12:30 – PLEASE HOLD THIS DATE IN YOUR DIARY**		**KG to circulate meeting invites shortly**