

Urology Tumour Site Specific Group meeting
Tuesday 28th April 2026
Maidstone Academic Centre
09:00 – 11:45
Final Meeting Minutes

Present	Initials	Title	Organisation
Sanjeev Madaan (Chair)	SM	Consultant Urological Surgeon	DVH
Jayasimha Abbaraju	JA	Consultant Urological Surgeon	DVH
Nicola Lancaster	NC	Macmillan Metastatic Oncology CNS	DVH
Mark Yao	MY	Consultant Urologist	DVH
Mohamed Ibrahim	MI	Urology ST3 Registrar	DVH
Alan Cossons	AC	Clinical Nurse Specialist	DVH
Emma Chamberlain	EC	Uro-Oncology Clinical Nurse Specialist	EKHUFT
Matt Crockett	MC	Consultant Urologist and Robotic Surgeon	EKHUFT
Thiwanka Karawita	TK	Consultant Histopathologist	EKHUFT
June Tay	JT	Consultant Urologist	EKHUFT
Jo Jackson	JJ	ED Project Manager	KMCA
Karen Glass (Minutes)	KG	PA / Business Support Manager	KMCA & KMCC
Colin Chamberlain	CC	Administration & Support Officer	KMCC
Sam Williams	SW	Administration & Support Officer	KMCC
Tahir Bhat	TB	Consultant Urologist	MFT
Michael Conroy	MC	ST8	MFT
Omar Algurabi	OA	Specialty Doctor	MFT
Clarissa Madla	CM	Clinical Research Delivery Manager	MFT
Muhammad Farooq	MF	Macmillan Urology CNS	MFT
Patryk Brulinski	PB	Consultant Clinical Oncologist	MTW / KOC
Mohamed Metawe	MM	Specialty Doctor	MTW
Erika Wade	EW	Lead Uro-Oncology CNS	MTW
Mark Cynk	MC	Consultant Urologist	MTW
Albert Edwards	AE	Consultant Clinical Oncologist	MTW
Hide Yamamoto	HY	Consultant Urological Surgeon / CRG surgical lead	MTW

Diletta Bianchini	DB	Consultant Medical Oncologist	MTW
Kathryn Lees	KL	Consultant Clinical Oncologist	MTW
Amit Goel	AG	Consultant Histopathologist	MTW
Alistair Henderson	AH	Consultant Urological Surgeon	MTW
Jeanette Smith	JS	Macmillan Metastatic Prostate Cancer CNS	MTW
Natalie Smith	NS	Urology CNS	MTW
Brian Murphy	BM	Patient Partner	
Apologies			
Desmond Owusu	DO	Consultant Radiologist	DVH
Suraj Menon	SM	Consultant Radiologist	DVH
Morna Jones	MJ	Urology Nurse Consultant, MSc – now retired	EKHUFT
Tracey Squire	TS	Macmillan User Involvement Manager	KMCA
Chris Singleton	CS	Senior Programme Manager	KMCA
Claire Blackman	CB	Macmillan urology cancer nurse lead	MFT

Item		Discussion	Agreed	Action
1.	TSSG Meeting	<p><u>Apologies</u></p> <ul style="list-style-type: none"> The formal apologies are listed above. <p><u>Introductions</u></p> <ul style="list-style-type: none"> SM welcomed the members to today's face to face meeting and the group introduced themselves. If you attended the meeting and have not been captured within the attendance log above please contact karen.glass3@nhs.net directly. <p><u>Review Action log</u></p> <ul style="list-style-type: none"> The action log was reviewed, updated and will be circulated to the members together with the final minutes from today's meeting. 		

		<p><u>Review previous minutes</u></p> <ul style="list-style-type: none"> The minutes from the previous meeting which took place on Thursday 14th October 2025 were accepted and signed off as a true and accurate account of the meeting. 		
<p>2.</p>	<p>CRG update</p>	<p><u>Update provided by Sanjeev Madaan</u></p> <ul style="list-style-type: none"> SM provided an update of the current Clinical Reference Group members which includes: <ul style="list-style-type: none"> Sanjeev Madaan – Chair - DVH Amit Goel – Histopathology - MTW Desmond Owusu – Radiologist - DVH Faisal Ghumman – Surgeon - MFT Hide Yamamoto – Surgeon - MTW Milan Thomas – Surgeon - EKHUFT Morna Jones – Nurse Consultant – EKHUFT - recently retired Chris Singleton – Programme Manager - KMCA Jo Jackson – Programme Support - KMCA Jonathan Bryant – Primary Care SM explained the CRG team were previously meeting on a monthly basis but this has now changed to bi-monthly. A summary of items discussed since November 2025 to date include: <ol style="list-style-type: none"> PSA Remote Monitoring in East Kent New Renal Cancer Pathway in East Kent Renal Biopsy Practice and standardization across trusts Mainstreaming Genetic Testing discussion with South East London Cancer Alliance (SELCA) – agreement to put together a business case to support the implementation across K&M with the aim to upskilling local teams, enabling direct referral to the genetic hub for testing, to receive and act on the results. 		<p>Presentation slides were circulated to the group on the 29th April 2026</p>

		<p>v) PSA Remote Monitoring Implementation and Early Experience at East Kent</p> <p>vi) MTW Early Diagnostic Prostate Pathway overview.</p>		
3.	Dashboard	<p><u>Update provided by Sanjeev Madaan</u></p> <ul style="list-style-type: none"> • 28-day FDS performance is 69.3% and K&M are in 6th position nationally. MTW have been doing well for some time and are consistently in the top quartile at 86.2%, with MFT - 77.7%, DGT – 72.7% and EKHUFT – 54.9%. • 62-day performance has improved in the last 6-months from 72.8% to 76.7% and K&M are in 3rd position nationally. MTW are again consistently in the top quartile at 92.9%, MFT – 85.8%, DGT – 70.7% and EKHUFT – 62.3%. • SM encouraged the group to sign up to the Live dashboard – see details below. • MC mentioned the Urology MDT at EKHUFT regularly discuss a large number of patients 70 – 75 each week. They have taken steps to improve the pre-screening numbers discussed in order to take 5-10 patients off of the MDT list. • JT stated GP’s are referring patients into Secondary Care with a PSA > 3 ng/mL. • EKHUFT have recently recruited their 11th Consultant (benign) of which 4/5 are Cancer Consultants. • SM navigated through the data pack slides highlighting the investigative and treatment indicator targets within the Prostate pathway and the other Urological pathways. • K&M are significantly lower than England (2018 – 2023) for 1-year survival for prostate cancer but similar to England for 5-year survival. SM is keen to look into this data more closely. • K&M is significantly higher than England (2018 – 2023) for 1-year survival from bladder cancer and also higher than England for 5-year survival. 		<p>Presentation slides were circulated to the group on the 29th April 2026</p>

		<ul style="list-style-type: none"> • K&M is similar to the England average for kidney cancer survival (2018 – 2023). <p><u>How to sign up to the Cancer Pathways and Cancer in Primary Care Dashboards</u></p> <ul style="list-style-type: none"> • Register for access to Kent and Medway ICB Power BI reports by completing the form at https://forms.office.com/r/svyPSvktHw. • Email David.Osborne11@nhs.net to inform him that you have completed the form for access to the dashboard. It can take up to a week for the ICB to grant access. • Once access has been granted, you can access the dashboard at https://app.powerbi.com/home?ctid=4cfbd3c4-a42e-48a1-b841-31ff989d016e. Click on the KM ICB Main app and you will see Cancer in Primary Care and Cancer Pathways listed on the left-hand menu. 		
<p>4.</p>	<p>Alliance cancer pathways:</p> <p>i) Bladder Cancer</p> <p>ii) Prostate Cancer</p>	<p><u>Bladder Cancer Pathway – update provided by Omar Algurabi</u></p> <ul style="list-style-type: none"> • OA confirmed that bladder cancer is the 10th most common cancer in the UK and worldwide. There has been a 2% increase in the UK in new cases diagnosed between 2019 – 2021. Bladder cancer can generally be categorised into non-muscle vs muscle invasive cancer. • GIRFT have issued guidance for bladder cancer but it is not as detailed as the guidance for prostate cancer - https://gettingitrightfirsttime.co.uk/wp-content/uploads/2021/12/Urology_2021-12-10_Guidance_Bladder-cancer.pdf • OA outlined the Haematuria pathway for patients at MFT. In the community patients are referred as an USC referral and the STT nurse triages all cases. • Visible Haematuria and Non-Visible Haematuria with risk factors will be booked for a CT Urography (CTU) before the flexible cystoscopy appointment which is carried out within 2-weeks of the community referral. 		<p>Presentation slides were circulated to the group on the 29th April 2026</p>

		<ul style="list-style-type: none"> • Non-visible Haematuria without risk factors will be booked for an Ultrasound of the urinary tract. • OA explained the Flexible Cystoscopy is performed and CTU / US is checked. If there is no abnormality the patient is discharged. However, if there is a lesion in the bladder the patient is booked for an urgent TURBT and referral to the CNS's – whereby appropriate patient leaflet guidance is provided. • All patients following a TURBT will be discussed in the pre-MDM on a Weds morning. Newly diagnosed bladder cancer cases will be stratified as low – intermediate – high – very high risk according to NICE and EAU guidelines. All new cases will be discussed at the MDT on a Friday morning. • Following the MDT an urgent clinic appointment will be sent out. The appointment will usually take place within a week and patients will be informed of their diagnosis and proposed plan moving forwards. For non-muscle invasive bladder cancer – second look TURBT for certain cases - booked within 6-weeks or routine follow up or intravesical therapy according to risk. • For muscle invasive or very high-risk patients – staging, CPEX. Reassess and either – neoadjuvant then cystectomy or primary cystectomy, radiotherapy or palliative. • MFT receives referrals for radical cystectomy from DVH, EKHUFT and MTW and on average 2 cases per week are carried out. • SM mentioned the coding at DVH has now been rectified and their finance figures have improved. There is no specialised commissioning in place for bladder cancer patients. SM concluded there needs to be local CA protocols in place for their bladder cancer patients. <p><u>Prostate Cancer Pathway – update provided by Hide Yamamoto</u></p> <ul style="list-style-type: none"> • HY referred to the 4 different Prostate Cancer Guidelines which are in place: <ul style="list-style-type: none"> i) EAU – most extensive guidelines and updated yearly 		
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		<ul style="list-style-type: none"> • There was a discussion regarding the inconsistencies in their treatment of the CPG3 criteria and it would be good to standardize this across the TSSG. • The group discussed the monitoring of patients – Active Surveillance and after radical treatment. K&M do a PSA test and assessment at 6-weeks after radical treatment. They felt it would be more reliable to do this after 3-months. MTW monitor their patients for 5-years. Patients at DVH go onto a Supported self-management (SSM) pathway after 3-months. • Postal point of care (POC) tests can be used to reduce attendance at community or GP sites – however these are currently only being done privately. • In conclusion: <ul style="list-style-type: none"> i) Prostate cancer guideline to align with GIRFT ii) Triage to either MRI first or clinic. Use PSA density (0.12 or 0.15) for decision on biopsy if no target on MRI. iii) Biopsy – make a good biopsy plan, target +/- sector biopsy. iv) Negative biopsy – discuss in MDT if PIRADS 4/5. v) Use CPG during MDT discussion (stratifies for mortality) vi) CT/BS vs PSMA for staging. vii) After radical treatment – consider discharge after 2 years if stable viii) Active surveillance – STRATCANS will allow reduced hospital appointments <p>Action – The TSSG have agreed to follow the GIRFT guidelines but with some modifications which will be discussed further at the next CRG meeting. An update will be provided at the next TSSG meeting in October.</p>		<p>HY / CRG</p>
<p>5.</p>	<p>Format of MDT Outcomes</p>	<p><u>Update provided by Diletta Bianchini</u></p> <ul style="list-style-type: none"> • DB explained that MDT’s have improved massively since they have had streamlining in place but wondered if there is still more they could do. • HY asked how MDT outcomes vary across the trusts? 		

		<ul style="list-style-type: none"> • MFT and MTW – have an MDT Co-ordinator in place who captures the outcomes and creates a list at the end of the MDT. • It was agreed they need to improve patient outcomes. The outcome can sometimes be confusing with no logic, including copy/pasted reports and no co-morbidity. • DB highlighted there needs to be a proper referral form and strict referral process in place which lists medication that the patient is taking, including co-morbidity. The MDT discussions are good but are limited to 5-mins for complex patients. They need to be more specific with an accurate outcome plan in order to improve the patient’s outcome. • The group agreed it is challenging for MDT co-ordinators who are not clinically trained and suggested the use of AI tools could be an option. • JT stated it should not be the responsibility of the MDT Co-ordinator but the clinician to dictate the detail discussed – providing detailed patient outcomes / clinical status. • MFT have a dedicated Consultant who sits with their MDT co-ordinator to ensure accuracy and also takes notes. This has helped with their training. • MC referred to the National Kidney data-set which is recorded on Inflex needs to be improvement. 		
6.	PMSA audit	<p><u>Update provided by Mohamed Ibrahim</u></p> <ul style="list-style-type: none"> • MI outlined the aim of the PMSA audit which was published in February 2025. To assess compliance with the NHS England commissioning policy (Policy 2307) for using PSMA PET-CT in adults with high-risk primary or recurrent prostate cancer. • Implementation – Inclusion Criteria for patients aged 18 years or over who are eligible for PSMA PET-CT scanning if they meet either of the following clinical indications: 		<p>Presentation slides were circulated to the group on the 29th April 2026</p>

		<p>i) Staging in high-risk primary prostate cancer ii) Detection of biochemical recurrence localisation</p> <p>Or</p> <ul style="list-style-type: none"> • Exclusion criteria – patients who are unable to undergo radical or salvage treatment due to <ul style="list-style-type: none"> i) Existing comorbidities preventing them from having further salvage therapy options ii) Patient choice. • In terms of the audit this included all prostate cancer patients who had PSMA scans done at DVH in a 12-month period in 2025. • There were 148 cases and these were sub-divided into 3 main groups of patients: <ul style="list-style-type: none"> i) Group I – initial diagnosis patients – 83 ii) Group II – post RALP – 45 iii) Group III – Post Radiotherapy – 20 <p>Key group findings:</p> <p>Group I – primary diagnosis</p> <ul style="list-style-type: none"> • 22 PSMA-positive scans (two were non-indicated). • Reasons for non-indicated scans included: lower Gleason scores, incidental findings on CT/bone scan, a lack of MRI (metallic fragments) and incomplete MDT documentation. <p>Group II – post-RALP</p> <ul style="list-style-type: none"> • All PSMA-positive scans were indicated. • No positive PSMA scans when PSA <0.2 ng/mL. • Detection rate increased with higher PSA: 33% at PSA 0.2–0.3, 71% at PSA 0.3–0.5 and 80% at PSA >0.5. <p>Group III – post-radiotherapy</p>		
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		<ul style="list-style-type: none"> • 15 PSMA-positive scans (two non-indicated). • Non-indicated reasons included rising PSA without adequate clinical history or equivocal imaging. <p>Repeat scanning reality</p> <ul style="list-style-type: none"> • 183 PSMA scans performed for 148 patients. • 19 patients had two scans, eight patients had three scans. • 147 scans were indicated, 36 were non-indicated. <p>Evidence base</p> <ul style="list-style-type: none"> • proPSMA Trial (2020): PSMA PET more accurate than conventional imaging (+27%). • OSPREY Trial (2021): Validated use in initial staging and recurrence. • PRIMARY / PRIMARY-2 Trials (2021–2026): PSMA superior to MRI in equivocal cases. <p>In conclusion:</p> <ul style="list-style-type: none"> i) PSMA has specific indications guided by NHS England ii) MDT discussions are important when to request PSMA if no typical indication iii) Equivocal conventional scans (CT chest and NM Bone scan) findings should be investigated further with PSMA (NICE guidelines). 		
7.	Primary Kidney SABR	<p><u>Primary Kidney SABR at KOC – update provided by Patryk Brulinski</u></p> <ul style="list-style-type: none"> • PB highlighted that new NICE guidelines were published in March 2026. • SABR is a very effective radiotherapy treatment technique, where a high dose of radiation is given to the tumour and the dose to surrounding areas is reduced. It is a precise treatment which uses a higher dose of radiotherapy per treatment compared to standard radiotherapy. This means that the treatment can be completed in fewer visits to hospital. • PB explained when deciding the management options suitable for suspected or confirmed 		<p>Presentation slides were circulated to the group on the 29th April 2026</p>

		<p>localized RCC and Bosniak 3 and 4 cysts they should consider:</p> <ul style="list-style-type: none"> i) Surgery being the preferred option for solid renal masses ii) SABR is not suitable for renal lesions larger than 7cm iii) SABR should not be used without prior biopsy confirmation of malignancy before treatment iv) Thermal ablation and SABR may have a higher risk of local recurrence <ul style="list-style-type: none"> • PB referred to the FASTRACK II multi-centre phase 2 clinical trial which investigated the efficacy of SABR for primary renal cell cancer and the clinical outcomes. Patients had good performance status but some were not suitable for surgery. The trial was generally well tolerated apart from some bowel issues. • Clinically the SABR team can deliver the service for the projected 12 new patients per year but would need the following to be in place: <ul style="list-style-type: none"> i) SABR MDT Operational with relevant expertise ii) Staff required – CCOs, Physics, Radiographers iii) Primary RCC SABR Protocol, Consent, PIS – in development • PB outlined the potential barriers: <ul style="list-style-type: none"> i) New service and new group of patients for Oncology ii) Number of predicted new patient referrals unknown – approximately 12 / per year iii) SABR MDT at capacity iv) No service provision has been granted by MTW Management v) RT delivery already stretched – limited capacity to absorb new referrals vi) Increased workload not recognized or appreciated in job planning vii) Concern regarding safety and quality • The TSSG collectively agreed to not go ahead with this treatment delivery at this time. 		
<p>8.</p>	<p>Renal pathway at</p>	<ul style="list-style-type: none"> • This agenda item was not discussed due to time constraints. 		

	EKHUFT			
9.	PSA remote monitoring implementation and early experience at EKHUFT	<ul style="list-style-type: none"> This agenda item was not discussed due to time constraints. 		
10.	Research update	<ul style="list-style-type: none"> This agenda item was not discussed due to time constraints. 		
11.	CNS update	<ul style="list-style-type: none"> This agenda item was not discussed due to time constraints. 		
11.	AOB	<ul style="list-style-type: none"> SM thanked the group for their attendance and interactive discussions. He apologised for not completing the whole agenda and these items would be picked up at the next meeting. SM explained the meeting had been shortened to accommodate an urgent Urology Consultants meeting which is taking place straight after today's TSSG meeting. 		
15.	Next Meeting Date	<ul style="list-style-type: none"> Thursday 8th October 2026 – 09:00 – 12:30 – diary invite has been circulated / Venue TBC 		KG to update once confirmed