NHS

Kent and Medway Cancer Collaborative

Urology Tumour Site Specific Group
Thursday 15th October 2020
MS Teams
13:30 – 16:30

Final Meeting Notes

Present	Initials	Title	Organisation
Jack Jacobs	**JJ**	Macmillan GP	Ashford and Canterbury CCG
Sanjeev Madaan **(Chair)**	**SM**	Consultant Urological Surgeon	DVH
Fay Fawke	**FF**	Head Uro-Oncology CNS	DVH
Alan Cossons	**AC**	Uro-Oncology CNS	DVH
Jade Pilcher	**JP**	Urology Cancer Pathway Navigator	EKHUFT
Thomas Cowin	**TC**	Deputy GM for Urology and Vascular	EKHUFT
Albert Edwards	**AE**	Consultant Clinical Oncologist	EKHUFT
Bana Haddad	**BHa**	Clinical Lead – Living With & Beyond Cancer	KMCA
Claire Mallett	**CM**	Programme Lead – Living With & Beyond Cancer	KMCA
Karen Glass **(Minutes)**	**KG**	Administration & Support Officer	KMCC & KMCA
Annette Wiltshire	**AW**	Service Improvement Facilitator	KMCC
Colin Chamberlain **(IT)**	**CC**	Admin Support	KMCC
Tracey Ryan	**TR**	Macmillan User Involvement Manager	KMCC
Tahir Bhat	**TB**	Consultant Urologist	MFT
Sue Green	**SG**	Macmillan Recovery Package Facilitator	MFT
Corinne Borley	**CB**	Clinical Research Practitioner for Urology	MFT
Howard Marsh	**HM**	Consultant Urologist	MFT
Hide Yamamoto	**HY**	Consultant Urologist	MTW
Heather Pagden	**HP**	Uro-Oncology CNS	MTW
Sarah Aylett	**SA**	Uro-Oncology CNS	MTW
Kathryn Lees	**KL**	Consultant Oncologist	MTW
Amanda Clarke	**ACl**	Consultant Clinical Oncologist	MTW / DVH
Patryk Brulinski	**PB**	Consultant Clinical Oncologist	MTW
Diletta Bianchini	**DB**	Medical Oncologist	MTW / MFT
John Donohue	**JD**	Consultant Urological Surgeon	MTW
Graham Russell	**GR**	Consultant Histopathologist	MTW

Brian Murphy	BM	Patient Representative	
Apologies			
Sona Gupta	**SG**	Macmillan GP	Canterbury CCG
Corrine Stewart	**CS**	Assistant Director of Commissioning	DGS CCG
Iain Morrison	**IM**	Consultant Radiologist	EKHUFT
David Stafford	**DS**	Urology Oncology CNS	EKHUFT
Ed Streeter	**ES**	Consultant Urologist	EKHUFT
Milan Thomas	**MT**	Consultant Urologist	EKHUFT
Alastair Henderson	**AH**	Consultant Urological Surgeon	MTW
Jane Hubert	**JH**	Head of Quality, NHS England South, Specialised Commissioning – KSS	NHSE

Item		Discussion	Agreed	Action
1.	**TSSG Meeting**	**Introductions** • SM welcomed the members to the meeting and stated this is the first time they have had a formal meeting via MS Teams. • SM highlighted the fact that the Urology TSSG meetings have been getting progressively better and he is keen not to lose that momentum. He added today's meeting would be more of a catch up to see how the group is coping through Covid. SM hoped the next meeting would be similar to the usual face to face meetings with an invited speaker. **Apologies** • The apologies are listed above. **Review full and mini TSSG action log** • To be updated separately and circulated with the final minutes.		

		Review previous minutes • SM asked if there were any objections to the previous minutes being signed off. There were no objections so SM confirmed the minutes were a true and accurate record of the previous meeting and were signed off. • The group introduced themselves and SM noted that there was no Consultant representation from EKHUFT. **Action** – SM asked AW to update the attendee lists from the 4 Trusts to include Faisal Ghumman from MFT. SM does not think the attendee list is currently up to date. TB agreed to liaise directly with AW.		**AW / TB**
2.	**LW&BC / Personalised care & support**	**Supportive Self-Management programme (treatment summaries x 4) - update by Claire Mallett** • SM mentioned they have been working on InfoFlex to support the self-management programme which is being used for the treatment summaries when patients have been referred back to their GP's. SM understood that HY and CNS's had been working on these. • CM explained there has been lots of work ongoing behind the scenes for the Personalized Care & Support Programme throughout the pandemic. • CM highlighted the consultation work which has been on going with CNS's, patients and the wider community based organisations supporting cancer to implement the Cancer Care Map. CM explained this was set up by the Dimbleby Trust and is an online directory offering available support services for patients with cancer and after. CM hoped this would be a very useful tool for the 4 Trusts and their patients. • SM asked what kind of service is on offer? CM elaborated this would include holistic services, befriending services, yoga, exercise and largely community-based services.		**KG circulated this document on the 16.10.2020**

		• CM alluded to the Prehabilitation Service which started at MFT and has now moved out as a virtual service for patients across Kent & Medway. CM explained this service was set up to get patients fit for treatment, including surgery, chemotherapy or radiotherapy. CM added there is ongoing work to embed the referral form for this service into InfoFlex. **Action** – SM would like a formal presentation by the Prehabilitation team for the next TSSG meeting. SM would like to see an audit of the teams' activity and the pathway of the patient from the start to the end of their referral. AW agreed to take this forward for the next meeting. • CM thanked the group for their engagement with the prostate remote monitoring follow-up system. This included protocol work, letters / templates, testing and piloting the remote tracking system and the patient portal. CM confirmed that in November this will be available to be piloted. **Action** – SM would also like to see a formal presentation of this work at the next TSSG meeting as this would be more advanced by next year. **Action** - SM asked if a smaller meeting prior to the next TSSG meeting could be set up for 5-10 people including SM, CM, HY, CNS's, TB and those involved. • CM provided an update on the bespoke treatment summaries involving collaboration between patients, GP's, KL for Oncology input and others. CM is keen to get the treatment summaries signed off to be used and added to the patient portal pathway so the record is all in one place. • CM explained the process of the treatment summary is that a copy of this would be sent to the patient and the GP at the end of each of the patients' treatments and before going onto the supported self-management pathway. • HY highlighted the treatment summaries are an important aspect for patient experience and also for auditing research purposes. • SM agreed the PSA referral treatment summary is important for when the patient		**AW / CM** **AW / CM** **CM**

		has been discharged from secondary care back to the GP rather than self-supported management. SM thanked the group for all the hard work that has gone into creating these summaries. • JJ asked for the PSA treatment summaries not to be released back to primary care until the contract has been activated with the GP's or it would cause chaos. JJ anticipated this being a few months away due to Covid. • SM asked that all Consultants were more explicit within their letters to GPs regarding a forward plan for the patient. SM suggested having two stages for the treatment summaries – when the patient moves to SSM and when the patient is fully discharged. **Action** – SM asked the GP's and Urologists on the call to look at the treatment summaries and feedback to SM within the next 7 days. If there is no feedback then they can be signed off with the changes that have been agreed at the meeting today.		**GP's / Urologists / CM**
3.	**Performance**	**DVH – update by Sanjeev Madaan** • SM confirmed they were managing their performance targets well for June and July due to less activity because of Covid. SM added once activity restarted in August this is where they fell down and was out of their control due to some patients self-isolating. SM confirmed they had 2 62-day breaches which brought them down to 75% in August. • SM highlighted some staff issues at DVH due to self-isolating and high-risk staff. • SM confirmed the 28-day FDS had been delayed but that all trusts are still shadow monitoring. SM stated they were slightly off the national target of 70% in July at 69% and 50% for August. **EKHUFT – update by Sanjeev Madaan** • TC apologised for the lack of Clinicians present on the call today from EKHUFT and was led to believe there would be someone attending.		**KG circulated the 4 Trusts presentations on 01.11.2019**

- AW explained MT hoped to join the call today but has been delayed due to interviews and activity.

- SM noted the performance was reversed for EKHUFT compared to DVH. SM mentioned in June some of the theatres were being used for ITU at KCH which accounted for the drop in performance figures for 62-day. SM added there was a backlog of prostate cancer patients but this had been rectified for July and August.

- SM was encouraged to see no 104-day patients with low backlog numbers and congratulated the EKHUFT Urology team.

MFT – update by Tahir Bhat

- TB confirmed they are doing consistently well across all the performance targets for June, July and August. TB added they are also doing very well for the 28-day FDS.

MTW – update by Hide Yamamoto

- HY explained their figures are similar to MFT with no issues across all performance targets and have worked very hard to achieve this.

- HY added for 28-day compliance they have achieved this against the national target.

- JD explained the overall data completeness target is a new government target which has not been fully sanctioned yet.

- SM is pleased to see how well the trusts are doing compared to the presentations of two years ago when they were bottom of the National Cancer Alliance performance tables.

4.	**Performance during Covid all Trusts**	• SM wondered what changes had been made during Covid for MTW and EKHUFT as these trusts were not generally represented at the mini Urology TSSG meetings. • HY explained the reduction in referral numbers during Covid which have now resumed. • HY confirmed they were not doing any transrectal prostate biopsies and only LATP's. HY added they were using PPE for trans perineal biopsies but due to the reduction of the prevalence in the disease they stopped doing it except for a small number of high-risk staff. HY confirmed the patients were triaged via the telephone and temperature taken when coming into the hospital. HY mentioned they have not conducted any Covid tests for any of their patients. • TB stated at MFT all patients are given a Covid test and will self-isolate for 3 days. • HY mentioned most of their general anaesthetic patients were transferred initially to KIMS but most of this work has now come back to MTW with only 1-2 lists per week still at KIMS. • PB provided an update from an Oncology perspective stating patients being referred later are presenting with more advanced disease. Consequently, the patient may not be suitable for radical surgical treatment and may need to be seen in an oncological or palliative setting. PB added they are using less chemotherapy for prostate cancer patients due to Covid. • PB confirmed they had stopped doing elective radiotherapy treatment for prostate cancer patients which resulted in a surge of patients in July. • PB confirmed with regards to new patients they are trying to see them face to face but follow up consultations are mainly conducted via video or telephone.		

5.	**Clinical Pathway Discussion**	**HOP** – this was not discussed at the meeting today. **Action** – SM agreed to update this document. **Bladder** • TB confirmed he had updated this document and emailed it back to AW a few days ago with some changes. **Action** - AW agreed to forward this updated document to SM for sign off. SM asked AW to additionally forward this document to Ed Streeter and the bladder surgeon team at EKHUFT for their feedback. **Testicular** • AW confirmed this pathway is due to be updated by Henry Taylor. **Prostate** • AW acknowledged she was working through this pathway with Ben Eddy. • SM hoped to finalise all of the above documents before the next TSSG meeting.		 **SM** **AW**
6.	**Prostate PSA for GP's**	**Update by Sanjeev Madaan** • SM confirmed with Rosie Baur and JJ this document had been agreed but due to Covid the implementation had been delayed. • JJ explained the CCG restructure and RB has moved on from cancer. JJ is not sure yet of RB replacement but hoped this will be sorted out in the next few weeks. • The group agreed that most clinics were followed up remotely rather than on a face to face basis.		

		• JJ referred to patients being referred back to Primary Care for blood tests and understood why this was happening and is often due to patient choice. JJ would like this recognized by the CCG's due to the extra work for GP's. • HY mentioned an issue at MTW regarding Roche antibody-based blood tests for PSA and they have run out of tests. HY asked if other trusts were having similar issues. HY added they have had no referrals from Primary Care in the last couple of days on the prostate pathway. SM was not aware of this. HY confirmed patients that have had blood tests at MTW there will be a huge backlog of PSA tests.		
7.	**Research**	• SM confirmed all Urology research stopped in March and was transferred to Covid research. • CB explained at MFT were in the process of re-opening Urology trials with one trial opening imminently. CB confirmed 4 studies currently open for follow up. One observational study - UK Genetic prostate cancer is on hold due to Covid. • CB added they are following the NIHR framework regarding the restart of the research activities. • CB clarified the 4 studies currently in follow up are – 2 bladder and 2 prostate cancer. CB confirmed a renal cancer study - a large commercial clinical trial is due to start shortly. CB added there are 6 potential studies they have expressed an interest in and are waiting to hear back from the sponsor to see if they have been selected as a site. • KL provided an update from an MTW perspective. KL confirmed they were back recruiting to trials previously open including radiotherapy, Ad Asprin and Atlantis – bladder cancer trial. KL added Stampede is not currently recruiting. UK DPS is ongoing. • AE confirmed from an EKHUFT perspective they were recruiting from the prostate side to Pivotol Boost for radical prostate radiotherapy, identifying patients for		

		PACE and refer onto PB. AE added they have no clarification on Ad Asprin yet for EKHUFT. AE confirmed they have 3 commercial studies for bladder cancer. • SM is pleased the trials are restarting and commented on the importance of them. • HY referenced another trial in which he is a collaborator and principal investigator working in conjunction with Oxford - to compare Trust biopsies and LATP. HY added it is still in the early stages of sign up but if accepted it could be a significant trial. HY agreed to let SM know if they wanted more centre's for this trial. • SM referred to a trial at Imperial which may interest HY and JD and is at the funding stage. SM said he was provisionally interested in this trial for selected patients. • PB mentioned the PACE trial is open. PB hoped the Stampede trial would start up in the New Year. **<u>Action</u>** – SM asked AW to email BH regarding the prescription of Degarelix by GP's as it is now a hospital only prescription. BH agreed to forward this on to Heather Lucas head of medicine management and CCG. SM would like this discussed again at the next TSSG meeting.		**AW / BH**
8.	**Clinical Audit**	**<u>Utility of nurse-led triage and G8 scoring on prostate pathway management - update by Hide Yamamoto</u>** • HY highlighted that prostate cancer unlike other aggressive cancers can be slow growing with good treatment (ADT) and even for patients with advanced disease. • HY referred to the decision regarding older patients and whether they offer any treatment or not. • HY explained they have been keeping a record for a long time but the data presented today is from June 2020. The data is based on 330 patients referred to		

		the 2ww prostate pathway the average age being 70. HY mentioned half of the referrals are patients over the age of 70 with a risk of overdiagnosis, overtreatment within this age bracket. HY highlighted the waste in resources and trips to hospital for patients that do not need investigations. • HY clarified they offer nurse led triage for the patients being referred including some consultant input. These are reviewed from referral received, patients' previous medical history and also a phone call to the patient. The patient will then be stratified to either an MRI / Rapid Diagnostics STT approach or clinic first. • HY explained the benefit of the MRI first is the reduction in time for diagnosis / treatment and the patient to visit the hospital. HY added the benefit of the clinic first is to reduce over investigation and over diagnosis particularly within those patients who are unfit or have elevated PSA levels. • HY referred to the G8 assessment tool which identifies both fit and frail patients over the age of 70. A G8 score of 3 ensured the patient attended a clinic first. HY highlighted that the triage process works well for fit patients. • HY concluded the G8 frailty score assessment works well because it: - i) identifies frail patients suitable for "clinic first" review ii) enables frail patients to be taken off of the pathway at the first review iii) reduces hospital footfall for unnecessary hospital visits and aids resource management • There was agreement there can be a lot of unnecessary referrals from Primary Care. FF agreed triaging is definitely beneficial.		
9.	**CNS Updates**	• FF confirmed there had been no CNS meetings recently and Ben Hearnden had now left his role. • The CNS's present on the call today (FF, HP and SA) agreed to set up a meeting via MS Teams.		

10.	Cancer Alliance Update	**Update by Claire Mallett** • CM provided an update on the overall aims of the phase 3 cancer recovery plan until March 2021. These slides have been presented previously by Ian Vousden at other meetings and have Cancer Alliance support. • The overall aims currently in the recovery phase are to: - i) Restore urgent cancer referrals back to pre-pandemic levels ii) Reduce the backlog to pre-pandemic levels for 62-day and 31-day path-ways iii) Ensure sufficient capacity to manage the increased demand including fol-low up care • CM explained supporting the recovery phase through: - i) Cancer Alliance ii) Tackling inequalities iii) Ensuring patients and staff have confidence that services are Covid pro-tected iv) Locking in innovations v) Ensure the correct workforce is in place vi) Re-starting the Long-Term Plan activity vii) Effective communications across the cancer community • CM mentioned some of the priorities have continued through the pandemic and been taken forward for the next 6 months. These include the Rapid Diagnostic Services, the targeted lung health check programme and personalised care and stratified follow up within prostate but also breast and colorectal. • CM referred to some of the Early Diagnosis initiatives including the VISS pilot in DVH and Lymphadenopathy Service in EKHUFT and STT Pathways. • CM mentioned the Faster Diagnosis Standard was due to go live in April but has been postponed and the providers are currently just shadow monitoring this.		**KG circulated this presentation on the 16.10.2020**

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<tr><td></td><td></td><td>• CM confirmed there has been further engagement with PCN colleagues which included some evening webinars advising on the implementation of the Early Diagnosis DES.</td><td></td><td></td></tr>
<tr><td>11.</td><td>AOB</td><td>• SM asked BM if he would like to add anything. BM thanked SM and confirmed they were not currently able to conduct any fundraising activities.

• BM promoted the Prostate Cancer Support Association Kent helpline which is still open to patients and families and the contact details are 03333 202360 and email support@pcsakent.org.

• GR mentioned there have been some staffing issues supporting Urological Pathology but this is gradually getting resolved.

<u>Feedback on mini TSSG meetings</u>

• SM explained the Urology mini TSSG meetings were set up on a monthly basis for a selected group from each Trust to share their experience during Covid which SM found very useful.

• SM mentioned a specialist MDT is yet to be set up for West Kent. TB clarified the specialist MDM would be starting in November. TB agreed to follow this up with SM next week to discuss the format for this. SM suggested having a mini TSSG meeting before this date.

• SM would like to continue the mini TSSG meetings for 45 mins to 1 hour every 6-8 weeks to monitor services going forward particularly due to the potential second wave of Covid.

<u>Action</u> – AW to liaise directly with the 4 Trusts to ensure the best attendance at these meetings.</td><td></td><td>AW</td></tr>
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		Frequency of future meetings
		
		• SM is keen for the future formal Urology TSSG meetings to continue twice yearly and not to change. Potential dates were provided as: -
		    o Tuesday 27th April 2021
		    o Thursday 14th October 2021
		
		Action – AW confirmed the invites would be sent out in the next few days.
		
		• HY commented on the lack of Consultant attendance at the meeting today particularly from EKHUFT. SM was not sure of the reason why due to the meeting date and time being circulated well in advance. TC apologised again on behalf of the EKHUFT Consultants and agreed to follow up with them regarding future meetings.
		
		• SM hoped to have more interesting clinical presentations at the next meeting in April.
		
		• HY asked if anyone wanted to present an audit at the next meeting to email him directly and he would be happy to help.
		
		• SM thanked the group for their attendance today.
				AW