Kent and Medway Cancer Collaborative

Urology Tumour Site Specific Group meeting
Thursday 6th October 2022
Great Danes (Mercure) Hotel, Maidstone
09:30 – 12:30
Final Meeting Notes

Present	Initials	Title	Organisation
Sanjeev Madaan **(Chair)**	**SMa**	Consultant Urological Surgeon	DVH
Anca Gherman	**AG**	Clinical Trials Research Nurse	DVH
Srijit Banerjee	**SB**	Consultant Urologist	DVH
Nicola Lancaster	**NL**	Macmillan Uro-oncology CNS	DVH
Sashi Kommu	**SK**	Consultant Urological Surgeon & Cancer Lead	EKHUFT
Milan Thomas	**MT**	Consultant Urological Surgeon	EKHUFT
Naomi Webb	**NW**	General Manager for Urology	EKHUFT
Beverley Saunders	**BS**	Radiologist	EKHUFT
Morna Jones	**MJ**	Lead Uro-oncology CNS	EKHUFT
David Stafford	**DS**	Macmillan Lead Nurse in Urology Cancer Services	EKHUFT
Sarah Barker	**SB**	Early Diagnosis Project Manager	KMCA
Karen Glass **(Minutes)**	**KG**	Administration & Support Officer	KMCC & KMCA
Annette Wiltshire	**AW**	Service Improvement Facilitator	KMCC
Colin Chamberlain	**CC**	Administration & Support Officer	KMCC
Emma Bourke	**EB**	Personalised Care & Support Facilitator	MFT
Suzanne Bodkin	**SB**	Cancer Pathway Manager	MFT
Clarissa Madla	**CMad**	Research Nurse	MFT
Claire Blackman	**CB**	Macmillan Urology CNS	MFT
Hazel Samson	**HS**	Cancer Support Worker	MFT
Tahir Bhat	**TB**	Consultant Urologist	MFT
Gayzel Vallejera	**GV**	Clinical Trials Practitioner	MFT
Maines Msiska	**MM**	Research Nurse	MFT
Diletta Bianchini	**DB**	Consultant Medical Oncologist	MTW / MFT
Albert Edwards	**AEd**	Consultant Clinical Oncologist & Joint radiotherapy lead	MTW
Helen Morgan	**HM**	Head & Neck Radiotherapy Radiographer	MTW

Niki Poulson	**NP**	2ww Haematuria pathway Nurse	MTW
Jennifer Pang	**JP**	Clinical Oncologist	MTW
Chris Singleton	**CS**	Senior Programme Manager – Kent and Medway Cancer Alliance Commissioning	NHS Kent & Medway ICB
Brian Murphy	**BM**	Patient Representative	
Apologies			
Fay Fawke	**FF**	Macmillan Lead Uro-oncology CNS / Deputy Lead Cancer Nurse	DVH
Michelle McCann	**MMC**	Operational Manager for Cancer and Haematology	DVH
Marie Payne	**MP**	Macmillan Lead Cancer Nurse / Clinical Services Manager	DVH
Claire Mallett	**CM**	Programme Lead – Personalised Care & Support	KMCA
Tracey Ryan	**TR**	Macmillan User Involvement Manager	KMCC
Faisal Ghumman	**FG**	Consultant Urological Surgeon	MFT
Angela Williams	**AW**	Macmillan Urology CNS	MFT
Amit Goel	**AG**	Consultant Histopathologist	MTW
Kathryn Lees	**KL**	Consultant Clinical Oncologist	MTW
Sona Gupta	**SG**	Macmillan GP and Cancer Lead	NHS Kent & Medway ICB
Jack Jacobs	**JJ**	Macmillan GP & Cancer Lead	NHS Kent & Medway ICB

Item		Discussion	Agreed	Action
1.	**TSSG Meeting**	**<u>Apologies</u>** • The apologies are listed above. **<u>Introductions</u>** • SMa welcomed the members to the meeting and asked the group to introduce themselves. • If you attended the meeting and have not been captured within the attendance log above please contact **karen.glass3@nhs.net** directly. **<u>Review Action log</u>**		

		• The action log was reviewed, updated and will be circulated to the members with the final minutes from today's meeting. **<u>Review previous minutes</u>** • The minutes from the previous meeting, which took place on Tuesday 26th April 2022 were reviewed and accepted as a true and accurate record.		
2.	**Fusion Biopsy for prostate cancer diagnosis**	**<u>MRI Fusion Biopsy: "A passing phase" or the "final destination" – provided by Srijit Banerjee</u>** • SB explained approximately 70 000 prostate biopsies are undertaken each year in the UK. • EAU guidelines recommend performing an MRI for new prostate cancer patients before a TRUS biopsy. • Transperineal prostate biopsy (NICE guidelines) – Local anaesthetic transperineal prostate biopsy (LATP) is a cost-effective way / good diagnostic tool to collect tissue samples from the prostate and incurs less complications. NICE has recommended the use of PrecisionPoint the freehand needle positioning device for diagnosing prostate cancer. • MRI fusion biopsy: the new era **Basic principles:** i) MR imaging preferably (Mp MRI) ii) Software / Cognitive iii) Electromagnetic tracking **Three commonly used software-based platforms are:** i) Artemis ii) Urostation iii) UroNav		**Presentation circulated to the group on 13th October 2022.**

		• Procedure – rigid and elastic fusion – software takes both into consideration. • Targeted biopsy diagnosed 30% more high-risk cancers versus the standard biopsy. Adding the standard biopsy to targeted biopsy led to more cancers being picked up. • SB referred to a number of study papers, relating to fusion biopsy for prostate cancer. • Higher PI-RADS will pick up more cancers. • MRI fusion: **Good** i) Easy technique to learn ii) Good reproducibility and hence likely helpful in AS patients iii) Risk of complications low **Bad** i) Limited evidence of superiority of one method of fusion over other **Ugly** i) Prohibitive cost (£128,000 for the Koelis system) • SMa referred to the PACIFIC trial which will be starting in the next couple of months. DVH will be looking at the fusion platform.		
3.	**Performance**	• SMa highlighted that K&M Cancer Alliance is the highest performing alliance with regards to the 62-day standard but improvement is needed to achieve the Faster Diagnosis 28-day standard. DVH and MFT are meeting the FDS target of 75% however, EKHUFT and MTW are below 50%.		**Performance slides were circulated to the group on 13th October**

		DVH – update provided by Sanjeev Madaan • **Please refer to the circulated performance slide pack for an overview of the Trust's data.** • SMa confirmed they have a STT nurse at DVH and the One Stop Haematuria clinic has helped support 28-day FDS. **EKHUFT – update provided by Naomi Webb** • **Please refer to the circulated performance slide pack for an overview of the Trust's data.** • STT pathway and nurses are evolving. Volume is their biggest issues. New robotic surgeon is being trained which is having an impact on capacity but this will help in due course. • **MFT – update provided by Suzanne Bodkin** • **Please refer to the circulated performance slide pack for an overview of the Trust's data.** • Patient choice is the main reason for the breaches at MFT. **MTW – no-one available to provide an update** • **Please refer to the circulated performance slide pack for an overview of the Trust's data.** • The group confirmed there were no Covid swabs being carried out across the patch. • SMa suggested it might be a good idea to visit other units for shared learning. He offered the Trusts the opportunity to visit the Haematuria clinic at DVH.		**2022.**
4.	**MDT Streamlining update**	**Update by Sanjeev Madaan** • SMa explained the National Cancer Plan in 2000 ensured all cancer patients were discussed at the MDT. However, this is no longer sustainable due to the increased number of referrals and		**Presentation circulated to the group on 13th October**

	New PSA referral criteria	more time which is needed to discuss the more complex cases. • SMa explained the Standard of Care is a point in the pathway of patient management where there is a recognised international, national, regional or local guideline on the intervention(s) that should be made available to a patient. SoC need to be agreed by all Cancer Alliances. • SMa outlined who he felt needed to be present in the MDT streamlining team and includes: i) Consultant Urologist – special interest in cancer care ii) MDT Co-ordinator iii) Cancer Nurse Specialist iv) Middle Grade / specialist doctor / SpR • **Prostate Cancer Streamlining – Metastatic Prostate Cancer Cases – the group agreed PS 2 should also be included. Action – SB agreed to amend the SoC document. It was agreed the importance of conducting an audit of the data.** • **Bladder Cancer Streamlining – agreed to add in "recurrences" – with patients to be discussed at MDT and re-stratify patients. Action – SB agreed to amend the SoC document.** • **Renal Cancer Streamlining – need a standard protocol – not taking to MDT. SoC document was agreed by the group.** • **Streamlining Testis Cancer – patient to go straight to Oncologist and bypass MDT – unless a complex case or recurrent cancer.** • All **new** cancers should be discussed at the MDT. • SMa summarised: i) Improve consistency and transparency of pathways ii) Adequate MDT discussion time where required iii) Improve clinical management iv) Not a one-size-fits-all		**2022.** **SB**

		• It was agreed further discussion was needed with regards to renal cancer – post operative histology for high risk patients. • SMa referred to the delays within radiology and pathology which directly impacts the MDM. **New PSA referral criteria – update by Sanjeev Madaan** • The group agreed to accept the new PSA NICE guidelines if 50% of other Cancer Alliances have done the same. This included increasing PSA range for 60 – 69-year olds from 3 to 4.5. They hoped this could be finalised before the next TSSG meeting. • The NG12 - 2ww referral form has been updated and is ready to circulate.		
5.	**Clinical Pathway Discussion** • **Bladder** • **Prostate**	**Bladder (in draft) – update provided by Tahir Bhat** • Haematuria section to be removed from the Bladder PoC and worked on as a separate document. • TB agreed to work on the Bladder PoC document. **Prostate (in draft) – update provided by Sashi Kommu** • SK agreed to work on the Prostate PoC document.		
6.	**Clinical Audit**	**Cystectomy Data – provided by Tahir Bhat** • TB provided an overview of the cystectomy service (WKUCC) based at MFT with patients also coming from DVH and MTW. The bladder cancer clinic at MFT also includes CPEX (Cardiopulmonary Exercise Testing) and pre-habilitation services. • TB highlighted the number of cystectomy cases over a 5-year period from 2018 – June 2022		**Presentation circulated to the group on 13th October 2022.**

		and those who had neo-adjuvant chemotherapy. The service was stopped for 3 months in 2021 due to Covid. The average number of cases per year is 26, operating time is on average 5 hours with an average length of stay in hospital as 7 days. • Over the 5-year period, 17 patients were re-admitted to hospital within a 30-day period with 1 mortality in 2020 which was due to Covid. • There were 6 robotic cystectomies performed at MFT in 2019, these were paused due to Covid but they hope to re-start in the next 2-3 months. • TB explained patients were offered pre-habilitation before neo-adjuvant chemotherapy and also after surgery to encourage better overall recovery. **<u>Robot Assisted Radical Prostatectomy – provided by Sashi Kommu</u>** • SK provided a detailed presentation on the background, technique, results and outcomes of robot assisted radical prostatectomies carried out at EKHUFT. SK compared RARP to surfing and the challenges involved with both. • SK stated he will explain the procedure in detail with each eligible patient and that RARP is not suitable for all patients. • Ben (Hearnden) has set up the Robotic Prostatectomy Patient Forum which takes place virtually every other Thursday at 14:00 – 17:00. • The average age of the patient was 67 – with ages that ranged from 48 – 75. 70% of patients had LATP compared to 30% TRUS biopsy. Average total operating time was 183 minutes on the console. • Of the 150 patients – 60% had T3 disease and 40% T2 disease. 96% patients after the RARP were discharged after 1 day. At EKHUFT they perform RARP for T3b disease particularly for young men. • Declan Cahill works at the Royal Marsden and is the highest volume robotic surgeon and SK's		**Presentation circulated to the group on 13th October 2022.**

		mentor. • EKHUFT uses 3D printed models and advanced image augmentation to help support patients ahead of their surgery. This helps the urology consultants explain the procedures visually to their patients. • IMAROP study for T3 disease - £2 million. TRANSLATE – at MTW and KCH. £20 million available funding for EKHUFT Urology Research projects. • The aim is to move from hospital as the centre to home as the hub.		
7.	**Bilateral testicular cancer**	**<u>Update provided by Diletta Bianchini</u>** • Testicular cancer is rare and represents 1 -5 % of malignancies in males, however the incidence rate has increased over the past 30 years. Testicular cancer is more common in men aged between 20 and 40. **Action - DB agreed to get a copy of the Royal Marsden pathway guidelines for testicular cancer and will circulate out to the group for comment and feedback. The group agreed it would be helpful to have an audit of the cases within K&M for the next meeting.** • Henry Taylor was confirmed as the oncology lead for testicular cancer at MTW and EKHUFT with DB as the lead at DVH and MFT.		**Presentation circulated to the group on 13th October 2022.** **DB**
8.	**Holistic Needs Assessment embedding Genetics for Prostate cancer patients**	**<u>Update provided by Anca Gherman</u>** • AG explained Holistic Needs Assessment represents an all-inclusive approach by CNS' with patients by identifying their concerns at different times in their cancer diagnosis journey -start / during / completion of treatment or follow-up visits. • Genetic Counselling helps a patient and their relatives to understand the risks and benefits of		**Presentation circulated to the group on 13th October 2022.**

		having a genetic test, the results of the test and how family members may-be affected - early detection and prevention. The additional risk of passing on a health condition to your children. • AG provided a summary of the emotional, physical, socio-cultural, financial, environmental, occupational, spiritual and intellectual considerations for meeting a patient's HNA health and wellbeing needs. • AG referred to the 280 newly diagnosed prostate cancer patients at DVH from May 2021 – April 2022. 181 of these patients had an HNA. 196 patients had a uro-oncology CNS present at diagnosis and 28 patients were referred to GLH at GSTT. • The National genomic test directory for cancer specifies the genomic tests commissioned by the NHS in England for cancer, the technology by which they are available, and the patients who will be eligible to access a test. • AG referred to the UK Genetic Prostate Cancer Study at DVH - detailing the inclusion criteria for the 91 patients who were recruited from 2003 to it closed in 2022. • PREDICT was a successful prostate trial – for use in men without metastatic disease, where conservative management and radical treatment options are being considered. • Lynch syndrome affects 175,000 people in the UK and increases the risk of several cancers. • Annual PSA tests are 8 times more likely to spot cancer in men with genetic changes, associated with Lynch syndrome. • Regular PSA testing from the age of 40 could detect early signs of prostate cancer.		
9.	**Research**	• Research has been slow due to the pandemic but numbers are now improving.		

		• Standard of Care for cancer patients – importance of recruiting into a good randomised trial. **Action – DB and AG agreed to provide a more detailed research update at the next meeting and asked for it to be put higher up in the agenda to allow for a more detailed discussion.**		**DB / AG / AW**
10.	**CNS Updates**	• The main CNS update from the meeting was to point out the shortage of CNS workforce across the patch with sickness and unfilled posts an issue.		
11.	**Prostate early detection project**	**<u>Update by Sarah Barker</u>** • The aim of the project is to get people into the system as early as possible, with an emphasis on timely presentation and ensuring effective primary care pathways are in place. • The PCN Early Cancer Diagnosis DES requirement 4 is to review referral data and to develop an action plan. • "Focusing on prostate cancer and informed by data provided by the local Cancer Alliance, to develop and implement a plan to increase the proactive and opportunistic assessment of patients for a potential cancer diagnosis in population cohorts where referral rates have not recovered to their pre-pandemic baseline." • The focus for this project is to identify patients who are at a higher risk and in doing so, help to address the inequalities in cancer care. • The Cancer Alliance has identified 3 key priorities within health inequalities: i) Coastal Communities ii) Black and ethnic minorities iii) Physical and sensory disabilities • 1 in 4 black men will develop prostate cancer in their lifetime, compared to 1 in 8 non-black.		**Presentation circulated to the group on 13th October 2022.**

		• A recent report has identified that black men have poorer survival rates; are less willing to opt for PSA testing and an examination; experience a longer diagnostic interval between first presentation of symptoms and a diagnosis. • Our project aims to address some of these inequalities by: i) Liaising with Prostate Cancer UK, who have done huge amounts of work to support black men at risk of/diagnosed with prostate cancer. ii) Working with people with lived experience – have identified one but would like to talk to others – if any CNS's can identify patients; also working closely with ICB engagement team. iii) Have identified areas across the patch where there is a higher % of black populations – mainly North Kent - Dartford/Gravesend areas. iv) Develop a public awareness campaign by working with the communities affected. v) Work with PCNs in the area to provide education for clinicians (working with PCUK) and CASE FINDING using clinical criteria (to be agreed). vi) Have input from secondary care and patients on this project – if interested please contact sarah.barker60@nhs.net. vii) Happy to bring back project evaluation to the group when complete.		
12.	**Cancer Alliance update**	**<u>Update by Chris Singleton</u>** • **Please refer to the presentation for a detailed breakdown of the National Cancer Programme for 2022/23 and specific K&M programme priorities** • CS explained the prostate patient portal is progressing well. There have been some delays but CS has been informed by Claire Mallett, that the clinician-focus testing will be starting in December and information will be sent out regarding this in due course. • Early conversations with clinical teams are taking place regarding further development of clinical protocols for remote monitoring. • PSA monitoring has been launched in primary care and is now live in Kent & Medway with most		**Presentation circulated to the group on 13th October 2022.**

		practices signed up. • CS asked if there were any questions regarding the CA update he would be very happy to be contacted directly - chris.singleton@nhs.net.		
13.	**AOB**	• AEd mentioned BCON radiotherapy (Bladder carbogen and nicotinamide) radiotherapy) is now being used at MTW. **Action – the group was asked to look at the 2ww Haematuria Pathway NICE guidance and to feedback any comments to karen.glass3@nhs.net.** **"Current NICE guidelines recommend urgent referral to an adult urological service for specialist haematuria investigation in the following:** • Aged ≥45yrs with either: Unexplained visible haematuria without urinary tract infection Visible haematuria that persists or recurs after successful treatment of urinary tract infection • Aged 60yrs with have unexplained non-visible haematuria and either dysuria or a raised white cell-count on a blood test." • BM asked SM if patient behaviour can affect urinary continence recovery rates and if there is data to support this. SM confirmed it does and it is important to maintain an exercise regime.		**Group**
	Next Meeting Date	• **Tuesday 25th April 2023 – 09:30 – 12:30 – venue to be agreed.**		**KG to circulate meeting invites.**