Kent and Medway Cancer Collaborative

Urology Tumour Site Specific Group meeting
Tuesday 25th April 2023
Great Danes (Mercure) Hotel, Maidstone
09:00 – 12:30
Final Meeting Notes

Present	Initials	Title	Organisation
Sanjeev Madaan **(Chair)**	**SMa**	Consultant Urological Surgeon	DVH
Srijit Banerjee	**SB**	Consultant Urologist	DVH
Nicola Lancaster	**NL**	Metastatic Uro-oncology CNS	DVH
Elaine Ritchie	**ER**	Uro-oncology CNS	DVH
Fay Fawke	**FF**	Deputy Lead Cancer Nurse / Lead Macmillan Uro-oncology CNS	DVH
Amanda Clarke	**AC**	Consultant Urologist	DVH / MTW
John Kyle	**JK**	InfoFlex Cancer Account Manager	CIVICA
Sashi Kommu	**SK**	Consultant Urological Surgeon & Cancer Lead	EKHUFT
David Stafford	**DS**	Macmillan Lead Nurse in Urology Cancer Services	EKHUFT
Claire Mallett	**CM**	Programme Lead – Personalised Care & Support	KMCA
Karen Glass **(Minutes)**	**KG**	Administration & Support Officer	KMCA & KMCC
Annette Wiltshire	**AW**	Service Improvement Lead	KMCC
Colin Chamberlain	**CC**	Administration & Support Officer	KMCC
Matt Hine	**MH**	KMCC InfoFlex Manager	KMCC
Suzie Chate	**SC**	KMCC InfoFlex Development Manager	KMCC
Faisal Ghumman	**FG**	Consultant Urological Surgeon	MFT
Suzanne Bodkin	**SB**	Cancer Service Manager	MFT
Angela Williams	**AW**	STT Urology CNS	MFT
Claire Blackman	**CB**	Macmillan Urology CNS	MFT
Hazel Samson	**HS**	Cancer Support Worker	MFT
Tahir Bhat	**TB**	Consultant Urologist	MFT
Henry Taylor	**HT**	Consultant Clinical Oncologist	MTW
Hide Yamamoto	**HY**	Consultant Urological Surgeon	MTW
Alastair Henderson	**AH**	Consultant Urologist	MTW
Alison Richards	**AR**	Uro-oncology CNS	MTW

Albert Edwards	**AEd**	Consultant Clinical Oncologist & Joint radiotherapy lead	MTW
Helen Morgan	**HM**	ePROMS Project Manager KOC Radiotherapy	MTW
Gissy George	**GG**	Uro-oncology CNS	MTW
Jeanette Smith	**JS**	Uro-oncology CNS	MTW
Jasper Dimairho	**JD**	Senior Coordinator - Urology	MTW
Amit Goel	**AG**	Consultant Histopathologist	MTW
Andrea Hodges	**AH**	Cancer Care Coordinator	Primary Care Network
Jo Meredith	**JM**	Cancer Care Coordinator	Primary Care Network
Apologies			
Anca Gherman	**AG**	Clinical Trials Research Nurse	DVH
Ed Streeter	**ES**	Consultant Urological Surgeon	EKHUFT
Morna Jones	**MJ**	Lead Uro-oncology CNS	EKHUFT
Naomi Webb	**NW**	General Manager for Urology	EKHUFT
Shikohe Masood	**SMas**	Consultant Urological Surgeon	MFT
Emma Bourke	**EB**	Personalised Care & Support Facilitator	MFT
Diletta Bianchini	**DB**	Consultant Medical Oncologist	MFT / MTW
Mark Cynk	**MC**	Consultant Urological Surgeon	MTW
John Donohue	**JD**	Consultant Urologist	MTW
Kathryn Lees	**KL**	Consultant Clinical Oncologist	MTW
Jennifer Pang	**JP**	Clinical Oncologist	MTW
Brian Murphy	**BM**	Patient Partner	

Item		Discussion	Agreed	Action
1.	**TSSG Meeting**	**<u>Apologies</u>** • The formal 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. **Review Action log** • The action log was reviewed, updated and will be circulated to the members with the final minutes from today's meeting. **Review previous minutes** • The minutes from the previous meeting, which took place on Thursday 6th October 2022 were reviewed and accepted as a true and accurate record.		
2.	**Performance**	• SMa mentioned K&M Cancer Alliance is the highest performing alliance with regards to the 62-day standard at 78.1% and this position has been sustained for the last couple of years. There are champions within the trusts across the patch driving forward these targets which has helped. • In terms of the 28-day FDS target of 75%, K&M's performance has improved over the last 6 months from 51.9% to 56.7%. The FDS target is due to supersede the 2ww performance target in due course. • The Urgent Suspected Cancer (USC) backlog for K&M patients waiting over 62-days is one of the lowest nationally at 6.5%. • SMa asked the group what they felt were the issues holding back their improvement within the 28-day FDS performance target? The group agreed the biggest hurdles were during the investigations including biopsy and MRI back on time and also workforce issues. • HT emphasised the importance of getting the best pathway for their patients, early triage is key on day 1 and improvements within pathology will improve the FDS target. HT mentioned K&M have been recognised nationally by health bosses on how well they are performing as a Cancer Alliance and they are a beacon for other alliances nationally. He added the group should be really proud of themselves for the improvements made over the last 5 years.		**Performance slides were circulated to the group on 2nd May 2023**

DVH – update provided by Fay Fawke

- **Please refer to the circulated performance slide pack for a complete overview of the Trust's data.**

- FF outlined some of the challenges and delays at DVH which are due to:

  i) GP's not booking into correct clinics
  ii) Diagnostic delays
  iii) Histology delays – due to shortage of laboratory staff
  iv) Complex patients / patient choice
  v) Multiple diagnostics.

- There is only 1 MRI scanner at DVH but they are expecting an additional scanner in September / October which should improve capacity.

- LATP slots had been a previous issue but this has now been resolved. They have 12 slots per week for prostate.

EKHUFT – update provided by David Stafford

- **Please refer to the circulated performance slide pack for a complete overview of the Trust's data.**

- DS outlined some of the challenges and delays at EKHUFT which are due to:

  i) Prostate diagnostic pathway delays
  ii) Diagnostic imaging booking / capacity delays
  iii) MRI reporting delays (turnaround can be between 16 – 25 days)
  iv) Histology reporting – often covered by Locums – 3 week reporting delays
  v) Benign letter discharge letter delays
  vi) Elective capacity – inadequate.

- **MFT – update provided by Suzanne Bodkin**

		• **Please refer to the circulated performance slide pack for a complete overview of the Trust's data.** • MFT consistently meet the 28-day FDS standard and the STT nurse in place has really improved this target. • MFT also consistently meet both the 31-day and 62-day performance targets. • There are 4 patients waiting over 104-days – 3 of these patients had been referred from West Kent after day 38 and 1 patient was initially referred to UGI and is waiting for a chemo start date. • There are 8 patients waiting over 62-days. 2 of these patients have also been referred from West Kent after day 38 – treated in target, 4 patient choice and 2 complex diagnostic pathways. **MTW – update provided by Jasper Dimairho** • **Please refer to the circulated performance slide pack for a complete overview of the Trust's data.** • JD mentioned there has been a dip in their FDS performance from December 2022 which is primarily due to patients delaying diagnostics or their outpatient appointments. There have also been challenges meeting biopsy demands and outpatient appointment capacity due to an increase in referrals since Covid. • JD confirmed they have met the 31-day performance target consistently for the last 6 months. • In terms of backlogs there are 23 patients waiting over 62-days and 8 patients waiting over 104-days. This has been impacted by patients delaying diagnostics, oncology capacity for outpatient appointments, treatment for brachytherapy patients and those patients referred externally for Robotic Assisted Laparoscopic Prostatectomy (RALP).		

3.	**Clinical Pathway Discussion**	**<u>Prostate PoC – update provided by Sashi Kommu</u>** • SK explained the last time this document was updated was in 2016/17. SK had made some alterations to this document in red which he navigated through and the group discussed at length. • SK proposed the document is circulated to the group (**action completed after the meeting**) as part of a peer review process and he hoped to have the final document formulated and agreed in 8-weeks-time. **<u>Bladder PoC – update provided by Tahir Bhat</u>** • TB agreed to update the Bladder PoC document and will circulate for comments prior to finalisation. **<u>WKUCC-IPT Policy – update provided by Tahir Bhat</u>** • TB explained when patients are referred for surgery they should be fit enough for the procedure. MFT have found a number of patients referred for surgery will breach because they are not fit enough. TB added CPET – Cardiopulmonary Exercise testing – waiting time is 1 week.		**Documents circulated to the group on the 2nd May 2023.**
4.	**MDT Streamlining update** **Sharing any SOC's**	**<u>DVH update by Srijit Banerjee</u>** • SB confirmed MDT streamlining does work and the main team should include: i) Consultant Urologist – with a cancer interest ii) Registrar iii) MDT Co-ordinator iv) CNS v) Radiologist • SB referred to 115 cases - 30% will be streamlined for the local MDT.		

		Action – SB agreed to share their Standard of Care document – to be circulated to the group. It was agreed to provide an audit of 6 months data at the next meeting in October. • HY mentioned often the histology is not ready for the MDM. AG explained pathology are very short-staffed, their workload is increasing and they often cover multiple tumour sites. Some of their work is outsourced electronically. Digital Pathology improvements have started with implementation due in 2024 which will vastly improve pathology services. HT suggested they considered an age threshold which would aid and limit demand within pathology. **MFT update by Tahir Bhat** • TB mentioned they have a pre-MDM on a Weds morning. The main MDM is 1 hour 15 minutes and they will discuss about 25 cases.		**SB / TB**
5.	**Managing Haematuria with Faster Access standards in 2023**	**Haematuria managing urgent referral in 2023 - provided by Alastair Henderson** • Faster diagnostic pathways – implementing timed urology cancer diagnostic pathways: bladder, renal, testicular and penile. • The volume of patients coming into Secondary Care on the haematuria / prostate pathways are increasing. The higher incidence of blood in the urine generally means there is an increased chance of there being a cancer. • The Service aim is to: i) Offer rapid diagnostic testing to patients at increased risk of being diagnosed with Urological Cancer (principally bladder or upper tract urothelial cancer, renal cancer and prostate cancer). ii) To avoid inappropriate investigation of patients with haemorrhagic cystitis who are in a low risk cohort. iii) To offer rapid reassurance to patients who do not require complex diagnostics and signposting to appropriate services.		**Presentation circulated to the group on the 2nd May 2023**

		• AH provided an overview of an audit of 114 - 2ww haematuria referrals: i) 111 used the e-referral form ii) 86 referrals were for visible haematuria iii) 14 for non-visible haematuria iv) 14 for cancer concern "where other criteria had not been met." • After triage: i) 23 referrals were judged to not meet the guidelines for suspected cancer and removed from the pathway. • 86 referrals for visible haematuria: i) 56 patients confirmed a history of visible heamaturia ii) 11 patients denied a history of visible heamaturia iii) 19 cases confirmation was not possible. • In conclusion: i) In excess 15% of suspected cancer referrals were inappropriate and would have had procedures which were not required. ii) In the future, all referrals will be fully triaged, with patients contacted by phone to confirm symptoms, history and urine culture results. • Redesigned the pathway – pathways 1 - 4 outlined. The outcomes and advantages are outlined within the slides. • 2ww – visible haematuria – CT Urogram is used. Patients that are frail – consent issues – protected STT nurse / US / Clinic appointment / Consultant appointment re diagnostic tests or not treated. • Outcomes 384 / 573 referrals – 10% conversion rate of cancer.		

		• NICE guidance is not clear with regards to the tests required. AH referred to both the DETECT and IDENTIFY studies. • NG12 – 2ww is not appropriate for the visible / non-visible haematuria pathways and there is no alternative urgent pathway in place.		
6.	**NICE PSA Thresholds**	**<u>Update provided by Hide Yamamoto</u>** • HY proposed what impact the NICE PSA (NG12) threshold changes will have on referrals, resource use, prostate cancer diagnoses and treatment. NICE guidance was last updated on the 15th December 2021. • HY highlighted the differences between current PSA thresholds and NICE PSA guidelines. • NICE PSA thresholds - Age-specific PSA thresholds for people with possible symptoms of prostate cancer: i) Aged below 40 – use clinical judgement ii) Aged 40 – 49 – more than 2.5 ug/l iii) Aged 50 – 59 – more than 3.5 iv) Aged 60 – 69 – more than 4.5 v) Aged 70 – 70 – more than 6.5 vi) Above 79 – use clinical judgement • Current PSA thresholds: * - agreed at the K&M Urology TSSG meeting on the 31st October 2019 and ** Prostate Cancer Risk Management Programme 2016: i) Aged 40 – 49 – 2.5 ug/l * ii) Aged 50 – 69 – 3.0 ** iii) Aged 70 and over – 5.0 * iv) Aged 80 and over – 10.0 * • The rationale for change from NICE is due to the regional variations in practice (particularly in		

		the 50 – 69 age range) the committee decided to define the age-specific PSA thresholds. • EAU states there are no agreed standards for defining PSA thresholds. AUA – increasing the prostate biopsy threshold based on evidence that men with a PSA level above 10 ng/ml are more likely to benefit from treatment of prostate cancer compared to those below 10. Both standards are non-committal in terms of PSA thresholds. • According to NICE guidance patients that have symptoms of prostate disease should be referred by their GP on a NG12 referral into SC. Patients that are asymptomatic with a PSA over 3.0 the GP is advised to consider comorbidities, age, family history and to use their clinical judgement if a referral is deemed appropriate. • A local audit was carried out at MTW from June 2021 – October 2022. They recorded all 2ww prostate cancer referrals to MTW including frailty scores at triage, PSA, age, Gleason score and symptoms. Results included: i) 782 referrals (all fit men and suitable for an MRI) ii) Average age of the patients – 63 iii) Average PSA level – 6.2 iv) 782 MRI's carried out (100%) v) 472 biopsies carried out (60%) vi) 158 clinically significant cancers diagnosed (20%) vii) 100% data completion • Full implementation of NICE thresholds would mean, reductions in: i) Urgent clinic appointments: 526 vs 780 (-33%) ii) Urgent MRI appointments: 526 vs 780 (-33%) iii) Urgent biopsies: 247 vs 318 (-22%) • 21% exclusion of clinically significant cancers. • A regional InfoFlex audit of all prostate cancer diagnoses was carried out across the 4 trusts and supported by MH (22% data completion rate).		

		• 27% exclusion of clinically significant cancers. Affects all stages and grade in a similar manner. • HY provided the group with a profile of excluded cases based on NG12 thresholds. • In Summary: i) NICE recommends age-specific PSA's for symptomatic patients ii) For asymptomatic patients – PSA 3.0 for 50-69 – clinical judgement iii) Most patients are symptomatic at referral (at MTW) iv) Benefits of early treatment most in those with life expectancy beyond 20 years v) Patient life expectancy average 85. • Proposals discussed and include: i) Keep all current referral thresholds the same ii) Change to NG12 thresholds for all PSA values (regardless of symptoms) iii) Symptoms-based thresholds (symptomatic use NICE threshold, asymptomatic use current threshold) iv) 2-tier referral v) Hybrid – keep threshold of 3ng/ml for age 69 and below but increase to 6.5ng/ml for age 70+. • The TSSG group agreed option 5 (as above).		
7.	**Bone health for men having androgen deprivation therapy**	**<u>Update provided by Nicola Lancaster</u>** • NL explained the impact of a bone fracture on patients that are on hormone therapy. • Approximately, 549,000 new fragility fractures occur each year and the cost to the NHS exceeds £4.7 billion per year. • NL outlined the reasons to consider bone health for men on Androgen Deprivation Therapy.		**Presentation circulated to the group on 2nd May 2023**

		• Patients assessed with bone fractures at DVH over the age of 80: i) 4 fractures – in 2022 ii) 9 fractures – in 2021 iii) 6 fractures – in 2020 iv) 11 fractures – in 2019 • NICE guidance states: i) Consider assessing fracture risk in people with prostate cancer who are having ADT, in line with the NICE guideline on osteoporosis; assessing the risk of fragility fracture ii) Offer bisphosphonates to people who are having ADT and have osteoporosis. iii) Consider denosumab for people who are having ADT and have osteoporosis if bisphosphonates are contraindicated or not tolerated. • EAU Guidelines were more robust. • NL referred to the FRAX (Fracture Risk Assessment Tool) scoring which is accessible online. • The current situation at DVH: i) It is unclear who should address bone health ii) Ad-hoc review for metastatic patients who are seen by metastatic CNS or Oncologist iii) FRAX Score, DEXA Scan if appropriate, bisphosphonates given through the Pine Unit iv) Follow up is picked up as part of the Oncology follow up v) Lifestyle advice is given by a CNS and Oncologist. vi) Future plans were also outlined at DVH. • In terms of referral: i) Anyone can refer to the service ii) All patients starting ADT with intention of 1 year or more iii) Patients who have been on ADT and not had a DEXA scan		

		iv) Can refer by letter / email to Uro-Oncology CNS – to go on PAS and link in with GP's. • NL mentioned setting up a clinic with AC to provide lifestyle advice. This used to be provided by prehabilitation but she thought the funding had now been withdrawn.		
8.	**Research**	**Update from Diletta Bianchini – via email to the group** • I would like though to express my serious concern about the lack of research staff that is adversely impacting on our ability not only to conduct clinical research but also to plan it. • Additionally, our routine clinical work is overwhelming and even if the point above was satisfied, I would not have the time to engage in a meaningful way into research planning and development. • I am currently on discussion with management in order to possibly change this at least from my end. • Every advice/opinion on the above is welcome. • The NIHR report highlights that: i) Prostate trial recruitment for the period of April 2022 to March 2023 was 245 participants. Nationally prostate cancer recruitment sits in 7th position out of 15 LCRNs. ii) Bladder trial recruitment for the period of April 2022 to March 2023 was 15 participants. Nationally bladder cancer recruitment sits in 10th position out of 15 LCRNs. • There was no renal or testicular trial recruitment for the period of April 2022 to March 2023.		
9.	**Cancer Alliance update**	**Update by Claire Mallett** **Due to time constraints please refer to the circulated presentation for the complete CA update`.**		**Presentation circulated to the group on 2nd May 2023**

		• CM provided an overview of the National Cancer Programme for 2023/24 which supports the various programmes of work. The priority areas for 2023/24 include: i) Faster Diagnosis and Operational Performance – to support Best Practice Timed Pathways including Prostate and other pathway improvements to support the 28-day FDS and 62-day backlog objectives ii) Early Diagnosis – to support local early diagnosis interventions including the prostate case finding project iii) Treatment and Care – Prostate patient portal – further details to follow. iv) Cross-Cutting – importance of patient feedback		
	Treatment Summaries	• No update provided.		
10.	**Prostate RMS & Portal**	**<u>Update by John Kyle</u>** • CM introduced JK and the InfoFlex team. CM explained the self-supported management work is a national requirement. They have been working closely with CIVICA to develop this work. The group is aware of the Governance issues encountered, Covid and NHSE Digital delays in setting up the patient portal. • JK explained the patient portal project was initiated about 3 years ago. • JK provided the group with a demo of the Prostate Patient Portal's design and patients will be able to log in from the internet. Access is available via PC / laptop / Mac / phone / tablet. Patients will be able to carry out the following: i) Use NHS Login to access – is now complete ii) Review PSA levels iii) Review the Macmillan eHNA iv) Fill out and review PROM questionnaires v) Message any concerns vi) View documents (Treatment Summaries initially)		**Presentation circulated to the group on 2nd May 2023**

		vii) View Patient Information - Cancer Care Map • The InfoFlex Patient Portal training will be delivered by the InfoFlex team (ekhuft.infoflexsupport@nhs.net) and will take place via Microsoft Teams on the following dates: *i)* Wednesday 10th May 2023 (09:30–10:30) *ii)* Friday 12th May 2023 (13:30–14:30) *iii)* Tuesday 16th May 2023 (09:30–10:30) *iv)* Thursday 18th May 2023 (13:30–14:30). • The PSA levels will not be automatically entered from their respective systems and will have to be input manually by the Support Workers. There was no timescale provided for the automation of this process. • HY raised his concern that this work had no clinician oversight and would be happy to offer his support. • The group agreed having automated resulting is a priority and this has been achieved for chemotherapy so they could not understand why this was not possible for PSA.		
11.	**CNS Updates**	**DVH** • New CNS in post. • A metastatic diagnosis service is in place. **EKHUFT** • Haematuria STT nurse is now in post. • Awaiting confirmation from the Cancer Alliance regarding the recruitment of a STT nurse. **MFT** • No update provided. **MTW** • A metastatic diagnosis service is in place.		

12.	**AOB**	• There were no further comments raised under AOB. • SMa apologised for the over running of today's meeting but felt it had been a very productive meeting. He thanked the group for their attendance and contribution.		
	Next Meeting Date	• **Thursday 12th October 2023 – venue TBC.**		**KG to circulate meeting invites.**