Kent and Medway Cancer Collaborative

Urology Tumour Site Specific Group meeting
Thursday 10th October 2024
Mercure (Great Danes) Hotel, Maidstone
09:00 – 12:30
Final Meeting Notes

Present	Initials	Title	Organisation
Sanjeev Madaan **(Chair)**	**SM**	Consultant Urological Surgeon	DVH
Anca Gherman	**AG**	Macmillan Uro-Oncology CNS	DVH
Fay Fawke	**FF**	Deputy Lead Cancer Nurse / Lead Macmillan Uro-Oncology CNS	DVH
Elaine Ritchie	**ER**	Macmillan Uro-Oncology CNS	DVH
Philippa Cooper	**PC**	Uro-Oncology CNS	DVH
Jayasimha Abbaraju	**AJ**	Consultant Urological Surgeon	DVH
Desmond Owusu	**DO**	Consultant Radiologist	DVH
Adeyinka Pratt	**AP**	Cancer MDM Streamlining Project Manager	DVH
Thom Cowin	**TC**	Urology and Vascular General Manager	EKHUFT
Milan Thomas	**MT**	Consultant Urological Surgeon	EKHUFT
Sarah Hyams	**SH**	Urology MDT Coordinator	EKHUFT
David Stafford	**DS**	Lead Nurse –Uro-Oncology	EKHUFT
Vicki Hatcher	**VH**	Head of Nursing - FDS	EKHUFT
Ruth Mount	**RM**	Improvement Practitioner	EKHUFT
Pippa Enticknap	**PE**	Deputy General Manager	EKHUFT
Ritchie Chalmers	**RC**	Medical Director	KMCA
Karen Glass **(Minutes)**	**KG**	PA / Business Support Manager	KMCA & KMCC
Jonathan Bryant	**JB**	Primary Care Clinical Lead	KMCA / NHS Kent & Medway ICB
Emma Forster	**EF**	Head of Service Improvement	KMCA / NHS Kent & Medway ICB
Claire Mallett	**CM**	Programme Lead – Personalised Care & Support	KMCA / NHS Kent & Medway ICB
Bana Haddad	**BH**	Clinical Lead for Personalised Care & Support (LWBC)	KMCA / NHS Kent & Medway ICB
Sharon Middleton	**SMi**	Workforce Lead	KMCA / NHS Kent & Medway ICB
Annette Wiltshire	**AWilt**	Service Improvement Lead	KMCC
Colin Chamberlain	**CC**	Administration & Support Officer	KMCC
Sam Williams	**SW**	Administration & Support Officer	KMCC

Roberto Laza Cagigas	**RLC**	Operations Lead - Senior Exercise Physiologist	Kent & Medway Prehab
Tahir Bhat	**TB**	Consultant Urologist	MFT
Claire Blackman	**CB**	Macmillan Urology CNS	MFT
Kelly McGowan	**KMc**	Cancer Support Worker	MFT
Hazel Samson	**HS**	Cancer Support Worker	MFT
Faisal Ghumman	**FG**	Consultant Urological Surgeon	MFT
Suzanne Bodkin	**SB**	Service Manager	MFT
Patryk Brulinski	**PB**	Consultant Clinical Oncologist	MTW / KOC
Alastair Henderson	**AH**	Consultant Urologist	MTW
Jodie Hotine	**JH**	Lead Radiotherapy Research Radiographer	MTW
Jennifer Pang	**JP**	Clinical Oncologist	MTW
Hide Yamamoto	**HY**	Consultant Urological Surgeon	MTW
Alison Richards	**AR**	Lead Uro-oncology Research Nurse	MTW
Rakesh Raman	**RR**	Consultant Clinical Oncologist	MTW
Debbie Webber	**DW**	Research Practitioner	MTW
Min Zhang	**MZ**	Uro-Oncology CNS	MTW
Claudia Simon	**CS**	Uro-Oncology CNS	MTW
Alison Watkins	**AW**	Faster Diagnosis Service Team Lead	MTW
Kathryn Lees	**KL**	Consultant Clinical Oncologist	MTW
Amit Goel	**AG**	Consultant Histopathologist	MTW
Shona Sinha	**SS**	Consultant Histopathologist	MTW
Verity Roberts	**VR**	Research Radiographer	MTW
Alecia Bell	**AB**	Clinical Trial Coordinator	MTW
Eleanor Pitman	**EP**	Clinical Trial Coordinator	MTW
Adele Cooper	**AC**	Urology /Oncology Clinical Nurse Specialist	MTW
Brian Murphy	**BM**	**Patient Partner**	
Apologies			
Suraj Menon	**SMe**	Consultant Radiologist	DVH
Jane Blofield	**JB**	Macmillan Urology Oncology Clinical Nurse Specialist	EKHUFT
Sashi Kommu	**SK**	Consultant Urological Surgeon & Cancer Lead	EKHUFT
Jemma Hale	**JH**	Consultant Urological Surgeon	EKHUFT
Shikohe Masood	**SMas**	Consultant Urological Surgeon	MFT
Nicola Cooper	**NC**	Divisional Director of Operations	MFT

Carys Thomas	**CT**	Consultant Clinical Oncologist	MTW
Sarah Aylett	**SA**	Macmillan Uro-oncology CNS	MTW
Diletta Bianchini	**DB**	Consultant Medical Oncologist	MTW

Item		Discussion	Agreed	Action
1.	**TSSG Meeting**	**Apologies** • The formal apologies are listed above. **Introductions** • SM welcomed the members to today's face to face meeting. • 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 Tuesday 23rd April 2024 were reviewed and accepted as a true and accurate record. **Urology CRG update** • SM confirmed the Clinical Reference Group (CRG) has now been created for the Urology TSSG and includes the following members: i) **Surgical Lead** – Hide Yamomoto		

		ii) **Radiology** – Desmond Owusu iii) **Pathology** – Amit Goel iv) **Nursing** – Morna Jones v) **Oncology** – NOG Chair – Carys Thomas (**TBC**) vi) **Primary Care** – Jonathan Bryant • SM acknowledged the Pathway of Care Leads will now be: **i)** **Bladder** – Tahir Bhat **ii)** **Prostate** – Hide Yamamoto **iii)** **Kidney** – Milan Thomas • SM explained the CRG will help support the TSSG with periodic meetings taking place between the TSSG meetings. • RC stated the importance of embedding a Primary Care representative within the CRG.		
2.	**Increasing engagement with black communities to increase awareness of Prostate Cancer**	**<u>Update provided by Kathryn Lees</u>** • KL outlined the following statistics: i) 1 in 8 men will be diagnosed with prostate cancer in their life time. ii) 1 in 4 black men will be diagnosed in their life time – there is a higher incidence but not mortality in black men when diagnosed at the same stage as white men. iii) Men with a first degree relative diagnosed with prostate cancer are 2 and a half times more likely to be diagnosed themselves than average. iv) Men living in socio-economic communities are 29% more likely to be diagnosed with advanced disease. • The NHSE report published in 2021 aimed at reducing healthcare inequalities. This report highlighted key clinical areas of health inequalities including: i) Maternity		**Slides circulated to the group on the 10th October 2024**

		ii) Severe Mental Illness iii) Chronic Respiratory Disease iv) Early Cancer Diagnosis v) Hypertension Case-finding vi) Smoking cessation • PSA screening tends to be patient driven and is more likely to be mainly middle-class white men. • KL provided an overview of the TRANSFORM study which was launched in November 2023 with recruitment starting in 2025. This includes a combination of fast MRI scans, genetic testing and PSA blood testing. Men with a higher risk of prostate cancer due to their age / ethnicity will be recruited through their GP practice and invited to a screening visit. The aim is for 1 in 10 participants to be black. • To tackle inequalities in the short term they plan too: i) Raise awareness in the at-risk populations. ii) Outreach programmes into communities at high risk to increase awareness of Prostate Cancer and their risk. • One such programme includes the 'Barbers Against Prostate Cancer' which was founded by Mark Rayment who was diagnosed with prostate cancer in 2022. https://barbersagainstprostatecancer.com/ • The aim is to engage with: i) Barber shops across West Kent targeting areas with a higher black population – such as Dartford and Medway. ii) Local prostate cancer support groups and Metastatic Nurse specialists iii) GP practices and Urology departments. • There are also AI innovative trials available which KMCA are keen to support.		

3.	**MDT Streamlining** **SOP**	**<u>Update provided by Adeyinka Pratt</u>** • AP provided an update from the last TSSG meeting and recapped on the MDM streamlining aims: i) To ensure sufficient time for discussing cases where it is most necessary. ii) To optimise the utilisation of clinical time for maximum effectiveness. iii) To enhance the clarity of decisions and promote greater consistency in care. • AP outlined the details of the Urology MDM including the challenges they faced before streamlining and the successes after. • Key challenges and recommendations: i) **Single point of failure** – include Pre-MDM in job plans ii) **Reporting delays** – more collaborative approach by cancer services and the reporting team iii) **MDT to MDT referrals** – complete all the details required in the pro-forma • SM mentioned there is currently only one consultant (at DVH) available to do the pre-MDM which has had an impact. This needs to be built into their job planning. • MDT Streamlining has been effective for DVH but needs collaboration from all specialities including the admin team. Their pre-MDM consists of 1 x MDT Co-ordinator, 1 x CNS and 1 x Consultant. • AP asked the following questions of the other 3 trusts: i) Have you implemented streamlining for your MDTs? ii) Are you finishing MDT meetings in a timely manner and are cases rolled over to future meetings? iii) Is there adequate time for discussion of individual cases where it is needed, allowing for focus on complex cases in the MDT?		**Slides circulated to the group on the 10th October 2024**

		• HY referred to inappropriate / incomplete referrals – by using the electronic referral system and completing the mandatory fields this will ensure the correct patients go to their MDM. They now discuss 35 - 40 cases per week at their MDM which has reduced from 50. • MT mentioned they have 2 cancer leads and triage their cases effectively. Previously they would have discussed 100 cases at their MDM and this has now reduced to about 50. They streamline but in a different way to DVH. • RC recommended taking cases out of the MDT discussion where there is not enough quality information and patients have a standard of care in place. RC alluded to Professor Martin Gore's MDT model. https://www.england.nhs.uk/south/wp-content/uploads/sites/6/2018/10/Transforming-MDTM-Martin-Gore-August-2017.pdf **Standard Operating Procedure – Cancer Services – Urology MDM Streamlining – update provided by Sanjeev Madaan** • SM navigated through the SOP document which has been previously circulated to the members. There has been no additional feedback provided. • RC recommended that the Cancer Alliance would like all trusts and tumour sites to incorporate streamlining within their MDT's to reduce inappropriate discussions, clinician time and length of MDT's.		
4.	**Dashboard** **Treatment Variation**	**Dashboard update - provided by Sanjeev Madaan** • SM highlighted that Urology FDS position has improved from 56.3% to 70.4% in the last 6 months and K&M are now ranked 2nd nationally. In terms of 62-day performance they are 5th nationally at 66.4% compared to the national average of 58.3%. • Overall, EKHUFT's performance has improved over the last 6-months but they are still lower		**Slides circulated to the group on the 10th October 2024**

		than the other trusts. This improvement is due to the implementation of STT nurses and their FDS performance is now 70% compared to 47.1%. • The dashboard has been welcomed by the group and proved to be very useful. David (Osborne) is keen for the dashboard to be widely used, be clinically effective and noted additional metrics can be added as required. Oncology data is due to be added in due course. • TB asked if the pathology delays data could be added to the dashboard. RC explained this detail will be available when LIMS goes live. **Action – Karen to recirculate the log on details for those who are yet to access the dashboard (action completed after the meeting).** **<u>KMCA Treatment Variation Programme – Prostate Cancer – provided by Emma Forster</u>** • EF highlighted the reason for change: i) Unwarranted variation in treatment can have a negative impact on the quality of care and outcomes for patients. ii) To ensure access to best practice / timeliness of treatment for multimodal pathways/ iii) Can lead to the efficacy of treatment pathways and in some cases tumour progression. iv) The national team have released metrics on treatment variations for collection and monitoring through quarterly planning returns. The outcomes of GIRFT visits and national cancer audits have informed these national requests. • The National Prostate Cancer Audit (published January 2024) found that nationally 69% of men diagnosed with high-risk / locally advanced prostate cancer were found to have undergone some form of radical local therapy within 12-months of diagnosis. Therefore, 31% (1 in 3 men) were potentially being under treated. This variation is after adjustment for age and comorbidity.		**KG - completed**

		• K&M is slightly below the national average (West Kent MDT – 66% and East Kent MDT – 68%). • It was noted the PSA score for data completeness was still low. Therefore, it is important the data is recorded in the correct InfoFlex field for auditing purposes. • AH expressed his dislike of InfoFlex and found it a poor system to use. **Action – Ritchie and Emma agreed to take the issue with InfoFlex offline and glitches in putting the data in the correct fields. Additional, training may be required with the InfoFlex team.** • KL referred to the age demographic of their patients and under treating older patients with locally advanced diseases. KL has 6-months data she would be happy to present. **Action – Emma to pick this action up with Kathryn and the MDT Leads to present the data at the next meeting.** • EF asked if they are doing enough to ensure patients are sufficiently informed to be able to make the right choice.		**RC / EF** **EF / KL**
5.	**Improving efficiencies of processing prostate core biopsies** **Validation of digital pathology across the KMPN network**	**<u>Update provided by Amit Goel</u>** • AG explained that needle core biopsies are used to minimize patient discomfort whilst still retrieving the essential information required. AG outlined the challenges in getting this information. • Pre-cassetted cores tend to come mainly from MTW. Pre-cassetted in a sponge is the best way forward and procedurally is much quicker. • AG highlighted the preferred order for LATP / GATP biopsies which would save 150 hours of laboratory time for their staff: **i) L anterior**		**Slides circulated to the group on the 10th October 2024**

		ii) L mid **iii) L posterior** **iv) L target** **v) R anterior** **vi) R mid** **vii) R posterior** **viii) R target** **<u>Digital Pathology Benefits and Go Live Impact – update provided by Shona Sinha</u>** • SS outlined the benefits of launching Digital Pathology and the impact this will have on the pathology service when it goes live. • The Laboratory Information Management System (LIMS) is the software used in K&M which allows the effective management of pathology testing and reporting. • SS explained the difference between analog and digital workflow in pathology. It was noted that within Cytology they will still use a microscope for tissue specimens. AG mentioned 5 departments nationally have gone completely digital and are no longer using a microscope. • SS highlighted the benefits of digital pathology in terms of: i) Efficiencies and Improved Workflow ii) Improved Workforce Factors and Collaboration iii) Improved Patient Safety iv) Evolving Technology / Research & Development Opportunities • The initial implementation impact and mitigation includes: i) System training will be provided by the supplier with ongoing support from the Kent & Medway Pathology Network team. ii) Each pathologist will need to verify their digital reporting against their analogue reporting to ensure clinical care level continuity. iii) This will impact the rate of reporting for the duration of verification which will vary		

		for each pathologist for an estimated period of 1-3 months. No more than five pathologists will be validating at one time. iv) The digital pathology project has accessible funding to utilise other resources during the validation phases. v) Removing patients from cancer pathways when endoscopic findings are normal / benign will help alleviate the pressure and allow pathologists to concentrate on cases of significant clinical significance. • SS mentioned there is extra funding in place to recruit locums to help during the validation phase. • SS referred to different AI platforms which can help report biopsies quicker. • Genomics platforms are still in place and samples should still be sent to the GLH.		
6.	**Clinical Pathway updates** **Bladder – including Synergo RITE service in K&M** **Renal** **Prostate**	**<u>Bladder Clinical Pathway – update provided by Tahir Bhat</u>** • TB explained not all bladder cases are discussed at the West Kent MDM. • All patients having radical treatment should be seen by a medical / clinical oncologist in order to discuss bladder preservation. • Patients waiting for Neoadjuvant treatment at DVH and MTW will be seen in the bladder clinic. • AH referred to the COBRA study which is due to open next summer and would be worth considering for K&M. • The primary treatment should be surgery. Cystectomy is the standard care and a CT scan is advised before a cystectomy. • EKHUFT refer their cystectomy cases to MFT. However, MFT have no access to the histology results just imaging. It was agreed to discuss this issue offline with the newly formed CRG.		

		• SM mentioned DVH currently offer the Synergo RITE service – for the treatment of non-muscle invasive bladder cancer. DVH have completed 105 cases to date – 30% are DVH patients with 70% coming from other trusts. This service is under threat due to funding and could potentially cease in 6-12 months' time. This has been raised previously with the Cancer Alliance. **<u>Renal Clinical Pathway – update provided by Milan Thomas</u>** • 1.0 - Advice for Primary Care no change other than refer Urology based on NICE guidance. • 2.0 - Renal Cancer Pathway – no need to change. EKHUFT have a local and specialist MDT in place. • No change to Upper Urinary Tract Transitional Cell Carcinoma – 12-week window as high-risk. • MFT do not have an on-site dialysis unit. • Updated Renal NICE guidance to be published. • Targeted and immunotherapy drugs such as adjuvant pembrolizumab can help some people with advanced kidney cancer however there is a risk of some side effects. These treatments are unlikely to cure the cancer but may help control it and help some people live longer. • MT explained the current treatment pathway is very much West Kent orientated and they need to consider the limitations of this service. • **Prostate Clinical Pathway – was not discussed at today's meeting.**		**Slides circulated to the group on the 10th October 2024**
7.	**Research update**	**<u>DVH – update</u>** • Trials that are open or planned for opening include:		

		- IP7-PACIFIC - IP9-ATLAS - TAPS02 - EASE **<u>EKHUFT – update</u>** • Radiotherapy staffing issues. • STAMPEDE – due to open. • Had TRANSLATE and PART. • Recruited for PARTIAL. • Systemic trials are limited. **<u>MTW – update</u>** • PIVOTAL-BOOST - closed. • PACE-C - closed. • TRANSLATE - closed • PACE-NODES - open. • PEARLS – to open • STAMPEDE-2 – to open • TRANSFORM study – just opened. • Systemic trials – have had workforce issues so this has been limited. • EOI have been sent for ABLE-32 and COBRA. **No update provided by MFT.**		
8.	**Prehabilitation**	**<u>Multimodal Prehabilitation in the Community – update provided by Roberto Laza Cagigas</u>** • RLC explained this is a free service provided for K&M patients who have been newly		**Presentation circulated to the group on the 10th**

		diagnosed with cancer. They take a multimodal approach in terms of targeting physical activity, nutrition and psychological support. • The programme lasts for a maximum of 8-weeks which can be split into prehab and rehab. Patients can be referred at any time however the earlier the better. • The Multidisciplinary team consists of: i) Anaesthetist ii) Nutritionist iii) Therapist iv) Physiotherapist v) Exercise Physiologist vi) Sport Scientist • There are 3 methods of referral: i) Online form – https://www.questprehab.com ii) InfoFlex iii) Self-referral • HY expressed his support for this excellent service.		**October 2024**
9.	**CNS Update**	• **EKHUFT** – The STT CNS service has been expanded. • **MTW** – More CNS support is needed in Oncology and they only have 1 x metastatic CNS. **SM is happy to support this.** • **No further update provided by MFT or DVH.**		
10.	**AOB**	• MT highlighted that EKHUFT have capacity issues and are struggling to deliver the 62-day pathway due to only having 2 cancer surgeons. A network solution is required – in order for		

		the specific skills of the surgeons to be shared across trusts. • RC mentioned a conversation she had with Matin Sheriff regarding a K&M Cancer Network Centre which would have sites in East and West Kent. An honorary contract passport is needed so that surgeons are employed by the ICB rather than the trusts. **Action – It was agreed to set up a separate Whatsapp meeting for the Urology cancer surgeons to discuss strategies in order for them to support each other.**		**Cancer Surgeons / Sanjeev Madaan**
11.	**Next Meeting Date**	• **Thursday 24th April 2025 AM - venue TBC** • **Tuesday 14th October 2025 AM – venue TBC**		**KG to circulate meeting invites shortly**