Kent and Medway Cancer Collaborative

Urology Tumour Site Specific Group meeting
Tuesday 23rd April 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
Michelle McCann	**MMC**	General Manager for Cancer (interim)	DVH
Jayasimha Abbaraju	**JA**	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
Adeyinka Pratt	**AP**	MDM Streamlining Project Manager	DVH
Srijit Banerjee	**SB**	Consultant Urologist	DVH
Nicky Lancaster	**NK**	Macmillan Metastatic Oncology CNS	DVH
Elaine Ritchie	**ER**	Macmillan Uro-oncology CNS	DVH
Philippa Cooper	**PC**	Urology Oncology CNS	DVH
Tolga Senel	**TS**	**Guest speaker** – Business Development Officer	Crossroads / Macmillan
Nicki Perry	**NP**	**Guest Speaker** - Clinical Lead GP – West Kent	NHS Kent & Medway ICB
Sashi Kommu	**SK**	Consultant Urological Surgeon & Cancer Lead	EKHUFT
Milan Thomas	**MT**	Consultant Urological Surgeon	EKHUFT
David Stafford	**DS**	Urology CNS	EKHUFT
Morna Jones	**MJ**	Urology Nurse Consultant	EKHUFT
Vicki Hatcher	**VH**	Clinical Lead for FDS	EKHUFT
Naomi Webb	**NW**	General Manager - Urology	EKHUFT
Alexis Warman	**AW**	COO Programme Director	EKHUFT
Rustam Karanjia	**RK**	Urology Specialist Registrar	EKHUFT
Emma Forster	**EF**	Head of Service Improvement	KMCA / NHS Kent & Medway ICB
Serena Gilbert	**SG**	Performance Manager	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 (LWBC)	KMCA / NHS Kent & Medway ICB
Linda Caine	**LC**	Associate Director ECT	KMCA / NHS Kent & Medway ICB

Karen Glass **(Minutes)**	**KG**	PA / Business Support Manager	KMCA & KMCC
Annette Wiltshire	**AWilt**	Service Improvement Lead	KMCC
Colin Chamberlain	**CC**	Administration & Support Officer	KMCC
Sam Williams	**SW**	Administration & Support Officer	KMCC
Matt Hine	**MH**	InfoFlex Application Manager	KMCC
Ashley Wilson	**AWils**	InfoFlex Project Manager	KMCC
Louise Black	**LB**	Macmillan Deputy Lead Cancer Nurse	MFT
Tahir Bhat	**TB**	Consultant Urologist	MFT
Mandeep Badyal	**MB**	Research Nurse	MFT
Gayzel Vallejera	**GV**	Research Nurse	MFT
Bakani Moyo	**BM**	Straight to Test Nurse	MFT
Claire Blackman	**CB**	Macmillan Urology CNS	MFT
Emily Hollands	**EH**	Cancer Team Lead	MFT
Elaine Best	**EB**	Cancer Patient Navigator	MFT
Penny Ashby	**PA**	Cancer Operational Co-ordinator and Team Lead for Urology	MFT
Hazel Samson	**HS**	Cancer Support Worker	MFT
Faisal Ghumman	**FG**	Consultant Urological Surgeon	MFT
Patryk Brulinski	**PB**	Consultant Clinical Oncologist	MTW / KOC
Diletta Bianchini	**DB**	Consultant Medical Oncologist	MTW
Alastair Henderson	**AH**	Consultant Urologist	MTW
Henry Taylor	**HT**	Consultant Clinical Oncologist	MTW
Hide Yamamoto	**HY**	Consultant Urological Surgeon	MTW
Summer Herron	**SH**	General Manager Cancer Performance	MTW
Hazel Spencer	**HS**	MDT Co-ordinator	MTW
Alison Richards	**AR**	Lead Uro-oncology Research Nurse	MTW
Jeanette Smith	**JS**	Metastatic Prostate CNS	MTW
Debbie Webber	**DW**	Clinical Trials Coordinator	MTW
Iveta Los	**IL**	Clinical Trials Coordinator	MTW
Alison Watkins	**AW**	Faster Diagnosis Team Lead	MTW
Katherine Pidwell	**KP**	Faster Diagnosis Specialist Nurse	MTW
Amit Goel	**AG**	Consultant Histopathologist	MTW
Pavnish Rai	**PR**	Research Radiographer	MTW
Verity Roberts	**VR**	Research Radiographer	MTW

Brian Murphy	**BM**	**Patient Partner**	
Apologies			
Jane Blofield	**JB**	Macmillan Urology Oncology Clinical Nurse Specialist	EKHUFT
Edward Streeter	**ES**	Consultant Urologist	EKHUFT
Ritchie Chalmers	**RC**	Medical Director	KMCA
Jonathan Bryant	**JB**	Primary Care Clinical Lead	KMCA / NHS Kent & Medway ICB
Shikohe Masood	**SMas**	Consultant Urological Surgeon	MFT
Suzanne Bodkin	**SB**	Cancer Service Manager	MFT
Jennifer Pang	**JP**	Clinical Oncologist	MTW
Adele Cooper	**AC**	Urology /Oncology Clinical Nurse Specialist	MTW

Item		**Discussion**	**Agreed**	**Action**
1.	**TSSG Meeting**	**Apologies** • The formal apologies are listed above. **Introductions** • SM 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 12th October 2023 were reviewed and accepted as a true and accurate record.		

2.	**Metachronous Oligometastatic SABR in Uro-Oncology**	**<u>SABR – Oligo-Metastatic Cancer – update provided by Patryk Brulinski</u>** • PB explained this service started 2 years ago and he outlined the benefits of SABR (Stereotactic Ablative Body Radiotherapy): i) Local Disease Control ii) Delay the need for SACT (Systemic Anti-Cancer Therapy) iii) Prolong Progression Free Survival iv) Improve Overall Survival v) Improve Quality of Life • SABR-COMET – a randomized phase II trial which has shown improved survival rates. • PB highlighted the inclusion and exclusion criteria for patients eligible to be treated with SABR. • Within the South East Radiotherapy Operational Delivery Network (serving a population of 3.7 million) there are two SABR MDT's: i) **GSTT** – Lung, Spine, Bone, LNs, Liver, Adrenals ii) **Kent Oncology Centre – MTW** – Lung, Spine, Bone, LNs and Liver & Adrenals in development. • There are currently 2 K&M SABR radiographers – one at MTW and one at KCH. • PB explained approximately 100 patients are discussed at the MDT per year, they are small numbers but are complex patients. • PB presented 3 separate patient studies using SABR / outcomes of using high ablative doses of radiotherapy. PB explained there is a good follow-up process in place for patients. The use of SABR is cheap compared to years of having systemic therapy. SABR has no bad side effects and tends to be well tolerated by patients. • They have treated approximately 100 patients so far and teamwork is paramount to run this		**Presentation was circulated to the group on the 24th April 2024**

		service. They will also be looking into treating liver and adrenal metastases in the future. • STAMPEDE2 is due to open imminently which is a clinical trial for men with prostate cancer which has spread to other parts of their body.		
3.	**MDT Streamlining – DVH early experience**	**<u>Cancer MDM Streamlining: Case Study of Urology MDT at DVH – update provided by Adeyinka Pratt</u>** • The Urology MDM streamlining pilot at DVH started in January 2024. This is considered the gold standard approach to improve the management of cancer patients. • AP explained the number of patients discussed at their MDM had increased due to patient's comorbidities, an ageing population and growing number of treatment options available. Their MDT meetings were lasting for several hours and as such had limited time to discuss each patient. • MDM Streamlining allows: i) Sufficient time for discussing the more complex cases. ii) Optimising the clinical time for maximum effectiveness. iii) To enhance the clarity of decisions and promote greater consistency in care. • AP outlined the approach they have taken at DVH, comparing the data before and after streamlining. • MDT case lists are split into two sections – the first section is for cases that require full MDT discussion and a treatment plan. The second section is for cases that have been streamlined. The Pre-MDT takes place on a Wednesday from 10:00 – 11:30 with the main MDT taking place on a Friday from 10:00 and finishes earlier than previously. • The pre-MDM team consists of a Consultant Urologist, Cancer Nurse Specialist and MDM Co-ordinator. • AP outlined the benefits of streamlining including:		**Presentation was circulated to the group on the 24th April 2024**

		i) Improved discussions, particularly concerning complex patients who will gain most from having comprehensive MDT input. ii) Better focus of MDT time. iii) Live data capture. iv) Outcomes from a pre-MDT is clearly communicated to the whole MDT team efficiently – there are no missed cases. v) One working document – agreed Standard of Care which is incorporated into the Standard Operating Procedure. • SM explained this has improved the quality of their discussions. The live data is captured in a realistic way with full oversight provided. SM mentioned an ongoing issue with job plans and providing cover. • AH suggested they stopped recycling those patients who were not ready to be discussed at the MDM and for those patient outcomes to be recorded on InfoFlex. • SM thought it was important for EKHUFT to streamline their MDM due to the much larger volume of patients they have compared to the other K&M trusts. • SG suggested having an MDM streamlining SoC / SoP which would be relevant for the whole of Kent & Medway and this could be presented back to the Cancer Alliance. **Action – SM agreed for DVH's SoC / SoP to be circulated out to the group and this could act as a template to be modified locally.**		**AP / SM**
4.	**Performance data discussions** **GIRFT Urology Model Hospital data**	**<u>Performance data update provided by Sanjeev Madaan</u>** • SM noted K&M's FDS performance had gone down and was 56.3% which is just above the England average. K&M's 62-day performance is above the England average at 67.8% and are ranked 3rd in the country. Additionally, their urgent suspected cancer backlog is one of the best in the country at 7.8%. • SM mentioned in terms of FDS performance MFT (91.1%) and DGT (82.2%) are doing really well		**Performance slides and GIRFT data were circulated on the 24th April 2024**

		and are way above the national target of 70%. MTW are performing just below the national average at 68.9% with EKHUFT struggling at 27.9%. SM stated they need to be working collaboratively to improve these targets for the benefit of K&M Cancer Alliance as a whole. • MJ suggested GP's completed the USS in the community and then send in the referral together with the completed report. This would give them the information to be able to discharge patients from the cancer pathway as appropriate. **<u>GIRFT Urology Model Hospital data – presentation provided by Sanjeev Madaan</u>** • SM referred to the number of TURBT procedures performed across the 4 trusts. He noted that EKHUFT were doing well with regards to TURBT procedures carried out within 62-days of diagnosis and cancers were not being delayed. • The average length of stay for TURBT varied across the trusts from 0.7 days at MFT – 2.1 days at DGT. • There is no cystectomy service carried out at DGT and MFT with limited numbers taking place at EKHUFT. **Action – SM suggested an audit is carried out by MFT regarding the length of stay for patients having a radical prostatectomy being 4.7 days compared to 1.3 days at EKHUFT (reason could be due to SMART).**		**MFT**
5.	**Clinical Pathway Discussions** **Snapshot update of GIRFT Prostate pathway** **Haematuria pathway**	**<u>Proposal for inclusion of reported USS embedded into the Rapid Access Haematuria referral form – provided by Sashi Kommu</u>** **Urgent – proposal to the TSSG for Haematuria Pathway GP referral with ultrasound reported** • SK outlined the huge increase (174%) in cancer referrals in the last year and at EKHUFT they are struggling to cope with the increased demand. • An estimated 80% of their referrals have had an USS in the community. They would like all		**Presentations circulated to the group on the 24th April 2024.**

	consensus points **Bladder POC**	referrals to come in with a minimum dataset of an USS report attached. • Patients are not receiving their results within the optimal time which is overwhelming and having an overall detrimental impact on K&M performance targets. • **Proposal** - would be to return any referrals to GP's that have no USS report attached. Surgeries with no access to Ultrasound will be granted support. • The clock would then start at the time of the USS being sent into SC by the GP. • BH highlighted the variation across West and East Kent in terms of USS's taking place within the community. It is important that the LMC (Local Medical Committee) and NHS Kent & Medway ICB are involved in any decision making. • MFT have a One Stop Clinic in place with a STT nurse for haematuria patients and this is working well. They do not carry out USS but do CT scans within 7-days. • NP is looking to optimise GP referrals and they will be releasing Urology pathways shortly. The new EROS referral system for GP's should make this much easier with less chance of having inappropriate referrals. • MT asked if there was any benefit of PC doing USS if they are not being reported. • AH suggested having FDS nurses at the beginning of the pathway would help triage patients at EKHUFT and weed out inappropriate referrals. MTW have 4 pathways in place with only 1 going to CT – they were happy to share these pathways. • SM concluded there would need to be further discussions if they decide to change the NG12 form as they would be going against NICE guidance. They cannot have 2 separate NG12 forms for East and West Kent. It will not be easy to do this and will take time. There would also need to be a full discussion with NHS Kent & Medway ICB / Kent & Medway Cancer Alliance. • SM suggested an audit of patients if they want to change the national standard and this will take time to collate.		

		• **In conclusion – it was agreed this proposal could not be signed off today by the TSSG clinical group.** **<u>Prostate Pathway of Care – update provided by Sashi Kommu</u>** • SK confirmed this is an evolving document and still currently in DRAFT. • SK navigated through some of the suggested changes made. **<u>Bladder Pathway of Care – update provided by Tahir Bhat</u>** • TB suggested this PoC was kept out of the local pathway and that selected cases are discussed within the MDT. • It was agreed the landscape is changing in terms of the drugs being used for both muscle and non-muscle invasive bladder cancer. **Action – KG to circulate the Prostate and Bladder PoC documents to the group for comments with a deadline of feedback by COP Tuesday 7th May 2024.**		**KG (action completed)**
6.	**Staging investigations for G4+3 prostate cancer – time to change guidelines**	**<u>Presentation provided by Rustam Karanjia</u>** • RK asked if CT and bone scans are useful for staging patients with intermediate risk Gleason 4+3 prostate cancer. If low risk they do not stage and if high risk they do. • In terms of abdominopelvic staging for prostate cancer, CT is a poor detector of prostate cancer lymphadenopathy - less than 2% is in ISUP Grade <4. • In two studies, a dominant Gleason pattern of 4 was found to be a significant predictor of positive bone scan. Bone scanning should be performed in symptomatic patients, independent of the PSA level. • The aim of EKHUFT's 4-year audit period included:		**Presentation circulated to the group on the 24th April 2024.**

		i) Determine detection rate of metastatic disease in intermediate risk Gleason 4+3 prostate cancer using: ○ Bone scan. ○ CT scan. ii) Identify the proportion of fully staged RALP patients with missed metastatic disease. • There were 169 patients identified, with 134 patients analysed – using inclusion and exclusion criteria. • Summary of the findings included: i) 0/124 (0%) positive bone scans for ISUP 3 intermediate risk ii) 3/83 (4%) positive CT scans: one already known from MRI and two borderline enlarged nodes only iii) Positive LND's / BCR despite negative staging. • RK concluded: i) Detection of metastases using CT and bone scan is poor, despite their presence in this cohort. **ii)** Staging could be avoided in this group (low detection rates, prevents pathway delay, theoretical benefit of treating despite oligometastatic disease and PSMA PET not yet validated). • SM suggested the guidance should not be changed at this stage until a bigger audit of findings and results have been collated over a four-year period.		
7.	**EROS pathways**	**<u>EROS referral system – presentation provided by Nicki Perry</u>** • NP explained the advantages of the new EROS system including:		**Presentation circulated to the group on the 24th April**

		i) Reduce referral rejections and optimize referrals into Secondary Care ii) Right place first time (better patient experience) iii) Reduce the myriad of referral forms iv) Up to date guidelines v) Easy access to patient information – relevant to the referral • They have started with MSK and ENT waiting lists and will move onto Gynae, Urology, General Surgery, Dermatology and Gastro. • NP highlighted there have been some software glitches but staff within the digital group meet regularly to resolve these issues. • Helpline email - kmicb.eros@nhs.net is manned 5 days a week. • The Urology pathway has been adapted from the pilot which took place at Northwick Park and worked well. There is a huge governance process in place including specialty group involvement (PC, SC, LMC and patient groups) with end to end testing to ensure patients go to the right clinics. • NP asked for the groups help to improve their Delivery of Service which will in turn direct patients to the right group.		**2024**
8.	**Case series on MRI fusion biopsy at DVH**	**Outcome of Ultrasound-MRI fusion prostate biopsies – presentation provided by Srijit Banerjee** • SB acknowledged and thanked his colleagues at DVH and Royal Marsden for their support. • SB highlighted the background for this work: i) Prostate biopsies were previously done using cognitive US/MRI fusion. ii) Since March 2023 – DVH switched to software fusion biopsies using the Trinity Koelis system for elastic fusion. KOELIS Trinity® MRI TPUS Biopsy System | KOELIS iii) Standard systematic as well as targeted biopsies are done using the trans-perineal approach.		**Presentation circulated to the group on the 24th April 2024**

		• EAU guidelines recommend carrying out the MRI before a prostate biopsy. • SB compared MRI / US fusion biopsy and if it was an accurate diagnostic tool – data was compared between DVH and RMH and was very similar. • In conclusion: i) MRI fusion biopsy seems to be promising technology with a short learning curve. ii) It has the potential of fusion with multiple platforms such as MRI (T2/DWI) as well as PET or CT. iii) DVH detected more clinically significant CaP with lesser number of cores (15 vs 24). iv) There is good grade concordance with final RALP specimen (70-76%). v) Await outcomes from the PACIFIC trial. • 11 Centre's nationally are using this platform. • MT mentioned in Germany they are moving to more targeted biopsies and MRI is improving. • SM confirmed at DVH they have reduced the number of biopsies and increased the number of targeted biopsies carried out. Depending on nursing support they are able to carry out on average 8 biopsy cases per day and this could increase in due course.		
9.	**Research update**	**<u>Update provided by Diletta Bianchini</u>** • DB highlighted the importance of the teams working collaboratively together to increase the uptake of clinical trials for their patients. • Each trust outlined the trials which were open to recruitment or in the set-up phase. **<u>DVH</u>** i) IP2-ATLANTA, BARCODE 2 and EASE - open to recruitment. ii) IP7-PACIFIC and TAPS02 – newly open to recruitment.		**Presentation circulated to the group on the 24th April 2024**

		iii) IP-ATLAS – being set up. **EKHUFT** i) PART and PARTIAL – open to recruitment. ii) CEPER and IMAROP – in submission **MFT** i) PARADIGM-E is open to recruitment. ii) PACIFIC, COBRA and STAMPEDE-2 – being set up. **MTW** i) PACE NODES and PIVOTAL BOOST - open to recruitment. ii) PEARLS, STAMPEDE-2, DURAVELO-2, POINTER, EQUATOR and STAR-TRAP – being set up. • DB highlighted the following issues: i) Shortage of staff ii) Research nurses (RT at EKHUFT and MTW) iii) Pharmacy – Aseptic Unit at MTW iv) Radiology support – 1 radiologist partially research funded at MFT v) Funding (grants, commercial studies, K&M Cancer Alliance) vi) Rewarding system to incentivize Clinical Research within the NHS – Academic Oncologist – recognized PA time in job plan vii) Tissue Bank – worth investing in Genomics – circulating DNA rather than tissue viii) Laboratory facilities and infrastructure • There is a research meeting scheduled in June / July 2024 for DB, AH and SK to attend.		
10.	**CNS Update**	**Update from MFT**		

		• CB mentioned there was a problem with the availability of Mitomycin at MFT. • **There were no further CNS updates from DVH, EKHUFT or MTW at today's meeting.**		
11.	**Prostate Portal update**	**<u>Update from Matt Hine & Claire Mallett</u>** • MH provided an update on the PSA feed into InfoFlex. All stakeholders have been lined up and end to end testing has now taken place. • Prostate Stratified Follow Up pathway has been well supported. • K&M Cancer Alliance transformational funding will be available early / mid-May to fund a Cancer Support Worker to support the PSA manual feed for 2024/25. • Challenges include IT Pathology Laboratory capacity – staff vacancies and long-term sickness across the patch. • There will be a different solution in place for MTW – as they require LIMS. The proposed interim solution is not viable due to there being a different / older system in place. • Long-term plan – following single LIMS implementation, to configure an interface from LIMS to InfoFlex – which allows other pathology results to be transferred in the future. MTW to go live March 2025 and EKHUFT – April 2025. **Action – SM asked if DVH and EKHUFT could provide some feedback at the next meeting regarding the manual entry of PSA results onto the Prostate Portal and if there have been any issues.**		**DVH / EKHUFT**
12.	**Crossroads Care Kent / Macmillan**	**<u>Presentation provided by Tolga Senel</u>** • Crossroads and Macmillan are working together to support cancer patients and their carers. The number of carers has increased over the last 10 years. The only time this number has		**Presentation circulated to the group on the 24th April**

		decreased was during Covid. • Crossroads help unpaid carers to make a life of their own outside of caring by providing quality care services offering peace of mind and time to enjoy some time to themselves. Their mission is to keep loved ones and the caring unit together. • An unpaid carer is a person of any age who provides unpaid help and support to a loved one, relative, friend or neighbour who are unable to manage without their support. • More than a third of carers have experienced a change in the number of services they receive due to: i) Care or support arranged by social services has been reduced, or closed with no replacement. ii) Cost has increased. iii) Personal budget no longer covers the cost. • It is crucial that informal carers are offered practical and financial support. • Unpaid carers are providing care worth £162 billion a year – higher than the annual NHS health service spending in England (2020/21 financial year) • The majority of recipients of unpaid care are older parents, spouses or partners. Due to the changes in the make-up of the population the number of dependent older people in the UK will increase by 113% by 2051. • Crossroads Care in Kent is able to offer the following services for their clients: i) Regular short breaks ii) Health appointment replacement care iii) Crisis response iv) Dementia Outreach and Support v) Young Carers Project vi) Carers Counselling – up to 12 weeks free.		**2024**

		• Macmillan Partnership offers: i) Trained, DBS-checked volunteers offer practical assistance and companionship at home or transportation to health appointments. ii) Provide a wide range of useful information and guidance, available in Kent & Medway, for patients and carers. iii) Free counselling with a counsellor in training, available for carers and supporters of a cancer patient. • The collaborative Macmillan / Crossroads service currently supports: i) Over 200 clients across K&M. ii) 270 active volunteers iii) 91 people get Macmillan grants (total - £32K) iv) 46 grants from other beneficiaries (total -£18K) v) 3,685 volunteer hours in 2023. • Anyone can refer, including self-referrals – via telephone, email or online. Please see contact details below: ○ 03450 956 701 ○ macmillan@crossroadskent.org ○ referrals@crossroadskent.org ○ counselling@crossroadskent.org		
13.	**AOB**	• SM asked the group to ensure they accept calendar meeting invitations if they plan on attending this meeting as this will help the admin team when setting up the meeting room / lunch etc. • MT mentioned they needed to be selective in their clinics when seeing T3A patients as some treatments are very expensive. **Action - SM requested the Kidney Cancer Pathway was looked at and suggested this was discussed at**		**SM / AW**

		the next meeting.		
14.	**Next Meeting Date**	• **Thursday 10th October 2024 – 09:00 – 12:30 – venue TBC.**		**KG to circulate meeting invites.**