Peninsula Cancer Alliance

Meeting of the PCA Urology Site Specific Group

Wednesday 7th November 2018: 14:00-17:00

Roadford Lakes, Broadwoodwidger, Devon

THIS MEETING WAS SPONSORED BY ASTELLAS, FERRING, PFIZER, CHUGAI AND JANSSEN

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(Stand-in) Chair: Mr Martin Moody (MM)
Consultant Urologist, North Devon Healthcare NHS Trust

Reference	DRAFT NOTES
1.0	**Welcome and Introductions**
1.1	Please refer to separate attendance record via this link.
1.2	MM conveyed apologies from Rob Mason (SSG Chair) who was unfortunately unable to attend the meeting.
1.3	The drafts minutes of the previous meeting (held on 16.05.2018) were considered;
1.3.1	***Ref 5.1***: timing of 2nd PSA test (raised PSA non-UTI related); in the absence of clear national guidance, it was agreed that the timing of the second PSA test will be undertaken 6 weeks after the first test.
1.3.2	***Ref: 7.0/7.1***-Shared Clinical Guidelines: **Action**: NK will circulate the draft clinical guideline documents for final comments.
1.3.3	In the absence of any further comments, the meeting notes were accepted as an accurate record.
2.0	**SSG Matters/Cancer Alliance**
2.1	**MDT Reforms**
2.1.1	NK provided an overview of the current NHSE national pilot project (led by Professor Martin Gore) the key aim of which is to highlight the need to for MDTs to review and streamline their MDT meetings in order to maximise efficient use of available time and resources. Data collection for the pilot draws to a close in December and new national guidelines for MDTs is expected to be published in 2019.

2.1.2 For further information on the pilot project, please follow this link to a short presentation.

3.0 Living With and Beyond Cancer

3.1 An update from Maria Bracey (LWBC Clinical Lead-RD&E)

3.1.2 Transformation money from the Cancer Alliance (received following a successful bid) is being used to help implement elements of the recovery package across Devon and Cornwall. The money (calculated on a pro-rata basis) has been assigned to each Trust who decide how the money is spent.

3.1.3 Investments have been made to employ support workers to help undertake Health Needs Assessments (HNAs) and support Health and Wellbeing Events. A number of trusts have also invested in project support managers and some CNS development posts. Funding has also been provided to help develop IT systems to support data collection and remote monitoring.

3.1.4 Each Trust is accountable for how they spend the money and performance is measured through regional reporting of agreed KPIs.

3.1.5 Funding is for 2 years; Trusts will need to demonstrate that continued funding of these posts thereafter will provide value for money in terms of the positive impacts of the project on patients and the wider workforce.

3.2 **Regional Updates-LWBC**

3.2.1 The Urology team in Exeter initially provided generic health and well-being (H&WB) events but have seen great benefit in moving towards site specific H&WB clinics for prostate cancer patients. Support from the Urology surgeons has been pivotal to the successful uptake of these clinics (97% attendance rate) and the H&WB clinics have now become embedded into the patient pathway. The ambition now is to focus on hormone therapies, physiotherapy and weight management.

3.3 Barnstaple has a new project manager and additional funding from Macmillan to help provide targeted events for patients undergoing hormone therapies +/- radiotherapy. The team are starting to implement eHNAs and they will be holding their first H&WB event in November.

3.4 Plymouth has support from Miranda Benney (Recovery Package Manager) and Nicky Bevan-French (LWBC Project Manager). The team provides both generic and site specific H&WB clinics.

3.5 Torbay is working on refining the data required to capture HNAs. 5 band 4 support workers and a project manager have recently commenced their posts and the team are currently assessing where their resources will be best placed.

3.6 Truro provide prostate cancer workshops and have employed some of their LWBC support workers from previous MDT support roles which is working quite well as relationships with the teams are already well established.

3.7 The PSA tracker is proving to be popular with patients as this provides an element of supported self-management post discharge.

3.8 The LWBC project group meet every three months to share practice and ideas and have prepared a draft SOP to clarify the expected standards of practice for the delivery of HNAs.

3.9 JM (a GP/Commissioner) is starting to see patients coming through who have had HNAs and end of treatment summaries (EoTs); they appear to be very well received. JM emphasised the importance of ensuring that EoTs include clear information/guidance on the late effects of treatments (what to look for) particularly for relatively new treatments/ immunotherapies.

4.0 NICE Guidance

4.1 **Stratified Follow-up**

4.1.1 NG2 (2015) provides very clear guidance on stratified follow up for bladder cancer.

4.1.2 MM commented that Torbay is not currently meeting follow-up guidance for MIBC and this is a potential area for audit.

4.1.3 Plymouth undertook an audit which led to a new waiting list initiative to flag patients whose follow-up cystoscopy is time critical.

4.1.4 **Action**: NK to contact RM and MM to establish the criteria for and plan a Pan-Peninsula Audit on MIBC follow-up.

4.2 Risk stratifying follow-up for prostate cancer patients is more complex. The group will await the updates to NG175 (due to be published in April 2019).

4.3 It was noted that follow-up procedures for kidney cancer differs across the Peninsula.

4.3.1 **Action**: NK to contact surgeons who undertake nephrectomies to establish clear guidance for follow-up.

5.0 Prostate Pathway Update: Sarah-Jane Davies (Project Manager)

5.1 **National Support Fund (NSF)**

5.1.1 The Peninsula Cancer Alliance has additional money from the NSFs to help meet and sustain the 62d standard. Criteria for the use of the money includes; 100% implementation of the prostate pathway in 100% of Trusts across the Alliance geography by March 2019.

5.1.2 It is proposed that bids for the money focus on service sustainability, one-stop clinics and re-ordering pathways to increase efficiency.

5.2 **Fry and Turnball Fund**

5.2.1 In addition to the NSF, a separate fund of £10m (£1m for the South West) has been made available to help manage additional demand following the media spotlight on Stephen Fry and Bill Turnball. The funds will help to address some of the more urgent capacity issues around prostate cancer.

5.2.2 NHSE have been identifying and consolidating potential bids for the SW Region's £1.113M 62d Urology Cancer improvement funding.

5.2.3 NHSE received bids totalling £2.222M and undertook a detailed review to produce a list of potential bids to fund. Unfortunately, these bids still total some £1.527M. Whilst overcommitted, NHSE will seek to ensure the final list of bids is supported through other potential funding sources.

5.3 **Update from the Steering Group**: Referral Guidance and Discharge Guidance Meeting 17th October 2018;

5.3.1 **Key points**

- Ambition to standardise the referral guidelines across the SW.
- Change to CK175 - PSA age specific range reference: 40-49 >2.5, 50-69 >3 and >70 >5
- CCG's consider cost implications / Providers prepare
- Guidance for asymptomatic men to be disseminated to GP's
- If a patient decides to have a PSA test, his GP should offer a digital rectal examination as well, even if he has no symptoms of a prostate problem.

5.4 **Discharge Guidance- Key Points**

5.4.1 Initial thoughts: Where clinicians have sufficient local confidence (through the database) that PIRADS 1 or 2 do not need a biopsy it is recommended that the patient is discharged if low risk but if high risk then they should be managed via the local tracker with instructions to the GP to refer if there is a % rise / MRI in a year's time and repeat biopsy (for those who had template)
PIRADS 4 / 5 stay in the secondary care system.

5.4.2 A detailed paper is to be drawn up for next SSG meeting.

5.5 **Benefits of the Database**

5.5.1 There is no widely available reliable data on the pathway (even number of 2ww suspected prostate cancer)

5.5.2 No standard management pathway –

- Triage- how (by whom) and who should be investigated?
- MP MRI – technique, standards and quality?
- If a PIRAD score is given, what does that mean? safe not to biopsy?
- Prostate biopsy technique - TRUS, Transperineal, targeted +systematic,

systematic alone, fusion or cognitive targeting?
- Histological analysis. Standardised reporting what do Urologists need?. Optimal number of biopsies and how many 'pots' (Histologists essential)

5.5.3 There are variations in all parts of the pathway and it is important to determine/agree some core principles, techniques and guidance to ensure that the pathways across the Peninsula are equitable and offer a timely, high quality pathway of care for all men with suspected prostate cancer.

5.5.4 For further information please follow this link to Sarah-Jane's full presentation.

6.0 Guest Speaker Dr Paul Burn-Consultant Radiologist

6.1 *"Results from the Southwest Prostate MRI Audit"*

6.1.1 Please follow this link to Dr Burn's presentation**.**

6.1.2 **Key Points**

- Over 40% of patients are not having a fully diagnostic quality scan
- There is fairly wide variation in image quality and compliance with standards
- Contrast might be helpful when using older scanners
- Feedback to departments may help drive improvements
- Older scanners need replacing

6.2 **Discussion**

6.2.1 ED questioned if scans should be undertaken at all if 58% of scans are of poor quality?

6.2.2 PHC thought that there should be a quality score attached to the report to help clinicians gauge the reliability of the scan and inform patients if a biopsy is required on that basis.

6.2.3 DR (pt rep) escalated his concerns over diagnostic imaging, to his local MP.

6.2.4 There are significant diagnostic challenges across the Peninsula; North Devon has significant reporting delays (only 1 reporting radiologist) and Exeter has capacity issues which mean that they can no longer provide support to North Devon. Outsourcing for this speciality is not a viable option as the specific reporting requirements cannot be met.

6.2.5 BP (commissioner) advised that this matter has been escalated appropriately.

7.0 Update from Bev Parker

(Head of planned care commissioning-Torbay and South Devon CCG)

7.1 **Key points**

7.1.1 2ww activity has increased by 7% (nationally) and there are significant challenges in getting patients through the pathway efficiently.

7.1.2 The Peninsula is not able to deliver diagnostics effectively. A diagnostics project manager has been appointed to work with the trusts, looking at endoscopy (variation and duplication in practice) as well as low value/no value tests.

7.1.3 Commissioning of services needs to be strategic and take account of emerging treatments. Derriford are offering PAE (Prostate Artery Embolisation).

7.1.4 Work is being undertaken in collaboration with the trust chief executives across Devon to consider possible service options;

1. Provision of a standalone alone service for routine urology +/- a 2ww haematuria clinic (some hospitals offer this already) or possible outsourcing of routine work.

2. Consolidation of CT and mpMRI procurement across the county.

7.1.5 There is also a focus on predicting robotic demand and increasing capacity for RALP, and CRUK are imminently publishing a paper on fusion MRI.

8.0 Research Update -Julie Cunningham

8.1 **Please refer to the following links;**

1. Summary of recruitment activity to cancer portfolio nationally and regionally for Q1 and Q2 2018/2019

2. Research Studies

9.0 AOB

9.1 GPs are not able to prescribe Degarelix; ED suggested that proposals to add this drug to the formulary are made via the formulary group.

9.2 Exeter are seeing an increase in referral for brachytherapy and are booking into March 2019 but happy to keep receiving referrals.

9.3 It was hoped that at the next meeting there will be more clinical representatives from Exeter's urology team.

9.4 **Date of Next Meeting**

TBC

-END-