Peninsula Cancer Alliance

Meeting of the PCA Urology Site Specific Group

Monday 29th April 2019 14:00-17:00

Roadford Lakes, Broadwoodwidger, Devon

THIS MEETING WAS SPONSORED BY BRISTOL MYERS SQUIBB, PFIZER, CHUGAI AND JANSSEN

FREEDOM OF INFORMATION

This group will observe the requirements of the Freedom of Information Act (2000) which allows a general right of access to recorded information including minutes of meetings, subject to specific exemptions. No one present today had any objections to their names being distributed in the minutes.

Chair: Mr Rob Mason
Consultant Urology Surgeon, Torbay and South Devon NHS Foundation Trust

Reference	DRAFT NOTES
1.0	**Welcome and Introductions**
1.1	Please refer to separate attendance record via this link
1.2	The drafts minutes of the previous meeting on the 7th November 2018 were considered;
2.0	**SSG Matters and Alliance Updates**
2.1	MDT Reform
2.1.1	The group discussed MDT Reforms throughout the Peninsula *(Ref: 2.1)*
2.1.2	Torbay are due to start piloting MDT reforms for the Peninsula, with focus on removing the straight forward and less complex cases from the MDT in order to allow further detailed discussion on complex cases.
2.1.3	Often some of the less complex or low risk patients require reduced discussions within smaller teams, and therefore have the potential to be removed from the MDT. The team felt that it might be more appropriate for some of these cases to be referenced on the patient lists only, but not discussed within the MDT.
2.1.4	RM asked the group for any MDT changes that have been made:
2.1.5	Plymouth – the team have changed the order of discussions within their MDT
2.1.6	The group discussed double reporting and how time can be utilised more efficiently. The MDT is an opportunity for quality control and for clinicians to review decisions. Without this opportunity, there is a concern that clinicians will lose their safety net.

2.1.7 The group discussed running an audit on MDT evidence within the Peninsula to see how many changes are actually made to histology and pathology reports, and how many of these reports are double reported.

2.1.8 The group agreed that It is important to minimalise the amount of patients that are coming back into the MDT by ensuring that members have all the relative information available to them at the meeting.

2.2 Prostate Template Biopsy Training Feedback

2.2.1 Feedback has shown that these are feasible but the group raised concerns about how many of these should be done.

2.2.2 Taunton have had a break from this whilst they sort out financing and a logical approach to biopsy.

2.2.3 Not all of members of the group have completed their training, but all agree that standardising 6 sets with 4 biopsies in each require completion in outpatients. This comes with capacity concern, and the group acknowledged that because of this there would be a struggle to get a consensus on the matter. The Royal College of Histopathogists recommend 6.

2.2.4 ACTION: The group agree that the Peninsula needs to agree a set of principles for Prostate Biopsy before the trusts settle into doing their own principles. RM to set up a conversation via email before the next meeting in order to report back.

2.2.5 SJD notified the group that a Peninsula Cancer Clinical Study Day will be held in Plymouth on Wednesday 18th September, with focus on “Advances in Prostate Cancer Imaging and Biopsy techniques”. To register your interest please follow the below link or email Sarah- Jane Davies for an opportunity to present at the event.

https://www.bmus.org/meeting-booking/south-west-prostate-study-day/

2.3 Implementing the 28d diagnosis standard

2.3.1 SJD explained that we can get a clear picture once regional and national data collected has been analysed, as it will be able to determine where each trust is on the pathway and where they were before.
All hospitals have contributed to the data nationally.

2.3.2 AA confirmed that the timer on the 28-day pathway stops when a patient is informed of a diagnosis.

2.3.4 The group expressed concern about target performance.

2.3.5 SJD confirmed that this target is at the diagnostic stage and has no effect on latter thinking time for patients. The purpose of the database is to identify delays and create sustainable solutions.

2.3.6 There was further concern raised from the group concerning patients and the worry that pushing them through diagnostics quickly in order to fulfil the 28-day pathway, has the potential to slow down diagnosis for other patients that do not have suspected cancer.

2.4 Prostate 2WW referral Criteria

2.4.1 Plymouth have implemented a nurse led PSA service, as gaps were identified in the referral forms sent from GPs.

2.4.2 Data shows that year on year Plymouth are receiving 1000 2WW referrals, amounting to approximately 60 referrals a month (double are being received during a Prostate Awareness week). Out of those patients referred, 10% of these patients did not meet the 2ww criteria. This leaves the question as to whether the Peninsula should; revert to a one PSA instead of 2. Change in the number of referrals could be monitored to see if it has had any impact on the referrals.

2.4.3 The teams have an interest in a nurse led triage of patients, but in order to implement this, protocols would need to be agreed.

2.4.4 The group moved on to discuss a borderline PSA and the cut off for PSA.

2.4.5 The Plymouth team have agreed that anything above a PSA level of 20 would not require a further PSA.

2.4.6. ED suggested to the group that it would be useful to change the referral forms for GPs into one standardised form. She explained that often 2WW are being rejected without the GP being contacted with an explanation of why this has happened. With the same criteria for all, communication can reach the GPs appropriately

2.4.7 Furthermore, ED suggested an educational event for GPs to communicate referral processes.

2.4.8 ACTION: The group agreed to do two PSA's unless the first PSA is above 20. In the meantime, Plymouth will audit to see if there is any difference before the next meeting.

3.0 **Service Developments**

3.1 The MPMRI audit is working within Plymouth to optimise the use of all machines. STP's are being notified of what is being used, the age of the scanner and recommendations to escalate.

4.0 **Patient Experience**

4.1 Due to time constraints, the group agreed for the feedback from the NCPES to be circulated within the minutes.

4.1.1 Please click here to view

5.0 **Quality Indicators, audits and data collections**

5.1 RCR National MBC Audit findings – *Dr Mohini Varughese*
Click here to view the presentation

6.0 **Research Trials**

6.1 Dr Mohini Varughese provided the group with a research update. Please click here to view slides.

7.0 **Living With and Beyond Cancer Update**

7.1 HWB Clinics in Exeter – *Jane Billing, Clinical Nurse Specialist*
Please click here to view slides.

8.0 **AOB**

8.1 RM announced to stand down as chair for the SSG. The group thanked Rob for his support over the last few years.

8.1.1 ACTION: NK to email group with procedure for appointing a new chair

8.2 NK is leaving the PCA to take on substantive role within the RD&E at the end of May. Whilst her post is vacant, please send any network queries to : rde-tr.peninsulacanceralliancessgs@nhs.net

9.0 Date of next meeting : TBC

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