London Cancer Urology Pathway Board

Date: **08/12/2016, 16:30 – 18:00**

Venue: **Boardroom, UCLH @ Westmoreland Street, 16-19 Westmoreland Street, London**

Chair: **John Hines, Pathway Director**

1. Welcome, Apologies and minutes of last meeting

JH welcomed members of the board, introductions were made and apologies heard. The minutes of the last Pathway Board were accepted as an accurate record with minor amendments made.

2. MRI sub Group

- CM summarised the last meeting of the MRI sub-group. The main points discussed were that there will be a series of visits to trusts to discuss the local provision of MRI services in diagnostic part of the prostate pathway and that CM has helped advise Prostate Cancer UK who are about to publish new MRI guidelines.
- AK mentioned that at BHRUT MRI is being offered to most patients but that it isn't currently being used to avoid biopsies in some patients. The London Cancer guidelines since 2014 have recommended that MRI can be used for this purpose, but this requires expert reporting of high-quality scans which might be a problem.
- CM: At the moment NICE guidelines do not recommend MRI before biopsy, but this might be revised when the results of the PROMIS trial have been published in a peer-review journal.
- CM highlighted the importance of investigating and mapping the MRI quality across the network beforehand before new guidelines are agreed by the pathway board. Until then the agreed guidelines should be used.
- JS enquired which trusts offer MRI scanning as part of the prostate diagnostic pathway. CM: All trusts can offer multi-parametric MRIs but there is no certainty what service is being offered at all sites.
- MA highlighted that some trusts do not currently use contrast with their MRIs, because of limitations in available time and money. PAH has audited the value of contrast MRI which shows an 81% chance of picking up significant disease although this is not a universally accepted finding.
- JH asked if MRI reporting issues were discussed by the sub group? CM mentioned that this was not discussed however discussions regarding cross network reporting did happen. It was felt that an agreed protocol was needed before this could happen.
- AK mentioned the current capacity issues regarding MRI reporting at BHRUT, and asked if a uro-radiologist was required to report. CM stated that a uro-radiologist was required who reports a minimum of 50 prostate MRIs per annum.
- AB (BHRUT) questioned the purpose of MRI. CM stated that a good quality MRI along with low PSA meant the patient had less than 3% chance of having significant prostate cancer which would help avoid unnecessary biopsies, currently a problem at BHRUT.

- Negative TRUS biopsies have a 33% chance of missing significant cancer, negative MRI has between 5-25% chance, depending on quality of MRI. So MRI is a better diagnostic test that TRUS biopsy.

3. Stratified Follow Up for Prostate Cancer.

Discussion points:

- SC, the sub-group lead, updated the board.
- NCL – NCL cancer board are leading prostate stratified follow up for the NCL region. A locally commissioned service specification has been created for primary care follow-up, largely based on the resource pack produced by the Stratified care sub-group and ratified by the Pathway Board. This service specification needs to be seen by the pathway board for comment.
- NEL is adopting a secondary care-led model again utilising the Resource Pack.
- AK: BHRUT are currently discussing stratified follow up with their CCG leads. Apparently they are waiting for the 2016 prostate guidelines before moving forward, but this will not help (JH) as the Resource Pack has all the guidelines required for stratified care. These recommendations are new, having never featured in the London Cancer guidelines.
- SC mentioned that NCL plan commence in April 2017. JH and SC will be meeting all trusts within NCL before April. It is important that local urologists help their CCGs implement stratified care.
- MA stated that GPs only see, on average, 2 cancer patients a year and usually if patients are discharged back into primary care they are referred back to hospital within 12 months. Often these are difficult cases and need specialist consultation. JH: previous work had shown that GPs have an average of 2 patients who have been treated for prostate cancer.
- SC highlighted the importance of GP education. JH mentioned that this was a national initiative along with breast and bowel.
- GS mentioned a programme running in Cambridge which looks at follow up in the community; it shows that GP oversight is needed to ensure patients are treated safely.
- JS felt that GPs should not be expected to understand the differences and complexities of prostate cancer patients.
- JH mentioned that concerns should be fed to SC.
- HB mentioned that GPs do not have access to the MDT which is the most important meeting within a pathway. JH: MDT decisions are available for GPs, but, in fact, the MDT does not decide individually which patients should be moved on to stratified care, just as it does not decide any routine post-treatment changes. A CNS overseeing stratified care was decided as a safe plan.
- JS highlighted the importance of computer software with regard to stratified follow up. SC mentioned that EMUS, the IT system used in primary care can be configured to help however it will require CCG funding.
- HG mentioned that in North Middlesex they currently have a CNS led follow up clinic which works well.
- HP mentioned that the use of analytical systems could be beneficial such as IBM Watson

ACTION: SC to circulate NCL stratified follow up service spec

4. Update from IGR

Discussion points:

- JH mentioned the London Cancer visit to Institut Gustav Roussy in which the team were shown the Urology MDT. Highlighted that all 5 tumour sites were seen by same clinicians.

5. Guidelines

Discussion points:

- **Bladder –** MF still awaiting feedback from provisional guidelines
- **Prostate –** JH currently working to update the Prostate guidelines Pan London, GS mentioned that Active Surveillance guidelines are different across the network and would like the London Cancer guidelines to be circulated. JH will circulate most recent Active Surveillance guidelines.
- **Penile –** guidelines were agreed at the last PBM. AM highlighted that sending suspected penile cancer patients to UCLH before biopsy saves 2 weeks off the pathway. All board members agreed to this. It was also agreed that CIS patient can be directly referred to either the penile or genital dermatologist departments.
- The use of pictures for MDT purposes was discussed, AM stated that they were useful but local policy does not allow them to be sent across trusts.
- JS felt that if patients from across the network were directly referred to UCLH there may be an increase in DNA's, JS agreed and felt appointments should be made appropriately so that patients do not have to travel during rush hour.
- AM highlighted that the ops policy states that patients who are too unfit to travel can be treated locally under special circumstances.
- **Testicular –** Guidelines have been updated for 2016, not much change from 2015. JS highlighted some issues with late referrals for patients with metastatic disease. Guidelines state that JS and the team should be contacted directly regarding these patients.
- JS agreed to circulate the main point of contact for referrals to Barts SNMDT.
- JS mentioned that sperm storage was another pressing issue for the service as it has been de-commissioned at Barts Health. AM stated that at UCLH all cancer patients have access to free sperm storage. It was agreed that JS would write to KPJ and JH who would take this up with the commissioners

ACTION: Team to send any queries regarding Bladder Guidelines to MF
JH to circulate active surveillance guidelines.
JS to circulate point of contact for testicular SNMDT
JS to write to KPJ and JH in regards to sperm storage.

6. Research Sub Group

Discussion points:

- GS introduced the Research sub group, remit is to get as many patients as possible into clinical trials. Aim to work closely with NIHR network to gain funding as Urology is currently under represented.
- GS aims to identify trials currently being ran across the network.
- MA mentioned that PAH now has a good research centre, mostly surrounding Focal therapy trials
- GS asked the board to send a current list of trials that can be put on the London Cancer website.

ACTION: Board members to send list of trials to GS.

7. Brachytherapy Sub Group

Discussion points:

- HP could not attend the meeting but had discussed them with JH who was able to represent the sub group.
- Currently the main purpose of the sub group is to develop a centre within the network which works to national and international guidelines for low dose Brachytherapy. Bart's Health provides a local service and has been suggested as the centre, but Bart's Health Trust has decided it is not in a position to provide for patients other than its own.
- JH mentioned that experts from outside the network have been asked to review the service and feedback.
- MA mentioned that PAH would be interested in providing Brachytherapy for the system. North Middlesex also expressed interest.

8. AOB

Discussion points:

- MA – wanted to remind the board that PAH is now also a centre for HIFU.

9. Next Meeting

02/02/2017, 16:30 – 18:00, Location TBC

ACTION LOG

Action reference	Action	Owner	Date Due	Status
	SC to circulate NCL stratified follow up service spec	SC	15/01/2017	
	Team to send any queries regarding Bladder Guidelines to MF	ALL	20/01/2017	
	JH to circulate active surveillance guidelines.	JH	20/01/2017	
	JS to circulate point of contact for testicular SNMDT	JS	20/01/2017	
	JS to write to KPJ and JH in regards to sperm storage.	JS	ASAP	
	Board members to send list of trails to GS.	ALL	On Going	

Attendees

Name	Role	Trust/Organisation
John Hines	Pathway Director	London Cancer
Anand Kelkar	Consultant Urologist	*BHRUT*
John Sandell	Patient Representative	
Veronica Brinton	Patient Representative	
Victoria Wood	Respect 21	UCL
Gillian Smith	Consultant Urologist	RFH
Jane Smith	Patient Representative	
Kate Farrow	Programme Lead	*London Cancer*
Hiten Patel	Consultant Urologist	PAH
Hilary Baker	CNS	UCLH
Caroline Moore	MRI Sub Group Lead	UCLH
Sharon Cavanagh	Programme Lead	London Cancer
Manit Arya	Consultant Urologist	*PAH*
Greg Shaw	Research Sub Group Lead	UCLH/Barts
Juliana Burke	CNS	North Middlesex
H.Godbole	Consultant Urologist	North Middlesex
A. Ballaro	Consultant Urologist	BHRUT
Asif Muneer	Consultant Urologist	UCLH
Jacob Goodman	Project Manager	London Cancer
Jonathan Shamash	Medical Oncologist	Barts Health
Michael Aitchison	Consultant Urologist	RFH

Apologies

Name	Role	Trust/Organisation
Christine Moss	GP	West Essex CCG
Gabriel Sayer		BHRUT
Thomas Powles	Medical Oncologist	Barts Health