

Urology Pathway Board Constitution 2015



Web | manchestercancer.org
Twitter | [@GM_Cancer](https://twitter.com/GM_Cancer)
Email | info@manchestercancer.org
Phone | 0161 918 2087

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1. INTRODUCTION

Cancer services in Greater Manchester and East Cheshire changed in 2013/14. The Greater Manchester and Cheshire Cancer Network ceased to exist in March 2013 when cancer networks nationally were amalgamated into strategic clinical networks as part of the NHS reorganisation. In Greater Manchester this coincided with the creation of Manchester Cancer, an integrated cancer system for Greater Manchester and East Cheshire.

Twenty Manchester Cancer Pathway Clinical Directors were appointed in late 2013 and took up their roles on 1st January 2014.

These clinical leaders have formed Pathway Boards, multi-professional clinical groups from across the region. Most Pathway Boards began meeting in spring 2014. For the purposes of the National Cancer Peer Review Programme, Manchester Cancer Pathway Boards are taken to be the *network group* for the relevant tumour type or cancer area.

2. CONFIGURATION (Measure 14-1C-101g)

2.1 Local Urology Cancer Teams

Local Configuration of Services

CCGs and General Practitioners will refer all new patients with cancer or suspected cancer to their local urological team under the terms of reference of the 2 week rule. The local team will provide care for their own catchment, referring patients on to the specialist urological cancer teams for specialist care and treatment as defined by the IOG plan, referring patients to Oncologists at the Christie Hospital for radiotherapy, and for chemotherapy if unable to provide locally. The procedures and treatments classed as local care will be delivered by the members of the local urological teams outlined below in Table 3. The procedures and treatments classed as local are below:

Kidney Cancer

- The diagnostic process
- Imaging for tumour extent
- Nephrectomy, excluding the cases outlined below under “specialist care”
- Palliative chemotherapy and radiotherapy
- Simple nephro-ureterectomy

Bladder Cancer

- The diagnostic process
- Trans-urethral resection (TUR)
- The diagnosis of newly presenting patients with suspected bladder cancer and determining tumour grade and stage

- The treatment for those initial cancers found to be low or intermediate risk superficial e.g. pTa (G1 or G2); pT1 (G1 or G2)
- Follow up procedures for low risk recurrent superficial cancers
- Intravesical therapy for superficial bladder cancer

Prostate Cancer

- The diagnostic process
- Active surveillance for localised disease (after the initial treatment decision has been taken at the SMDT)
- Orchiectomy for Androgen Deprivation
- Medical hormone therapy
- Palliative surgery / Intervention radiology

* In the case of non-cancer “simple” nephrectomies, these can be discussed at the SMDT and, if felt to be appropriate, undertaken by the specialist team given the complexity of some “simple” nephrectomies. In the case of challenging/ large T2 renal tumours, it is suggested that these are undertaken by high volume surgeons.

Local Urology Teams and catchment populations

| Host Hospital/Trust | Local Urology team Lead Clinician | Referring CCGs | *Catchment Population |
|--|-----------------------------------|---|--|
| Royal Bolton Hospitals NHS Foundation Trust | Ms Z Gall | Bolton | 297,958 |
| Central Manchester University Hospital NHS Foundation Trust | Mr D Barnes | Manchester (Central) Trafford | 215,295 236,996 |
| East Cheshire NHS Foundation Trust | Mr RJ Brough | East Cheshire | 204,353 |
| Mid Cheshire NHS Foundation Trust | Mr J Oates | Central Cheshire | 278,945 |
| Pennine Acute NHS Trust | Mr J Calleary | Bury Heywood, Middleton and Rochdale Manchester (North) Oldham TOTAL Pennine | 196,730 223,934 193,497 242,669 856,830 |
| Salford Royal NHS Foundation Trust | Mr SB Maddineni | Salford | 253,112 |
| Stepping Hill Urology (covers Stockport, Tameside and East Cheshire) | Mr RJ Brough | Stockport Tameside & Glossop East Cheshire | 301,096 241,875 See above |
| University Hospital of South Manchester NHS | Ms H Warburton | Manchester (South) | 168,678 |

| | | | |
|--|---------------|-------------------------|------------------|
| Foundation Trust | | | |
| Wrightington, Wigan and Leigh NHS Foundation Trust | Mr A Thompson | Ashton, Leigh and Wigan | 321,084 |
| TOTAL | | | 3,376,222 |

*Figures from <http://www.england.nhs.uk/wp-content/uploads/2013/12/ccq-allocation-big-table-v2.pdf>

** based on combined 2011 population figure for South Cheshire Health CCG and Vale Royal CCG

2.2 Specialist Urology Cancer Teams

Specialist Teams

The three specialist urological multi-disciplinary teams (SMDT) will provide specialist care for their referring catchment. Each SMDT will be based at named hospitals indicated within each of the Associate Cancer Centres (ACC). Each of the specialist teams will also provide local care to the catchment for their localities. Specialist surgery and immediate post-operative care will be provided by the specialist teams in the named hospitals. Members of the UHSM and Salford teams also work in the supra-network team at The Christie.

Complex Urological / pelvic cancer, robotic assisted laparoscopic prostatectomy, penile cancer, renal cancer surgery and post treatment salvage surgery for testis cancer are currently managed there.

Where necessary this will be in conjunction with The Christie inter-disciplinary pelvic surgical team. All radiotherapy will be undertaken at the Christie or Christie @Oldham. The specialist teams will provide counselling for patients with T2 muscle invasive bladder cancer

The specialist surgical teams will undertake the following range of treatments:

Bladder cancer

- Radical surgery (cystectomy)
- Bladder reconstruction
- Surgery for urinary diversion
- Resection of urethral cancer
- Resection of squamous or adenocarcinoma
- Partial cystectomy for cancer

Prostate Cancer

- Radical prostatectomy

Kidney Cancer

- Resection of primary tumours which have or are suspected to have invaded renal vein, vena cava or right atrium
- Resection of metastatic disease
- Resection of both primary and associated metastatic disease

- Resection of bilateral primaries or resection of any primary where it is predicted that the patient will subsequently require dialysis
- Surgical management of patients with von Hippel-Lindau disease or hereditary papillary tumours
- Resection of complex urothelial cancers of the upper urinary tract (bilateral or multi focal disease, cases requiring reconstruction)
- Resection by nephron-sparing surgery
- Resection of non-renal cell kidney cancer treated by nephro-ureterectomy to be discussed at SMDT and decision made on local treatment site.

Specialist Urology Cancer Teams

| Host Trust | Urology SMDT Lead Clinician | Referring local MDTs | Catchment Population * |
|---|-----------------------------|---------------------------------------|------------------------|
| CMFT (operating site CMFT) | Mr Neeraj Sharma | Pennine | 856,830 |
| | | CMFT | 215,295 |
| | | Trafford | 236,996 |
| | | Total | 1,309,121 |
| Salford (operating sites Salford/Christie) | Mr Satish Maddineni | Wrightington, Wigan & Leigh | 321,084 |
| | | Salford | 253,112 |
| | | Bolton | 297,958 |
| | | Total | 872,154 |
| Stockport (operating site Stockport) | Mr Richard Brough | High Peak (out of Network) | 50,000 |
| | | Stockport | 301,096 |
| | | East Cheshire and Mid Cheshire Trusts | 204,353 |
| | | Tameside | 241,875 |
| | | Total | 797,324 |
| South Manchester (operating site UHSM) | Ms Hazel Warburton | UHSM | 168,678 |
| | | GRAND TOTAL | 3,147,277 |

*Figures from <http://www.england.nhs.uk/wp-content/uploads/2013/12/ccq-allocation-big-table-v2.pdf>

The Specialist teams and their core membership are listed below

| Specialist MDT | Specialty | Team Members |
|---|---|--|
| 1. Central Manchester and Manchester Children's Hospitals NHS Foundation Trust | Urology Consultants | Mr N K Sharma (Lead Clinician) Mr Dan Burke Mr Douglas Barnes (CMFT/NMGH) Mr J Calleary (Pennine - via video conferencing) |
| | Consultant Oncologist | Dr A Choudhury (Christie/CMFT) Mr J Livsey |
| | Consultant Histopathologist | Dr Lorna McWilliam Dr H Denley |
| | Consultant Radiologist | Dr P Taylor (CMFT) Dr N Jeyagopal (Pennine) |
| | Clinical Nurse Specialists | Jane Tunstall (Pennine) Lisa Buckley (Pennine) Jo Dickens (CMFT) Cath Colborn (CMFT) |
| | MDT Co-ordinator | Melissa Norton |
| Referral Process for Local Population | Central Manchester Specialist MDT also covers the local population for the provision of local urology services. | |

| | | |
|--|--|--|
| 2. Salford Royal/Christie NHS Foundation Trusts | Urology Consultants | Prof NW Clarke (Salford/Christie) Mr MW Lau (Salford/Christie) Mr ML Pantelides (Bolton) Mr DC Shackley Mr Vijay Ramani (UHSM/Christie - Chair) Mr Vijay Sangar (UHSM/Christie) Mr N George Mr T Gunendran (UHSM/Trafford) |
| | Clinical Oncologists | Dr T Elliott (Chair) (Christie/Salford) Dr R Cowan (Christie/Salford) Dr James Wylie (Christie/UHSM) |
| | Radiologists | Dr H Mamtora Dr A Cowie Dr A Bradley (Lead) Dr J Tuck |
| | Pathologists | Dr S Verma Dr E Salmo Dr F Knox (Lead) Dr M Howe |
| | Clinical Nurse Specialists | Mrs J Taylor Ms H Johnson Mrs J Youd Fiona Murtagh (UHSM/Trafford) Karen Robb (UHSM/Trafford) Elaine Rowe (Trafford) |
| | MDT Co-ordinator | Mrs A Bowmer / Ann Christos |
| Referral Process for Local Population | Salford Royal Specialist MDT also covers the local population for the provision of local urology services. | |

| | | |
|---|-----------------------------|--|
| 3. Stepping Hill Urology Stockport FT Tameside and Glossop East Cheshire Trust Mid Cheshire Trust (plus High Peak) | Urology Consultants | Mr B Adeyoju Mr R Brough (Chair) Mr S Bromage Mr S Brown Mr G Collins Miss Kujawa Mr S Maddineni (MCHT) Mr N Oakley Mr P O'Reilly Mr Sinclair Mr Siraj (ECHT) Mr Zafar (ECHT) <u>Leighton</u> Mr J Oates Mr S Stubington Mr R Mukerjee Mr P Irwin |
| | Consultant Oncologist | Dr John Logue Dr Catherine Coyle Mr J Wylie (Leighton) |
| | Consultant Histopathologist | Dr U Hatimy (Stockport) Dr Preethi Joseph (Stockport) |

| | | |
|---------------------------------------|---|--|
| | | Dr Claire Lelonek (UHSM) Dr Michael Scott (UHSM) Dr Nyla Nasir (MCHT) |
| | Consultant Radiologist | Dr N Lynch (Stockport) Dr Alf Pollard (Stockport) Dr Maryna Lewinski (Stockport) Dr Andrew Counsell (Stockport) Dr Sue Tebby-Lees (ECHT) Dr Ian Brett (Tameside) |
| | Clinical Nurse Specialists | Linda Martin Mandy Bellini Lucy Pilling Tracey Brown Mandy Bell Diane Wallace (ECHT) Emma Ryan (ECHT) Evelyn Pearson Kerry Fallon (Tameside) Liz Jefferson (Tameside) Sarah McKenna (Research) Mary Cowen (Leighton) Lorraine Thornycroft (Leighton) |
| | MDT Co-ordinator | Julie Smith |
| Referral Process for Local Population | Stepping Hill MDT also covers the local population for the provision of local urology services. | |

| | | |
|--|--|--|
| 4. UHSM NHS Foundation Trusts | Urology Consultants | Miss Hazel Warburton (chair) Mr Vijay Ramani Mr Vijay Sangar Mr Karyee Chow Mr Thiru Gunendran Mr Graham Young Mr Richard Montague |
| | Clinical Oncologists | Dr James Wylie (Christie/UHSM) |
| | Radiologists | Dr A Bradley (Lead) Dr J Tuck Dr Y Lim |
| | Pathologists | Dr M Scott Dr M Howe Dr P Hyder |
| | Clinical Nurse Specialists | Fiona Murtagh Karen Robb Elaine Plage |
| | MDT Co-ordinator | Mrs Wendy Nickerson |
| Referral Process for Local Population | Salford Royal Specialist MDT also covers the local population for the provision of local urology services. | |

2.3 Supra-Network MDTs for Testicular and Penile Cancers

Manchester Cancer

The Christie Hospital also hosts the Supranetwork MDTs (SnMDTs) for testicular and penile cancers in populations covered by GMCCN and neighbouring network(s). The testicular SnMDT also serves populations from Lancashire and South Cumbria Cancer network (LSCCN), and the penile SnMDT also serves populations of LSCCN and Merseyside and Cheshire Cancer Network (MCCN).

Supra Network Penile and Testicular Teams

| Tumour Group | Networks included in Supranetwork MDT | Populations | Supra-network Team Base |
|--------------|--|------------------|---|
| Penile | Greater Manchester and Cheshire Cancer Network | 3.3m | The Christie NHS FT (operating site at Christie) |
| | Merseyside and Cheshire Cancer Network | 2.0m | |
| | Lancashire and Cumbria Network | 1.7m | |
| | Total | 7,000,000 | |
| Testicular | Greater Manchester and Cheshire Cancer Network | 3.3m | The Christie NHS FT (operating site at Christie for post chemotherapy RPLND) |
| | Lancashire and Cumbria Network | 1.7m | |
| | North Wales | 0.6m | |
| | Total | 5,600,000 | |

Taken from <http://www.england.nhs.uk/wp-content/uploads/2013/12/ccg-allocation-big-table-v2.pdf>

The Supra-network MDTs' core membership

| SupraNetwork MDTs | Specialty | Team Members |
|--|--|--|
| Penile Supranetwork MDT Hosted at The Christie NHS FT | Consultant Surgeons | Mr Vijay Sangar (Chair) Mr Maurice Lau Mr Nigel Parr (MCCN) |
| | Clinical Oncologists | Dr Tony Elliott Dr Peter Kirkbride (MCCN) |
| | Histopathologist | Dr Jonathan Shanks Dr Ranjala Seneviratne (MCCN) |
| | Radiologist | Dr Bernadette Carrington Dr Ben Taylor Dr Hans Ulrich Laasch Dr Jon Bell Dr Prakash Manoharan |
| | Clinical Nurse Specialists | Ms Jane Booker Ms Catherine Pettersen Ms Sharon Capper Ms Beverley Rogers (MCCN) |
| | MDT Co-ordinator | Miss Andrea Harrison |
| | Testicular Supranetwork MDT Hosted at The Christie NHS FT | Consultant Surgeons |
| Clinical Oncologist | | Dr John Logue Dr James Wylie Dr Richard Welch Ms Alison Birtle (LSCCN) Dr Wiebke Appel (LSCCN) |
| Medical Oncologist | | Dr Michael Leahy (Chair) |
| Histopathologist | | Dr Jonathan Shanks |

| | | |
|--|---------------------------|---|
| | Radiologist | Dr Ben Taylor Dr Bernadette Carrington Dr Hans Ulrich Laasch Dr Prakash Manoharan Dr Jon Bell |
| | Clinical Nurse Specialist | Ms Catherine Pettersen Ms Jane Booker Ms Sharon Capper |
| | MDT Co-ordinator | Miss Andrea Harrison |
| Renal / Pelvic at The Christie NHS FT | Clinical Oncologists | Dr Tony Elliott Dr James Wylie Dr John Logue |
| | Medical Oncologist | Prof. R Hawkins Dr F Thistlethwaite |
| | Research Nurses | |
| | Data Managers | |

2.4 Manchester Cancer

Manchester Cancer is the largest cancer network in the country, outside of London, covering a population of over 3 million served by the following Acute Hospital Trusts:

North West Sector:

- Wrightington, Wigan and Leigh NHS Foundation Trust
- Royal Bolton Hospital NHS Foundation Trust
- Salford Royal NHS Foundation Trust

North East Sector:

- Pennine Acute Hospitals NHS Trust (Bury, North Manchester, Oldham, Rochdale Hospitals)
- Central Manchester University Hospitals NHS Foundation Trust

South Sector:

- Tameside Acute NHS Foundation Trust
- Stockport NHS Foundation Trust
- Christie Hospital NHS Foundation Trust
- East Cheshire NHS Trust
- Mid Cheshire NHS Foundation Trust
- University Hospital of South Manchester NHS Foundation Trust

The Christie Hospital is the Tertiary Referral Centre for the conurbation and area. Radiotherapy is delivered at the Christie Hospital and the satellite radiotherapy units are based at Royal Oldham Hospital and Salford Royal. Chemotherapy and clinical trials are currently managed and administered by the Christie Hospital.

2.5 Pathway Board (14-1C-103g)

The Urology pathway board is a multi-professional group chaired by Mr Satish Maddineni, Consultant Urological Surgeon.

The core of the pathway board is drawn from the multi-disciplinary teams (MDT) from each specialist and local team, and clinical support services involved in tumour management along the patient care pathway.

The purpose of the pathway board is to ensure that the services for patients with suspected or diagnosed Urological Cancer (of the Kidney, Prostate, Bladder, or Penis/Testicle) are being delivered in accordance with objectives of Manchester Cancer, NICE Improving Outcomes Guidance (IOG) and Peer Review Cancer Quality Measures

2.6 Pathway Board Terms of Reference

The pathway board has nominated membership from all of the member organisations of Manchester Cancer. Where necessary the group may identify and recommend membership of other appropriate professionals, commissioners and patient and user representatives required to achieve the objectives of the group.

The Urology pathway board will be recognised as:

- Manchester Cancer's primary source of clinical opinion on issues relating to Urology cancer
- Having corporate responsibility, delegated by Manchester Cancer Provider Board, for Urology cancer policy, practice guidelines, audit, research, and service improvement across the conurbation area.
- Responsible for consulting with other pathway boards on issues involving chemotherapy, radiotherapy, diagnostic imaging, histopathology and laboratory investigations, radiotherapy, and specialist palliative care.

These terms of reference were agreed on 23rd April 2014 by Mr Satish Maddineni, Pathway Clinical Director for Urology Cancer, and Mr David Shackley, Medical Director of Greater Manchester Cancer Services, on behalf of the Greater Manchester Cancer Services Provider Board. The terms of reference will be subject to future review.

2.6.1 The Pathway Board

The Urology Cancer Pathway Board is a cancer care specific board with responsibility to improve cancer outcomes and patient experience for local people across Greater Manchester and areas of Cheshire (a catchment population of 3.2 million). This area is synonymous with the old Greater Manchester and Cheshire Cancer Network area.

The Pathway Board is led by a Pathway Clinical Director and is formed of a multidisciplinary team of clinicians and other staff from all of hospital trusts that are involved in the delivery of Urology cancer care in Greater Manchester. The Pathway Board

also has membership and active participation from primary care and patients representatives.

The Urology Cancer Pathway Board reports into and is ultimately governed and held to account by the Greater Manchester Cancer Services Provider Board.

2.6.2 Manchester Cancer Provider Board

The Greater Manchester Cancer Services Provider Board is responsible for the service and clinical delivery arm of Manchester Cancer, Greater Manchester's integrated cancer system. Manchester Cancer has two other arms: research and education (see appendix for the structure of Manchester Cancer).

The Provider Board is independently chaired and consists of the Chief Executive Officers of the ten acute hospital trusts in the Greater Manchester area:

- Bolton NHS Foundation Trust
- Central Manchester University Hospitals NHS Foundation Trust
- East Cheshire NHS Trust
- Pennine Acute NHS Trust
- Salford Royal NHS Foundation Trust
- Stockport NHS Foundation Trust
- Tameside Hospital NHS Foundation Trust
- The Christie NHS Foundation Trust
- University Hospital of South Manchester NHS Foundation Trust;
- Wrightington, Wigan and Leigh NHS Foundation Trust;

The Provider Board regularly invites representatives of commissioners, the Strategic Clinical Network, and Manchester Cancer to its meetings.

2.6.3 Purpose of the Pathway Board

The purpose of the Pathway Board is to improve cancer care for patients on the Greater Manchester Urology cancer pathway. Specifically, the Pathway Board aims to save more lives, put patients at the centre of care, and improve patient experience. The Board will represent the interests of local people with cancer, respecting their wider needs and concerns. It is the primary source of clinical opinion on this pathway for the Greater Manchester Cancer Services Provider Board and Greater Manchester's cancer commissioners.

The Pathway Board will gain a robust understanding of the key opportunities to improve outcomes and experience by gathering and reviewing intelligence about the Urology cancer pathway. It will ensure that objectives are set, with a supporting work programme that drives improvements in clinical care and patient experience.

The Pathway Board will also promote equality of access, choice and quality of care for all patients within Greater Manchester, irrespective of their individual circumstances. The

Board will also work with cancer commissioners to provide expert opinion on the design of any commissioning pathways, metrics and specifications.

2.6.4 Role of the Pathway Board

The role of the Urology Cancer Pathway Board is to:

Represent the Greater Manchester Cancer Services professional and patient community for Urology cancer.

Identify specific opportunities for improving outcomes and patient experience and convert these into agreed objectives and a prioritised programme of work.

Gain approval from Greater Manchester's cancer commissioners and the Greater Manchester Cancer Services Provider Board for the programme of work and provide regular reporting on progress.

Design and implement new services for patients where these progress the objectives of commissioners and Greater Manchester Cancer Services, can be resourced, and have been shown to provide improvements in outcomes that matter to patients.

Ensure that diagnosis and treatment guidelines are agreed and followed by all teams in provider trusts, and are annually reviewed.

Ensure that all providers working within the pathway collect the pathway dataset measures to a high standard of data quality and that this data is shared transparently amongst the Pathway Board and beyond.

Promote and develop research and innovation in the pathway, and have agreed objectives in this area.

Monitor performance and improvements in outcomes and patient experience via a pathway scorecard, understanding variation to identify areas for action.

Escalate any clinical concerns through provider trusts.

Highlight any key issues that cannot be resolved within the Pathway Board itself to the Medical Director of Greater Manchester Cancer Services for assistance.

Ensure that decisions, work programmes, and scorecards involve clearly demonstrable patient participation.

Share best practices with other Pathway Boards within Greater Manchester Cancer Services.

Contribute to cross-cutting initiatives (e.g. work streams in living with and beyond cancer and early diagnosis).

Discuss opportunities for improved education and training related to the pathway and implement new educational initiatives.

Develop an annual report of outcomes and patient experience, including an overview of progress, difficulties, peer review data and all relevant key documentation. This report will be published in July of each year and will be the key document for circulation to the Provider Board. A template for this report is available so that all Pathway Boards complete the report in a similar manner.

2.6.5 Membership principles

All member organisations of Greater Manchester Cancer Services will have at least one representative on the Pathway Board unless they do not wish to be represented.

Provider trusts not part of Greater Manchester Cancer Services can be represented on the Pathway Board if they have links to the Greater Manchester Urology cancer pathway.

All specialties and professions involved in the delivery of the pathway will be represented.

The Board will have at least one patient or carer representative within its membership

One professional member of the Pathway Board will act as a Patient Advocate, offering support to the patient and carer representative(s).

The Board will have named leads for:

- Early diagnosis
- Pathology
- Radiology
- Surgery
- Oncology
- Specialist nursing
- Living with and beyond cancer ('survivorship')
- Research
- Data collection (clinical outcomes/experience and research input).

It is possible for an individual to hold more than one of these posts. The Pathway Clinical Director is responsible for their fair appointment and holding them to account.

These named leads will link with wider Greater Manchester Cancer Services Boards for these areas where they exist.

All members will be expected to attend regular meetings of the Pathway Board to ensure consistency of discussions and decision-making (meeting dates for the whole year will be set annually to allow members to make arrangements for their attendance).

It is expected that board members will attend all meetings in a 12 month period. In the instances when board members are unable to attend they may send identified deputies, having informed the Pathway director before the meeting.

When a board member's attendance is less than 66% in 12 month period, the Pathway Director, in collaboration with Greater Manchester Cancer services Medical Director, reserves the right to terminate their board membership and liaise with the relevant member organisation to submit a new nomination.

2.6.6 Frequency of meetings

The Urology Cancer Pathway Board will meet every two months.

2.6.7 Quorum

Quorum will be the Pathway Clinical Director(or nominated deputy) plus fifty per cent of the named members of the Pathway Board or their named deputies.

If the pathway Board meeting is quorate then there will be a voting system implemented for the decision making process. The decision of the board will be made if the majority of the members present agree.

2.6.8 Communication and engagement

Accurate representative minutes will be taken at all meetings and these will be circulated and then validated at the next meeting of the Board.

All minutes, circulated papers and associated data outputs will be archived and stored by the Pathway Clinical Director and relevant Pathway Manager.

The Pathway Board will design, organise and host at least one open meeting per year for the wider clinical community and local people. This meeting or meetings will include:

- An annual engagement event to account for its progress against its work programme objectives and to obtain input and feedback from the local professional community
- An annual educational event for wider pathway professionals and interested others to allow new developments and learning to be disseminated across the system

Representatives from all sections of the Greater Manchester Cancer Services professional body will be invited to these events, as well as patient and public representatives and voluntary sector partners.

An annual report will be created and circulated to the Medical Director of the Greater Manchester Cancer Services Provider Board by 31st July of each calendar year.

The agendas, minutes and work programmes of the Pathway Board, as well as copies of papers from educational and engagement events, will be made available to all in an open

and transparent manner through the Greater Manchester Cancer Services website once this has been developed.

2.6.9 Administrative support

Administrative support will be provided by the relevant Pathway Manager with the support of the Greater Manchester Cancer Services core team. Over the course of a year, an average of one day per week administrative support will be provided.

2.7 Pathway Board membership (14-1C-102g)

The pathway board will comprise of representatives nominated by the Chief Executives of Cancer Units and Centres within the Network. Core membership of the Urology pathway board can be found in below.

Pathway Board Membership

| Pathway Board Member | Profession/Specialty | Trust/Organisation |
|----------------------------|--|----------------------|
| Mr Satish Maddineni | Chair – Consultant Urologist | Salford Royal |
| Dr Anna Tran | Oncologist | Christie |
| Dr Cath Briggs | GP | Stockport CCG |
| Mr Dan Burke | Consultant Surgeon | CMFT |
| Ms Hazel Warburton | Consultant Surgeon | UHSM |
| Helen Johnson | CNS, Prostate Cancer | Christie |
| Mr. J Calleary | Consultant Surgeon | Pennine |
| Mr J Husain | Consultant Surgeon | WWL |
| Jane Booker | Specialist Nurse | Christie |
| Dr G Yeung | Consultant Radiologist | Bolton |
| Jeannette Lyons | CNS, Oncology | Christie |
| Mr Jeremy Oates | Consultant Surgeon | Mid Cheshire |
| Mr Kieran O’Flynn | Consultant Surgeon | SRFT |
| Dr Maryna Lewinski | Consultant Radiologist | Stockport |
| Dr Mike Scott | Consultant Pathologist | UHSM |
| Prof Noel Clarke | Consultant Surgeon | Christie |
| Mr Stephen Bromage | Consultant Urological Surgeon | Stockport |
| Dr Steve Elliot | GP | Salford CCG |
| Mr Ted Chatt | Patient representative | |
| Dr Tony Elliott | Oncologist/Pathway Board Research Lead | Christie |
| Dr Fiona Thistlethwaite | Medical Oncologist | Christie |

Manchester Cancer is committed to user involvement and representation on all aspects of its work.

Manchester Cancer

For the Urology pathway board, the appointed user representative is Mr Ted Chatt, who invited to participate in all discussions with the opportunity for user issues to be raised at every meeting of the board.

For a more structured user feedback and input into the group's work programme Manchester Cancer will work with their developing patient involvement team and in collaboration with Macmillan cancer.

3. PATHWAYS AND GUIDELINES

3.1 Primary Care Referral Policy

A patient who presents with symptoms or signs suggestive of urological cancer should be referred to one of the named local teams listed above under Section 2.

Prostate cancer

- Patients presenting with symptoms suggesting prostate cancer should have a digital rectal examination (DRE) and prostate-specific antigen (PSA) test after counselling.
- Prostate cancer is also a possibility in male patients with any of the following unexplained symptoms:
 - Haematuria
 - Lower back pain
 - Bone pain
 - Weight loss, especially in the elderly

These patients should also be offered a DRE and a PSA test.

- Urinary infection should be excluded before PSA testing, especially in men presenting with lower tract symptoms. The PSA test should be postponed for at least one month after treatment of a proven urinary infection.
- If a hard, irregular prostate typical of a prostate carcinoma is felt on rectal examination, then the patient should be referred urgently. The PSA should be measured and the results should accompany the referral. Patients do not need urgent referral if the prostate is simply enlarged and the PSA is in the age-specific reference range.
- In a male patient with or without lower urinary tract symptoms and in whom the prostate is normal on DRE but the age-specific PSA is raised or rising, a referral should be made. However, in those patients whose clinical stage is compromised by other co-morbidities, a discussion with the patient or carers and/or a specialist in urological cancer may be more appropriate before considering referral.
- Symptomatic patients with high PSA levels should be referred urgently.
- If there is doubt about whether to refer an asymptomatic male with a borderline level of PSA, the PSA test should be repeated after an interval of 1 – 3 months. If the second test indicates that the PSA level is rising, the patient should be referred urgently.

Bladder and Renal cancer

- Male or female adult patients of any age who present with painless macroscopic haematuria should be referred urgently.
- In male or female patients aged 40 or over with symptoms suggestive of a urinary infection who also present with macroscopic haematuria, investigations should be undertaken to diagnose and treat the infection before consideration of referral. If infection is not confirmed the patient should be referred urgently.
- In all adult patients aged 40 years and older who present with recurrent or persistent urinary tract infection associated with haematuria, an urgent referral should be made.

- In patients under 50 years of age with microscopic haematuria, the urine should be tested for proteinuria and serum creatinine levels measured. Those with proteinuria or raised serum creatinine should be referred to a renal physician. If there is no proteinuria and serum creatinine is normal, a non-urgent referral to a urologist should be made.
- In patients over 50 years and older who are found to have unexplained microscopic haematuria, an urgent referral should be made to a haematuria clinic.
- Any patient with an abdominal mass identified clinically or on imaging that is thought to be arising from the urinary tract should be referred urgently.

Testicular cancer

- Any patient with a swelling or mass in the body of the testis should be referred urgently.
- An urgent ultrasound should be considered in men with a scrotal mass that does not transilluminate and/or when the body of the testis cannot be distinguished.

Penile cancer

- An urgent referral should be made for any patient presenting with symptoms or signs of penile cancer. These include progressive ulceration or a mass in the glans or prepuce particularly, but can involve the skin of the penile shaft. Lumps within the corpora cavernosa not involving penile skin are usually not cancer but indicate Peyronie's disease, which does not require urgent referral.

*based on NICE Guideline – “Referral guidelines for suspected cancer” (2005)

3.2 Clinical guidelines (14-1C-105g/106g/107g/108g/109g)

Manchester Cancer Pathway Boards have been in place since spring 2014 and are going through the process of reviewing the clinical guidelines and patient pathways inherited from the old cancer network groups.

Where they exist, updated guidelines and pathways have been posted to the relevant pages of the Manchester Cancer website www.manchestercancer.org.

Where guidelines and pathways are yet to be reviewed and updated then the legacy documents from the cancer network continue to be current. Where they exist, these legacy documents have also been posted to the relevant pages of the Manchester Cancer website www.manchestercancer.org.

The guidelines for the management and treatment of Urology Cancer can be found on the Manchester Cancer website (www.manchestercancer.org/urology), as listed below

| |
|---|
| Network Agreed Guidelines for the Management of Kidney Cancer |
| Network Agreed Guidelines for the Management of Bladder Cancer |
| Network Agreed Guidelines for the Management of Prostate Cancer |
| Agreed policy on active surveillance for prostate cancer patients |
| Network Agreed Guidelines for the Management of T2, Muscle Invasive |

| |
|--|
| Bladder Cancer and Organ-Confined Prostate Cancer |
| Network/Supra-Network Agreed Guidelines for the Management of Testicular Cancer – Diagnosis and Assessment |
| Specialist Team Referral Guidelines for Testicular Cancer |
| Network/Supra-Network Agreed Guidelines for the Management of Penile Cancer – Diagnosis and Assessment |

3.3 Chemotherapy algorithms (14-1C-110g)

All chemotherapy algorithms can be accessed via the intranet of The Christie NHS Foundation Trust. These are live documents:

<http://nww.christie.nhs.uk/documents/default.aspx?Category=Y&Category1=1>

Search for:
Policies & Guidelines

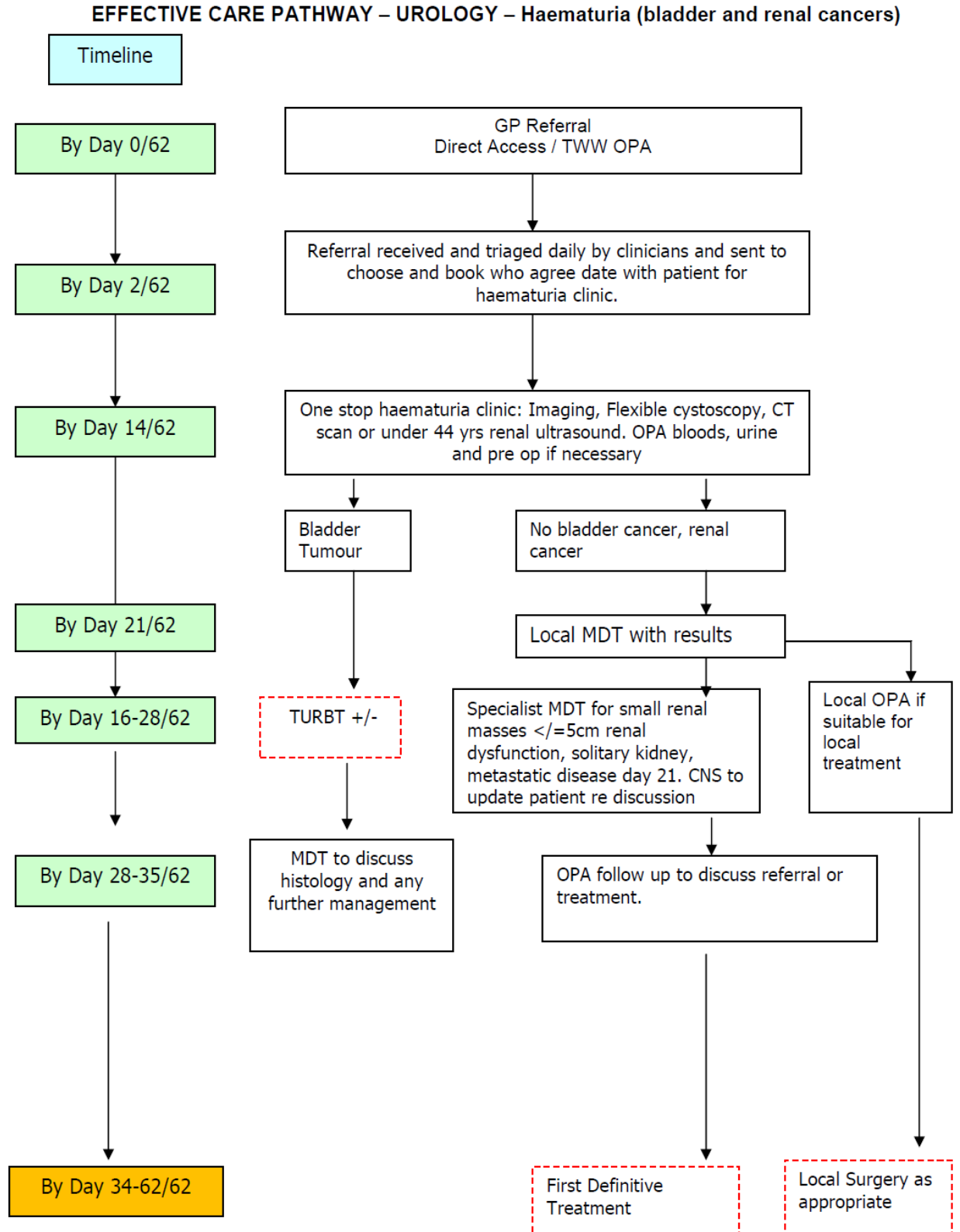
Sub-category 1:
Chemotherapy protocols

3.4 Patient pathways (14-1C-111g/112g/113g/114g/115g)

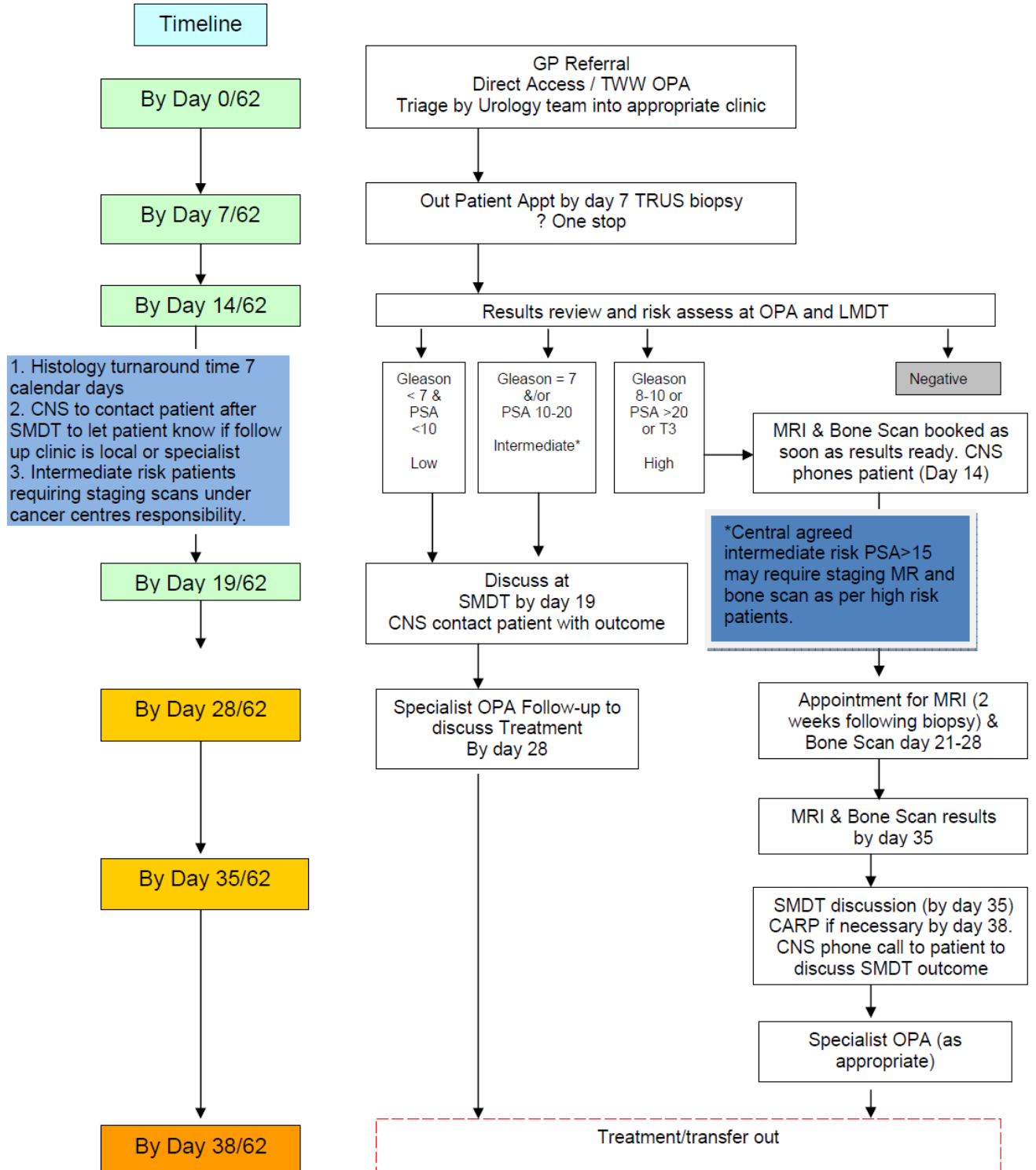
See appendix 1 for the Manchester Cancer urology cancer 62-day pathways.

For the teenage and young adult cancer pathways developed under the old Greater Manchester and Cheshire Cancer Network see <http://manchestercancer.org/services/teenagers-and-young-adults/>.

Appendix 1: 62-day Pathways



Prostate Cancer Pathway



Note: for a 2 way pathway 1st seen trust has until day 42

Prostate Cancer Pilot Pathway South Sector

