Date: 20 November 2015

Our Ref: FOI 2015-506

Dear Requester

Thank you for your information request received by us on 23 October 2015

This request has been handled under the Freedom of Information Act 2000.

*Please note that Chelsea and Westminster Hospital NHS Foundation Trust merged with West Middlesex University Hospital in September 2015, for this reason our response covers both sites.*

**Your request**

**Question 1:** Please supply to following information in relation to the period lasting from 01 January 2014 – 31 December 2014:

a) The total number of patients diagnosed with renal cell carcinoma.
b) The stage of renal cell carcinoma recorded at the time of diagnosis.
c) The number of renal cell carcinoma patients diagnosed in an emergency setting.
d) Following the agreement of a treatment plan, the time to treatment for patients diagnosed with renal cell carcinoma.
e) The number of patients who received sunitinib or pazopanib for the treatment of their renal cell carcinoma.
f) The number of patients who received axitinib for the treatment of their renal cell carcinoma.
g) The number of patients with renal cell carcinoma who took part in a clinical trial.

**Question 2:** Does your trust produce local guidance for the management of treatment of renal cell carcinoma? If so, please can you provide a copy?

**Question 3:** Are patients with renal cell carcinoma managed by a Multi-Disciplinary Team? If so, please provide the standard operating procedure, terms of reference, or similar, outlining the characteristics (including how often they meet) of the MDT.

**Question 4:** Do you routinely record patient experience or satisfaction with your oncology services? If so, please provide the results.

Our response:

Please see the attached summary and associated documents at the end of this document.
If you are not satisfied with this response

If you are not satisfied with how your request has been handled then please either

1. Respond to this email and we will review our answers and get back to you or
2. Write directly to:

   The Chief Executive
   Chelsea and Westminster Hospital NHS Foundation Trust
   4 Verney House
   1B Hollywood Road
   London
   SW10 9HS

If, after we have addressed your complaint, you remain dissatisfied with how we have responded, you are entitled to appeal to the Information Commissioner at:

The Information Commissioner's Office, Wycliffe House, Water Lane, Wilmslow, Cheshire, SK9 5AF.

Telephone: 08456 306060 or 01625 545745
Website: www.ico.org.uk
There is no charge for making an appeal.

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You must take into account the exemptions and any other conditions such as the non-endorsement condition below

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Further information can be found at:
http://www.opsi.gov.uk/advice/psi-regulations/index.htm

Yours sincerely

The Information Governance team
Chelsea and Westminster Hospital NHS Foundation Trust
Email: foi@ChelWest.nhs.uk
Please find below a request for information on the diagnosis, treatment and management of renal cell carcinoma. I would be grateful if you could provide answers to these questions within the time frame specified by the Freedom of Information Act 2000.

<table>
<thead>
<tr>
<th>Questions</th>
<th>Chelsea &amp; Westminster Hospital Site</th>
<th>West Middlesex Hospital Site</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Question 1:</strong> Please supply the following information in relation to the period lasting from 01 January 2014 – 31 December 2014:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>a) The total number of patients diagnosed with renal cell carcinoma.</td>
<td>5</td>
<td>22</td>
</tr>
<tr>
<td>b) The stage of renal cell carcinoma recorded at the time of diagnosis.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>c) The number of renal cell carcinoma patients diagnosed in an emergency setting.</td>
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<td>3</td>
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d) Following the agreement of a treatment plan, the time to treatment for patients diagnosed with renal cell carcinoma.

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<th>Patients in Timescale</th>
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</thead>
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<td>8</td>
<td>1</td>
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<td>23</td>
<td>1</td>
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<tr>
<td><strong>Grand Total</strong></td>
<td><strong>5</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Days to Treatment</th>
<th>Patients in Timescale</th>
</tr>
</thead>
<tbody>
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</tr>
<tr>
<td>3</td>
<td>1</td>
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<td>6</td>
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</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td><strong>22</strong></td>
</tr>
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</table>

e) The number of patients who received sunitinib or pazopanib for the treatment of their renal cell carcinoma.

f) The number of patients who received axitinib for the treatment of their renal cell carcinoma.

g) The number of patients with renal cell carcinoma who took part in a clinical trial.

**Question 2:** Does your trust produce local guidance for the management of treatment of renal cell carcinoma? If so, please can you provide a copy?

Yes

Operational Policy embedded below

[LUMDT Operational Policy Final 2015.pdf](#)

The organisation follows clinical guidelines developed in partnership with the London Cancer Alliance. Copies of the guidelines can be @

[London Cancer Alliance Guidelines](#)
<table>
<thead>
<tr>
<th>Questions</th>
<th>Chelsea &amp; Westminster Hospital Site</th>
<th>West Middlesex Hospital Site</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Question 3:</strong> Are patients with renal cell carcinoma managed by a Multi-Disciplinary Team? If so, please provide the standard operating procedure, terms of reference, or similar, outlining the characteristics (including how often they meet) of the MDT.</td>
<td>Yes see question 2</td>
<td>Patient referred with or under investigation of a renal cell Carcinoma are managed by a local MDT for the diagnostic part of their pathway and then centrally at a specialist MDT for the conformation of diagnosis and treatment plan. Embedded below are sections from the operational policy.</td>
</tr>
<tr>
<td><strong>Question 4:</strong> Do you routinely record patient experience or satisfaction with your oncology services? If so, please provide the results.</td>
<td>The organisation takes part in the National Cancer patient Survey on an annual basis. Results can be found at the following link <a href="https://www.quality-health.co.uk/surveys/national-cancer-patient-experience-survey">https://www.quality-health.co.uk/surveys/national-cancer-patient-experience-survey</a></td>
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</tr>
</tbody>
</table>
CHELSEA & WESTMINSTER HOSPITAL NHS TRUST

Urology Cancer Locality Multi-disciplinary Team for the Chelsea & Westminster Hospital

Operational Policy for the care of Patients with Urological Cancer

2015

This policy has been agreed and signed off by:

Name: Mr Bijan Khoubehi
Position: Local Urology MDT Lead Clinician
Organisation: Chelsea and Westminster Hospital Foundation Trust
Date Agreed: 3rd June 2015

And

Name: Professor Mark Bower
Position: Trust Lead Cancer Clinician
Organisation: Chelsea and Westminster Hospital Foundation Trust
Date Agreed: 3rd June 2015

The contents of this policy document have been discussed with all core members of this multidisciplinary team, agreed by us collectively, and signed off by the MDT Clinical Lead(s) on 3rd June 2015 and by each member of the appropriate core membership.

Date for review June 2016
Contents

1. PURPOSE OF THE LUMDT  Page 4
2. LEADERSHIP ARRANGEMENTS AND RESPONSIBILITIES  Page 4
3. MEMBERSHIP ARRANGEMENTS  Page 5
   - Core members
   - Extended members
   - Oncology core members
   - National Advanced communication Skills Training
   - Clinical Nurse Specialist responsibilities
4. REFERRAL ARRANGEMENTS  Page 8
5. DIAGNOSTIC SERVICES  Page 8
   - CWH dedicated assessment clinics
   - Histo-pathology EQA
6. THE MDT MEETING  Page 9
   - Treatment planning decision between MDTs
   - New patients and initial treatment plan
   - Treatment planning decisions
   - Follow up of MDT decisions
   - Communication
   - Role of the key worker
   - Annual meeting
7. DATA COLLECTION  Page 13
8. PATIENT AND CARER FEEDBACK & INVOLVEMENT  Page 14
9. TREATMENT  Page 15
   - Network Guidelines for treatment and Follow up
10. NETWORK & GENERAL AUDITS  Page 16
11. RESEARCH  Page 16
<table>
<thead>
<tr>
<th>APPENDIX 1</th>
<th>REFERRAL ROUTES AND PATIENT PATHWAYS</th>
<th>17</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>PROSTATE CANCER/RAISED PSA</td>
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<tr>
<td></td>
<td>BLADDER CANCER PATHWAY</td>
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<td>RENAL CANCER PATHWAY</td>
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<td>TESTICULAR CANCER PATHWAY</td>
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<td></td>
<td>PENILE CANCER PATHWAY</td>
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</tbody>
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| APPENDIX 2 | LCA Urology Urgent Suspected Cancer Referral Form | 19 |

| APPENDIX 3 | LIST OF RESPONSIBILITIES FOR MDT COORDINATOR ROLE | 21 |

| APPENDIX 4 | CWH MDT PROFORMA | 22 |

| APPENDIX 5 | KEY WORKER POLICY | 23 |
Introduction
The Local Urology Multidisciplinary Team (LUMDT) is a multi-professional group, comprised of surgeons, physicians, radiologists, histo-pathologists and other healthcare professionals from Chelsea and Westminster Hospital Foundation Trust. The organisation serves the localities of Kensington & Chelsea, Westminster and parts of Wandsworth, Putney and Battersea. The LUMDT falls within the boundaries of the London Cancer Alliance (LCA). This document outlines the Operational Policy for the LUMDT, and is to be reviewed on a yearly basis at the Urology Cancer Operational Meeting, Chaired by the Lead Clinician of the MDT Mr Bijan Khoubehi – Consultant Urology Surgeon.

1. Purpose of this MDT
The aim of the LUMDT is to ensure a coordinated approach to diagnosis, treatment and care services for all patients diagnosed with any kind of urological cancer within the locality served by Chelsea and Westminster Hospital Foundation Trust (CWH). The LUMDT also plays a role in shaping urology cancer services in West London by commitment to the Network Site Specific Group (NSSG) and the London Cancer Alliance Urology Pathway Group. The London Cancer Alliance (LCA) took over the role of what was the North West London Cancer Network (NWLCN) in April 2013. As this report reflects the audit period for 2014/15, all reference to NSSG will relate to work carried out under that group.

CWH is also part of the Specialist Urology MDT which provides a forum for discussion of complex urology cancer patients covering the localities served by Imperial Healthcare College Healthcare NHS Trust, West Middlesex University Hospital and Ealing Hospital NHS Trust. This MDT is covered in a separate Operational Policy.

The LUMDT has the combined function of diagnosis (to rapidly assess and achieve histo-pathological confirmation of cancer), treatment (discussing the management of all newly diagnosed urology cancers) and communication (with the appropriate General Practices within Primary Care and/or referring organisations).

2. Leadership Arrangements and Responsibilities (14-2G-101,104)
The Lead LUMDT clinician is Mr Bijan Khoubehi, Consultant Urology Surgeon. The responsibilities of this position are detailed below and have been agreed by Professor Bower the lead clinician at the CWH:

- Lead the clinical activity of the multi-disciplinary team, working to agreed guidelines, ensuring a high quality integrated service which meets local, regional and national standards.
- Ensure that objectives of MDT working (as laid out in Manual of Cancer Service Standards) are met:
  - To ensure that designated specialists work effectively together in teams such that decisions regarding all aspects of diagnosis, treatment and care of individual patients and decisions regarding the team’s operational policies are multidisciplinary decisions.
  - To ensure that care is given according to recognised guidelines (including guidelines for onward referrals) with appropriate information being collected to inform clinical decision making and to support clinical governance/audit.
To ensure mechanisms are in place to support entry of eligible patients into clinical trials, subject to patients giving fully informed consent.

- Overall responsibility for ensuring that MDT meeting and team meet Peer Review Quality Measures.
- Ensure attendance levels of core members are maintained, in line with Quality Measures.
- Ensure that target of 100% of cancer patients discussed at the MDT is met.
- Provide link to the NSSG, either by attending 2/3 of NSSG meetings or by nominating another MDT member to attend.
- Lead on, or nominate a lead for service improvement.
- Organise and chair annual meeting examining functioning of team and reviewing operational policies, and collate any activities that are required to ensure optimal functioning of the team (e.g. training for team members).
- Ensure MDT’s activities are audited and results documented.
- Ensure that the outcomes of the meeting are clearly recorded and clinically validated and that appropriate data collection is supported.
- Ensure target of communicating MDT outcomes to primary care is met.

3. Membership Arrangements (14-2G-101,102,104)
All patients with urological cancers are managed by the multi-disciplinary urological cancer team. This team functions in the context of dedicated specialist services, with working arrangements and protocols agreed throughout the NSSG.
Consultants who provide elective specialist surgery, chemotherapy, or radiotherapy for patients with the specified conditions listed below must also be a member of the Specialist MDT, held at Charing Cross and networked with St Mary’s, Chelsea & Westminster and Northwick Park. The specialist MDT is divided into four organ-specific meetings for testis, kidney, bladder and prostate cancer.

The Core members or their arranged cover should attend at least 2/3 of the number of LUMDT meetings. The following have agreed to be members of the Core Team and their cover, see table 1:

Table 1

<table>
<thead>
<tr>
<th>Core Members</th>
<th>Cover</th>
<th>Contact details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant Urology Surgeons</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mr Bijan Khoubehi</td>
<td>MD/NB</td>
<td>Secretary 020 331 58559</td>
</tr>
<tr>
<td>Mr Michael Dinneen</td>
<td>BK/NB</td>
<td>Secretary 020 331 58559</td>
</tr>
<tr>
<td>Mr Nigel Borley</td>
<td>MD/BK</td>
<td>Secretary 020 331 58559</td>
</tr>
<tr>
<td>Mr Hama Attar (Locum Consultant)</td>
<td>NB/MD/BK</td>
<td>Secretary 020 331 58559</td>
</tr>
<tr>
<td>Consultant Oncologists</td>
<td>SS/SpR</td>
<td>Secretary 020 331 55054</td>
</tr>
<tr>
<td>Dr Cathryn Brock (Medical Oncology)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Role</td>
<td>Consultant</td>
<td>Contact Details</td>
</tr>
<tr>
<td>-----------------------------</td>
<td>-----------------------------------</td>
<td>----------------------------------------</td>
</tr>
<tr>
<td>Consultant Uro-Radiologists</td>
<td>Dr Catriona Davies</td>
<td>020 331 55152 or X-ray reception on Ext: 58570</td>
</tr>
<tr>
<td>Consultant Histopathologists</td>
<td>Dr James Canton</td>
<td>020 331 21354</td>
</tr>
<tr>
<td></td>
<td>Dr Jo Lloyd</td>
<td>020 331 21354</td>
</tr>
<tr>
<td></td>
<td>Dr Nyethane Ngo</td>
<td>020 331 21354</td>
</tr>
<tr>
<td></td>
<td>Dr Emma Ethna Mannion</td>
<td>020 331 21354</td>
</tr>
<tr>
<td>Clinical Nurse Specialist</td>
<td>Teresa Kua</td>
<td>020 331 55460</td>
</tr>
<tr>
<td></td>
<td>Caroline Websdale</td>
<td>020 331 55348</td>
</tr>
<tr>
<td>MDT Coordinator</td>
<td>Lillian Izurieta</td>
<td>020 331 52090</td>
</tr>
<tr>
<td>Clinical Lead for User/Patient Information Issues</td>
<td>Teresa Kua</td>
<td>020 331 55460</td>
</tr>
<tr>
<td>Clinical Trials Lead</td>
<td>Dr Cathryn Brock</td>
<td>020 331 55054</td>
</tr>
</tbody>
</table>

Extended Membership of the Joint MDT (14-2G-105)
The following have agreed to be members of the extended team as listed below in Table 2:

Table 2

<table>
<thead>
<tr>
<th>Extended Members</th>
<th>Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stoma Nurse</td>
<td>Melanie Jerome</td>
</tr>
<tr>
<td></td>
<td>Mandy Gunning</td>
</tr>
<tr>
<td>Counsellor</td>
<td>Russ Hargreaves</td>
</tr>
<tr>
<td>Specialist Palliative Care</td>
<td>Gary Artiss</td>
</tr>
<tr>
<td>Clinical WLCN Research Co-ordinator</td>
<td>Vikram Bohra</td>
</tr>
</tbody>
</table>
Clinical Physicist for Brachytherapy: Ion Coles
Clinical Psychologist: Dr Troy Chase
Chemotherapy Nurses: Shauna McCann (CWH)
Occupational Therapist: Esther McDonald (CWH)
Social Worker: Teresa Birkett
Research Nurse: Sarah Kelly

**Oncology MDT Core members**
Both the clinical and medical oncologists listed above (Dr Simon Stewart, Dr Cathryn Brock) are also core members of the Specialist Urology MDT held at Imperial College Healthcare NHS Trust on a weekly basis, just before the local MDT.

Cancer Services at CWH are managed by Laura Bewick.

**Responsibilities of Nurse Specialists**
The responsibilities of this post, as agreed by the LUMDT Lead Clinician comprise the following:

- Allocation of key worker, the key worker has responsibility for ensuring Holistic Needs Assessment (HNA) are recorded/docuumented in patient records
- They will ensure that the results of the HNA are taken into account when decisions on treatment are made
- They will contribute to the multidisciplinary discussion and patient assessment/care plan decisions of the team at the weekly MDT meeting;
- They will provide expert nursing advice and support to other health professionals in the Core and Extended MDT membership and other healthcare professionals involved in the patient's care;
- They will participate in clinical audit;
- They will ensure that patients and carers have access to and effective communication with the appropriate members of the LUMDT when required, and will nominate different Key Workers for any portion of the cancer journey as appropriate;
- They will co-ordinate the management plan for patients, ensuring that delays are avoided wherever possible
- Along with the MDT co-ordinator, they will ensure written and verbal communication between the MDT, referring clinicians, GP’s and specialist centres;

**Additional Nurse Specialist Responsibilities**
Contribute to the management of the service;

- They will undertake research as appropriate and work with the NWLCN research facilitator based in the Trust;
- They will be professionally accountable to the Cancer services lead nurse and/or the Nurse director(s) in respective organisations;
- They will have post-registration qualifications in cancer care / specialist urological nursing;
• They will advance the development and practice of evidence based cancer nursing for urology patients in line with national recommendations and measures as and when available;
• They will act as the first point of contact between GP’s, patients and the core LUMDT membership and where appropriate, be the main Key Worker and Patient Advocate throughout the cancer journey;
• They will educate, support and counsel patients and relatives, providing written information as appropriate, or direct patients and carers to other sources of information;
• They will work with the Cancer Service Manager and the Outpatient team to co-ordinate collection of regular data on urological cancer services to allow effective audit of the work of the LUMDT;
• They will work as part of the Service Improvement team representing the LUMDT

4. Referral Arrangement (14-2G-106,110))
All patients referred to the CWH are discussed in the LUMDT meeting. Patients with high risk superficial bladder cancer are discussed in the Specialist Bladder MDT and patients diagnosed with kidney cancer potentially suitable for nephron sparing surgery are discussed within the specialist renal MDT (please see LCA guidelines attached here)

The majority of referrals are received from primary care, either as patients referred urgently with suspected cancer under the “2 week rule”, or as urgent referrals, though some may be referred as routine referrals with symptoms from allied urological conditions. A minority of referrals are In-House or Tertiary. Please see appendix 1 for routes of referral and all organ specific patient pathways.

CWH have dedicated assessment clinics for Prostate Cancer and Haematuria.

Clinic Booking Rules and follow up care for Suspected Prostate Cancer (CWH)( 14-2G-107)
All urgent 2-Week Wait Suspected Prostate Cancer referrals are booked by the Clinical Nurse Specialist or her cover into Mr. B. Khoubehi outpatient clinic on Monday afternoons within 2 weeks as per the attached outpatient timetable. If a GP referral is made on GP letterhead and states “Urgent”, the letter is vetted and prioritized by the consultants before being booked into outpatient slots. There are 2 slots available on each consultant outpatient clinic to be booked in

- This clinic is held in the outpatient department clinic and is for new patients who potentially have prostate cancer
- The clinic follows the guidelines agreed by the network
- This clinic provide same day MRI scan
- This clinic is accessible and identified in GP information and has a contact point for GP referrals
• The clinic slots are bookable and numbered
• The clinic is run by surgical core members of the MDT
• This clinic is part of the timetable and/or work plan of the nurse specialist.

Haematuria Clinic (CWH) (14-2G-108)
This clinic is under both Mr Dinneen and Mr Khoubehi and is nurse led each Monday morning and follows the same criteria as set out above with the added benefit of G.Ps being able to book directly into the clinic using the Choose and Book system.

• This clinic is held in the outpatient department clinic
• The clinic follows the guidelines agreed by the network
• This clinic is accessible and identified in GP information and has a contact point for GP referrals
• There is direct access into the clinic via the Choose and Book system.
• The clinic slots are bookable and numbered
• The clinic is run by surgical core members of the MDT
• The Haematuria Clinic provides flexible cystoscopy.
• This clinic also proved same day CT Urogram which make it a one-stop clinic

Prostate Biopsies (CWH):
Prostate biopsies are perform in the treatment centre.

Post-Biopsy – All patients having a prostate biopsy are pre-booked for a follow up appointment 14 days later to be given their result.

General Histo-pathology EQA
Both Dr Jo Lloyd, Dr Nyethane Ngo and Dr James Carton take part in the general histopathology EQA which includes urology pathology. Their EQA histo-pathology certificates can be found in the annual report.

6. The MDT Meeting
Meetings are held weekly at 10:30am on Wednesday mornings in the X-Ray Seminar Room at Chelsea & Westminster Hospital. The Histopathologist joins the meeting via a video link in the Glazer MDT Room, 3rd Floor QEQM, St Mary’s Hospital. The following contingency plans for MDT decision making if video conferencing fails are:

Planned maintenance or downtime – The core members of the MDT will be encouraged and supported to attend the MDT meeting at the host site. All patient information will be transferred to the relevant host MDT coordinator in a timely and secure manner.

Unexpected failure of video conferencing system – If there is an urgent need to discuss a patient’s clinical management, every effort should be made to contact the histopathologist by telephone to agree a management plan. This reflects the policy applied if a treatment decision is required outside of the MDT meeting. The patient should then be discussed in retrospect at the following meeting. Non-urgent cases should be deferred but appropriately prioritised for discussion at the next MDT meeting.
All core members and/or their cover must be present for at least 2/3 of all the meetings throughout the year. All core members should also attend without cover at least 2/3 of the meetings. Core member attendance will be recorded by the MDT Coordinator, the attendance record can be found in the Annual Report.

The MDT co-ordinator shall be responsible for collecting and auditing the availability of patients’ notes for the weekly meeting. The MDT co-ordinator shall be responsible for compiling the list of cases to be discussed with appropriate information from any of the core team members or deputy, who in turn will inform the co-ordinator of such cases at least 24 hours before the meeting except in emergencies. Each member of the team will be informed by e-mail on the Monday prior to the meeting of the names of the patients to be discussed in the meeting and the responsible consultant. Additional patients may be added on the Tuesday morning but only if a consultant and his team will be present at the meeting the following day to present the case. A full list of the roles and responsibilities of the MDT Coordinator can be found in Appendix 2.

The Urological Surgical and oncological core members or their deputies assisted as necessary by the Urology Cancer CNS will prepare a short summary of the history and investigations to date according to the MDT Proforma. The proforma will indicate the names of the responsible clinician and their key worker as well as a contact telephone number.

A member of the consultant team must be present at the meeting at which the patients’ case is discussed. Cases will be deferred until the next meeting if there is no one from the referring team.

**Treatment Planning Decisions between MDT’s (14-2G-111)**
Where an urgent treatment planning decision is needed before the next scheduled meeting the responsible clinician should discuss this with the chair of the particular section or their deputy. The patient’s management will be discussed at the subsequent MDT meeting.

Responsibility for the patient’s care remains with the designated consultant, including, organization of scans, x-rays, outpatient appointments, provision of written patient information regarding urological cancers, local / network services, help and support groups etc.

**Radiology** – Scan reports that show a suspected urological malignancy will have a message sent to the consultant’s inbox on email to highlight this. The MDT co-ordinator will also receive an email message from the radiology secretary/consultant and the patient’s case will be discussed at the next MDT. An urgent outpatient appointment will be made within 10 working days or less to see the patient to inform of results, further investigations or treatment.

Where possible, patients should be given opportunity to choose and pre-book their investigation appointment, elective admission or treatment date after discussion by the MDT.
New cancer patients to be reviewed by a multidisciplinary team for discussion of initial treatment plan (14-2G-103,109,110)

All cases (including High Risk Superficial Bladder Cancer, Kidney Cancer suitable for nephron sparing surgery, Testis Cancer, Penile Cancer and candidates for radical treatment of localised Prostate Cancer) will be re-discussed in the relevant section (Based on Organ of Origin) at the weekly Joint Imperial Hospitals Group Specialist MDT meeting the following week or as soon as all appropriate staging investigations have been completed.

The LUMDT has also agreed a policy that all patients with
- Early organ confined prostate cancer
- Kidney cancer
- Early Stage 1 penile cancer
- High risk superficial bladder cancer
- Muscle invasive bladder cancer
- Testis cancer

should be offered a multidisciplinary consultation with an appropriate surgeon (with specialist nurse present) and an oncologist. This consultation may take place in combined clinics or sequentially after an appropriate interval (for assimilation of information) at the choice of the patient.

If the patient is unaware of the diagnosis when their case is presented at the MDT, they will be booked in for an urgent outpatient appointment to see a Consultant within 10 working days or less of the MDT. Patients should be informed of their diagnosis by a consultant whenever possible. Staff should follow the Trust guidelines for “Breaking Bad News”.

Treatment Planning Decisions (14-2G-111)

Individual patient management plans will be recorded by the lead clinician of the MDT or the clinician in charge of the patients care. Alongside the decision the lead clinician should indicate who is responsible for the next step in clinical management, where this should take place and if the case needs to be discussed again before a decision regarding definitive treatment can be made. All discussions that occur within the MDT meeting will be recorded on an individual form (proforma) in the database, which will be added to the patient’s notes. The MDT will complete an annual audit against the recording and filing of this documentation. The Proforma will include the following information from the MDT meeting where relevant: (copies of the MDT Proforma can be found in Appendix 3)

- The identity of patient discussed

  - New Cancer Diagnosis
  - Further staging investigations necessary and urgency (preferably arranged with dates)
  - Further endoscopic management plan with timescale-dates
  - Need for further intra-vesical adjuvant therapy with timescale-dates
  - Need for Pre-operative neo-adjuvant chemotherapy / radiotherapy / hormonal therapy / other
  - Need for staged treatment (e.g brachytherapy plan and implant)
  - Involvement of other surgical specialities or referral to other specialist MDT
  - Type of operation to be performed (subject to patient choice)
  - Planned Post-operative adjuvant therapy
  - Follow-up plan
In the cases of patients with:
- penile cancer;
- high risk superficial bladder cancer;
- kidney cancer with the potential for nephron sparing surgery;

The decision from the LUMDT should be updated if necessary after discussion with the relevant specialist or supranetwork team. In the case of patients referred for specialist/supranetwork care to another team in the network or a neighbouring network, the team to which they are referred should be named.

**Joint Treatment planning for TYAs**
The Primary Treatment Centres (PTC) for teenagers and young adults with cancer in North West London is based at University College London Hospital or the Royal Marsden Hospital for South West London.

Young adults aged 16-18 should be seen and treated at the TYA PTC and have their management plans discussed by the TYA PTC. Shared care may be arranged as part of the pathway and as defined by the PTC on an individual patient basis following discussion between the PTC and the local team.

Young People aged 19-24 years should be offered the choice of being seen and treated at the TYA PTC or in a designated TYA Unit. Patients in this age group with a known or suspected cancer or who are found to have a cancer whilst under the care of the LUMDT must be offered the opportunity to have their care delivered at the PTC or if appropriate at a designated TYA unit. Chelsea and Westminster has been designated as a TYA unit.

**Follow up of MDT Decisions (14-2G-109)**
All patients with newly diagnosed organ-confined prostate cancer, early (Stage 1) penile cancer, high risk superficial bladder cancer and muscle invasive bladder cancer, and selected other patients (to be decided at the time of MDT discussion e.g. organ confined recurrent prostate cancer, salvage radiotherapy for local failure after radical prostatectomy) will be discussed at the LUMDT and then offered a multidisciplinary consultation (synchronous, sequential or staged) with the surgeon, oncologist and specialist nurse prior to deciding which modality to choose.

**Communication (14-2G-109)**
The consultant responsible for the patient’s care or his/her nominated deputy will inform all newly diagnosed cancer patients of their diagnosis within 1-2 weeks of MDT discussion of the case, and of any additional decisions made at the MDT discussion preceding this visit. This discussion will take place in a face-to-face meeting. The Urology Specialist Nurse will meet all patients at their first attendance to the 1-stop diagnostic clinics (majority of patients), or after the “Breaking Bad News Consultation” has taken place (minority of patients).

**Role of the Key worker (14-2G-113)**
There will be a single named key worker for the patient’s care at any time during the pathway. The key worker will take a central role in co-ordinating the
patient’s care and promoting continuity e.g. ensuring the patient knows who to access for information and advice. It is the responsibility of the CNS to ensure the key worker is allocated for each patient and the name is recorded in the patient’s notes. Please see appendix 4 for Key worker Policy. An annual audit will be completed to ensure compliance (see work plan and annual report).

Besides the regular LUMDT meetings the team shall hold an annual meeting to discuss, review, agree and record some operational policies and produce a report on clinical trials.

**Annual Meeting**
There will be an Annual Meeting to discuss, review and agree operational policies. Please see Annual Report for agenda and minutes.

**7. Data Collection (14-2G-117)**
Data will be collected on all aspects of the LUMDT’s functioning to allow audit of it’s effectiveness in delivering high quality care. Specifically the following information will be collected:

The MDT must provide information on the following surgical procedures performed by the LUMDT during the previous year:
- The total number of radical prostatectomies
- The total number of Cystectomies,
- The total number of radical prostatectomies by each surgeon (requirement is that there be more than 5 for each individual surgical member of the MDT who is currently performing this operation)
- The total number of cystectomies by each surgeon (requirement is that there be more than 5 for each individual surgical member of the MDT who is currently performing this operation)
- The combined total of radical prostatectomies and/or total cystectomies, recorded above and performed under the care of the LUMDT, should be 50 or more

This data can be found in the Annual Report.

**Urology Cancer Data** – The demographic data, diagnosis, investigations, treatment plan, subsequent referrals and dates of investigations, clinical stage and final pathological stage and grade will be recorded on all patients on the LUMDT proforma, and this will ultimately be recorded in the “active patients” database (InfoFlex) to allow analysis. All new urological cancer diagnoses and whether they were made by 2-week urgent referral will be identified during the LUMDT and recorded on the LUMDT proforma for subsequent entry into the cancer waiting times database. Pathology and cancer registry data will also be recorded for all cancer cases.

**Referral data** – Waiting times for urgent and suspected cancer (especially 2 week referrals) and the appropriateness of referrals made under these guidelines will be collected by the Trust Outpatients 2 week wait co-ordinator, discussed monthly with the Clinical MDT Lead, MDT co-ordinator, urology team and service improvement facilitator at Service Improvement (SIP) meetings. Breach analysis will be undertaken in order to improve patient journey times.
and to ensure that targets are met. Feedback will be given to the 2-week wait co-ordinator, GPs, directorate leads accordingly.

Minimum Datasets – The minimum datasets for urological cancer have been agreed at Network Level and these will be used. The MDS includes the following:

- The cancer waiting times monitoring, including Going Further on Cancer Waits, in accordance with DSCN 20/2008, to the specified timetable as specified in the National Contract for Acute Services;
- The Cancer Registration Dataset as specified in the National Contract for Acute Services.

The MDT records the Cancer Waiting Time element of the MDS electronically,


Patients will be given an opportunity to have a permanent record or summary of their consultation between them and the doctor, specifically when diagnosis, treatment options and follow up arrangements are discussed. However the LUMDT should be aware that a permanent record may be required at other parts of the patient’s journey.

Permanent record/summary process (14-2G-115)

When patients are given their diagnosis or a significant event has occurred the consultant and or the CNS will offer a written summary of the consultation. This is given within the information provided by the team along with key worker contact details. The formal clinic letter is also copied to the patient. This process should be audited on an annual basis.

Patient Feedback (14-2G-116)

The MDT should survey patients’ experience of the services every two years and discusses the result at the Annual MDT Operational Meeting and be included in the Annual Report. The survey will include finding out whether patients were offered a key worker, the MDT’s information for patients and the opportunity of a permanent record of a consultation at which the treatment options were discussed. The team must implement at least one action point as a result of the survey.

Patient Information (14-2G-114)

The LUMDT will provide patients and carers with written material which includes:

1. information specific to that MDT about local provision of the services offering the treatment for that cancer site;
2. information about patient involvement groups and patient self-help groups;
3. Information about the services offering psychological, social and spiritual/cultural support, if available;

4. Information specific to the MDT’s cancer site or group of cancers about the disease and its treatment options (including names and functions/roles of the team treating them).

Health needs assessment (HNA)
All patients should be offered an holistic needs assessment (HNA) at diagnosis and subsequently if their disease status changes. Patients should be offered advice and support to address any immediate concerns – physical, mental, spiritual or financial – on completion of the HNA with onward referrals made as necessary.

9. Treatment (including palliative care) (14-2G-110,111)

Network Guidelines
These guidelines have been agreed by the Lead Clinician of the LUMDT and the Chair of the NSSG. (Clinical Guidelines attached at page 9)

They are as follows;
- Kidney Cancer
- Bladder Cancer
- Prostate Cancer
- T2 Muscle Invasive Bladder and Organ-confined Prostate Cancers

For the network guidelines relating to Testicular and Penile Cancer, these have been agreed by the Lead Clinician of the LUMDT and Chair(s) of the Boards of any other referring networks.
- Testicular Cancer Diagnosis and Assessment
- Testicular Cancer Referral for Treatment to another Team
- Testicular Cancer MDT discussion
- Testicular Cancer defining specialist care for the network
- Testicular cancer referral of histology and radiology
- Penile Cancer-diagnosis assessment and MDT Discussion
- Penile Cancer defining specialist and Supranetwork care for the network

All patients undergoing cancer excisional surgery or excisional biopsy will be reviewed the same week or the week after such operative treatment. Patients undergoing chemotherapy will be reviewed at the discretion of the Medical Oncologist during and at completion of chemotherapy, at 3 months after completion of chemotherapy and regularly thereafter. Patients undergoing Radiotherapy will be reviewed in the outpatients on completion of the full course of treatment and brought back to the LUMDT for discussion as necessary for reasons of morbidity, failure to respond, relapse, or progression.

Network Agreed Follow-Up Guidelines (11-2G-114)
Written follow-up guidelines should be agreed between the specialist team and the referring teams and endorsed by the NSSG. The follow up guidelines can be found within the Urology NSSG Clinical Guidelines (attached at page 9)
- Kidney cancer
- Bladder cancer (non muscle invasive)
- Prostate cancer
• Bladder cancer (muscle invasive/metastatic)
• Testicular
• Penile

10. Network & General Audits (14-2G-117)

Network Audit (11-2G-138) The MDT will participate in the network audit project which is agreed by the lead clinician of the MDT and the chair of the NSSG. The progress of the network audit will be reviewed and discussed at the Annual Operational Meeting. Details of the current audit can be found in the Annual Report and Work Plan.

General Audits – The MDT will participate in a locality audits on all major aspects of the services it provides. Each Surgeon or surgical team performing major pelvic and renal cancer extirpative surgery will collect the following outcomes data with special emphasis on numbers and types of procedures performed annually, re-operation rates, morbidity relevant to the procedure, hospital stay, blood transfusion rates, pathological margin negativity for organ extirpative surgery performed with curative intent, salvage rates after primary treatment with curative intent has failed, and mortality (overall and cancer specific). These data should be annually updated for each surgeon and be available if requested to patients, GP’s, PCT’s in case of specialist commissioning, and the Network.

Service Improvement – Changes in service provision will be based on outcomes of audit data, process mapping exercises and user satisfaction surveys, and will be presented to the MDT Annual Operational Meeting before implementation in full subject to availability of funding.

11. Research (14-2G-118)

Participation in clinical trials and entry of patients with urological cancer is actively supported at Chelsea and Westminster Hospital Foundation Trust, Imperial College Health Care Trust and by the Network Urology Tumour Board. Eligibility of patients for trials is discussed at MDT meetings. A list of trials currently approved within the Network is available and reviewed regularly at Network Urology Tumour Board meetings. There is also a comprehensive program of local research activity which is linked to the MDT in terms of Trial Recruitment. A full list of all Network agreed trials can be found in the Annual Report, page 8.
APPENDIX 1 – Referral arrangements and patient pathways

Primary Care

Urgent “2 week rule” referrals - These are received by the 2-week wait coordinator in the Appointments Team via a dedicated fax line, and are vetted by a Consultant Urological Surgeon (or his deputy – nominated colleague, sub-specialist CNS, Staff Grade or SpR in Urology) at least 2 x week and given an appointment for the most appropriate 1-stop or appropriately designated outpatient clinic slot. For cases of suspected testicular cancer, patients will be seen within 48 hours of referral receipt (outpatients or rapid assessment unit) and be listed for surgery on the next elective urological operating list (must be within 1 week except by patient preference). For patients with suspected prostate cancer, an appointment is made for either the 1-stop Prostate Clinic (now available at CWH) or first available outpatient clinic. Patients with macroscopic haematuria are given an appointment in the 1-stop Haematuria clinics at either site. Patients with suspected penile cancer are given an appointment in the regular outpatient clinic within 2 weeks of referral. The same services are offered to urgent suspected cancer referrals not made under the 2-week rule as appropriate after vetting by a core team member.

Routine referrals - All other referrals are vetted by a Consultant Urological Surgeon, Staff Grade Urological Surgeon or Urological SpR on a weekly basis at the end of the outpatient clinic. Any patients who may have urological cancer, meeting the 2-week criteria on the basis of the referral letter contents are referred urgently, directly to the 1-stop clinics. All other outpatients with suspected cancer are seen in an urgent designated outpatient slot.

Referrals from hospital based teams

In-patient and Emergency referrals – Patients with possible urological cancer who are referred as in-patients or admitted through A&E will undergo appropriate diagnostic tests in the 1-Stop Clinics (prostate or haematuria), in-patient operating lists (3 x week), day surgery unit urological operating lists (5 x week), or in routinely held radiology sessions (US, CT, MRI, prostate needle biopsy). The case should be discussed with a member of the urology or oncology team at the time of formal referral. This individual shall take responsibility for informing the MDT co-ordinator in order that the case is discussed at the next urological MDT meeting. Where immediate action is required (e.g. spinal cord compression risk, bilateral renal obstruction etc), the case will be discussed urgently with a core member clinician (Urological Surgeon or Oncologist) as appropriate and appropriate action taken and reported for documentation purposes at the next MDT meeting.

Out-patient referrals – Routine outpatient referral letters will be vetted by a Consultant Urological Surgeon or nominated deputy in the same way as referrals from primary care. Any patient with suspected cancer meeting the 2-week wait criteria will be seen urgently in the 1-stop Prostate, Haematuria or outpatient clinics. Any routine or urgent referrals can be ‘Upgraded’ by the clinical team member in accordance with the new cancer waiting time targets (Going Further with cancer Waits (Dec 2008) and the MDT Coordinator is made aware.

Referrals from other hospitals – All patients with a diagnosis of urological cancer from other hospitals will be seen within 2 weeks of referral, and will be discussed at the next MDT meeting after they have been seen. They should be discussed with the urological or oncological Consultant.

Tertiary Referrals Histology

Any patient with prostate cancer accepted for treatment by the MDT shall have any outside histology requested (and if deemed necessary, any scans) for review by the MDT lead pathologist and the responsible core team clinician before such treatment is undertaken.
Urological Cancer Pathway

Prostate Cancer Pathway

Bladder Cancer Pathway

Renal Cancer Pathway

Penile Cancer Pathway

Testicular Cancer Pathway
## LCA Urology Urgent Suspected Cancer Referral Form

**Date of GP decision to refer:**

**No. pages faxed:**

**PLEASE COMPLETE THIS FORM AND FAX TO THE RELEVANT URGENT REFERRAL TEAM WITHIN 24 HOURS**

### Patient Details – please provide multiple contact details

<table>
<thead>
<tr>
<th>Last name:</th>
<th>First name:</th>
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<tr>
<td>Gender: M / F</td>
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<td>Address:</td>
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<tr>
<th>Telephone No (daytime):</th>
<th>Telephone No (evening):</th>
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<tbody>
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<td>Mobile no:</td>
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<td>Email:</td>
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<tr>
<th>DOB:</th>
<th>Interpreter: Y / N</th>
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<tbody>
<tr>
<td>Language:</td>
<td>Ethnicity:</td>
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<td>NHS No:</td>
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### Urgent referrals criteria (tick category)

1. Clinically malignant prostate on rectal examination. PSA result to be sent with referral

2. Raised age-related PSA (50-60, 60-69, 70+), unless the prostate test is malignant or the PSA is over 20 when immediate referral is appropriate

3. Visible haematuria in adults >18 years old

4. Non-visible haematuria greater than a trace on dipstick in adults >50 years old

5. Symptoms of UTI with persistent sterile pyuria >60 years old

6. Palpable renal mass, or renal lesion which is suspicious for malignancy identified clinically or radiologically

7. Testicular lump which appears to be intratubular or solid suspicious of cancer

8. Raised/suspicious penile lesion or phimosis with discharge

### Other information or symptoms:

### GP Details

<table>
<thead>
<tr>
<th>GP name and initials:</th>
<th>Practice code:</th>
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<tbody>
<tr>
<td>Address:</td>
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<tr>
<th>Telephone No:</th>
<th>Fax No:</th>
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<tr>
<td>Practice email address:</td>
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### Investigations Required for Referral

- **PSA** (required for urgent referrals criteria 1 & 2)
  - First PSA: [ ]
  - Second PSA: [ ]

- **MSU** (required for urgent referrals criteria 1–5):

  Creatinine level (request at time of referral required for all urgent referral criteria)*:

  *Please tick if creatinine result to follow:

### Patient Medical History

**Current medication**:

**Existing conditions**:

**Otherwise please fax current medication list and medical history**

### Discussions with Patient Prior to Referral

1. Has the patient been told it is a suspected cancer referral?

2. Has the patient been given the urgent referral letter?

3. Have you told the patient where they are being referred to?

4. Have you told the patient they need to be seen within 14 days?

---

**Clinical guidelines and hospital contact details are on the reverse of this form**
Appendix 3 – List of Responsibilities for MDT Coordinator Role

1. Facilitate and co-ordinate the functions of the multidisciplinary team meetings;

2. Ensure the appropriate proportions of patients are discussed at MDT’s;

3. Help with the introduction and changes to proformas used to ensure all patients are discussed, treated appropriately and outcomes are recorded and reviewed. Ensuring patients’ diagnoses, investigations, and management and treatment plans are completed and added to the patient’s notes;

4. Managing systems that inform GP’s of patient’s diagnosis, decisions made at outpatient appointment etc;

5. Working with staff to ensure all patients have a booked first appointment, investigation and procedure and record details of patients coming via a different route;

6. Working with key MDT members to identify areas where targets are not achieved, undertake process mapping to identify bottlenecks;

7. Undertake demand and capacity studies where appropriate;

8. Data collection and recording of data;

9. To manage the systems according to guidelines, monitoring milestones and submitting the required reports in the given format and required times;

10. Keep comprehensive diary of all team meetings and record attendance at meetings;

11. Take minutes at the multidisciplinary meetings, type notes back in the required format and distribute to all concerned;

12. The post holder will be expected to be instrumental in the development of databases to capture patient information and report this to the clinicians on a weekly basis;
13. Inform lead cancer manager of waiting times for patients when these exceed appropriate targets;

14. Ensure lists of patients to be discussed at meetings are prepared and distributes in advance;

15. Ensure all correspondence, notes, x-rays, results, etc are available for the meetings;

16. Ensure action plans for patient care are produced with agreed reviews;

17. Assist in capturing cancer data on all patients and assist in the development of systems to complement the cancer audit system;

18. Ensure members or their deputies are advised of meetings and any changes of date, venue, etc.
## Appendix 4 – CWH MDT Proforma

Cancer Diagnosis: Please note this fax contains confidential information. MDT form to be faxed to GP within 24 hours of the MDT decision.

**Chelsea and Westminster Hospitals**

**Urological Cancer MULTI-DISCIPLINARY TEAM (MDT) MEETING**

Summary sheet / Patient checklist

(Chelsea and Westminster Hospital Direct Tel Line: 020 8746 8559 & Fax 020 8746 8459)

<table>
<thead>
<tr>
<th>Date:</th>
<th>Name of Key Worker:</th>
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<tr>
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<th>GP Name:</th>
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<tbody>
<tr>
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<td>GP Address:</td>
</tr>
<tr>
<td>NHS Number:</td>
<td>GP phone no:</td>
</tr>
<tr>
<td>DOB:</td>
<td>GP fax no:</td>
</tr>
<tr>
<td>Consultant:</td>
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**Reason for discussion at MDT:**

- New Diagnosis: [ ]
- Staging: [ ]
- Review of Management: [ ]

<table>
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<tr>
<th>Referral Source:</th>
<th>2-week</th>
<th>Routine</th>
<th>Tertiary</th>
<th>Inpatient</th>
<th>Established Patient</th>
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<tbody>
<tr>
<td>2-week referral date:</td>
<td>31-D target exp. date:</td>
<td>62-D target exp. date:</td>
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<th>DRE:</th>
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**Presentation/Co-morbidity/Past Medical History:**

- Results of Investigations:
- Diagnosis:
- Management Options:
- Plan of follow-up:
- What insight does the patient have into illness/diagnosis?
- Entry into clinical Trial: Yes [ ] No [ ]

**Signature of MDT member:**

(Print name and title):

---

Local CWH/Urology MDT Operational Policy FINAL 21
Appendix 5– Key Worker Policy (08-2G-112)

- The key worker is usually identified as the Urology Cancer Clinical nurse specialist
- The key worker is to co-ordinate the patient care and treatment pathway, promote continuity, and ensure that patients and carers know how to access information and advice
- Attend and actively participate in weekly MDT and other relevant meetings
- All patients to be informed of a named key worker (CNS) with contact details on diagnosis and this information to be entered in case notes by a member of the MDT
- Provide sensitive, non judgemental support and information to patients and families affected by a diagnosis of urology cancer
- Operate between the hours of 9-5 Monday to Friday inclusive
- Ensure effective referrals to appropriate services and access to information to suit individual patient’s preferences / needs
- Ensure open communication by use of telephone and answering machine for patients
- To be present in clinic when patients are given their diagnosis and their treatment plan is discussed
- Discuss complex aspects of care with the appropriate physician (Surgeon / oncology/palliative)
- Maintain appropriate contact with patients throughout disease trajectory
- Ensure the information given to patients is accurate and where appropriate evidence based
- Support the lead clinician for Urology cancers, implementing local and national policies
- Role of the key worker will be passed on where appropriate
- Utilise research and clinical audit appropriately

Key workers can be any of the following;
- Cancer Nurse Specialists / Consultant
- Medical Consultant or Registrars
- Palliative Care Team
- Community Specialist Palliative Care Team
- Other Allied Health Professionals as appropriate
Extracts from Operational Policy

The objectives of the MDT are:

- To discuss all patients diagnosed with a urological malignancy in a timely fashion.
- To ensure that all healthcare professionals within the MDT communicate the management choices to the patients and their carers, which enable them to make informed decisions about their treatment.
- That the communication is with clarity, sensitivity and expertise and in a timely manner with appropriate information.
- To work within the clinical guidelines as agreed by the LCA urology Pathway group for urological cancers.
- In partnership with patients and their carers, the cancer services department and the network service improvement team to continually evaluate the service provided and identify areas of improvement and implement changes accordingly.
- To participate in regular audit, to include any audit projects agreed by the Urology Cancer LCA pathway group.

MDT MEETING FOR THE DISCUSSION OF PATIENTS

The Urology MDT meets weekly on a Monday 09.00 – 09.45 to formally discuss and agree the initial treatment plan for every new patient diagnosed with a urological cancer. The meeting takes place in the Education Centre at The West Middlesex Hospital. All members are present. Facilities are available in the room for viewing of pathology/cytology slides and for accessing imaging via the hospital PACS system.

Referral to Specialist Urology MDT Team

Following discussion at the local MDT a decision may be made to refer a patient to the Specialist Urology MDT at Imperial Healthcare NHS Trust, Charing Cross Hospital (CXH) Site. It is part of the operational policy for the local urology MDT that the following are discussed by the named specialist team prior to either referral to that team or management by the local team. The MDT agree to work to the Network (LCA) guideline on the patient pathways.
Kidney Cancer –

Patients with kidney cancer, potentially suitable for nephron sparing surgery (as per Network guidelines) are referred to the specialist MDT for discussion and treatment.

As soon as the consultant has informed the patient of their diagnosis and the referral to the specialist urology MDT the MDT coordinator at West Middlesex Hospital contacts the MDT coordinator at CXH so that the patient can be added for discussion. The specialist MDT meeting at CXH takes place weekly on a Wednesday morning from 0900-1300. Most documents and scans are transferred electronically. Occasionally the consultant takes documents. Any histopathology, radiology discs or clinic letters are collated by the urology secretary. The consultant takes these to the CXH MDT for presentation of the patient. The consultants who attend the local urology MDT are also core members of the specialist urology MDT at CXH