Meeting of the SWAG Network Urological Cancer Clinical Advisory Group (CAG)

Thursday 26th June 2025, 13:00-17:00

Aerospace Bristol, Hayes Way, Patchway, BS34 5BZ

This meeting was sponsored by Astellas, AstraZeneca and Bristol Myers Squibb

Chair: Jonathan Aning

REPORT **ACTIONS**

(To be agreed at the next CAG Meeting)

1. Welcome and apologies

Please see the separate list of attendees and apologies uploaded on to the SWAG website here.

There was good representation from across the region online and in person.

2. Review of last meeting's report and actions

As there were no amendments or comments following distribution of the report from the meeting on Tuesday 7th January 2025, the report was accepted as finalised.

Uro CAG are pleased to note that Consultant Urologist Helena Burden has been appointed to develop the GIRFT Bladder Cancer Best Practice Guide, with a plan to be finalised by December 2025.

3. Patient Experience

3.1 Outputs from the Clinical Nurse Specialist (CNS) Breakout Meeting

Presented by Lead Cancer Nurse Rosalie Helps

Ros Helps held a CNS break-out meeting on 9th June 2025 in response to an action from the previous meeting to reinstate the group, which had paused since the COVID-19 pandemic.

Eleven representatives attended; it had not been possible for CNS representatives from Gloucestershire or Somerset to attend on this occasion. Although it is recognised that clinical work takes priority, it would be ideal if CNS teams are supported to send at least one representative.

Consensus was favourable on reinstating the meeting at alternating venues or via MS Teams every 6 months.

CNS Michelle Syms from Weston General agreed to undertake the role of Chair, with the length of tenure to be determined.

The next meeting date will be held on Tuesday 3rd February 2026, to follow the main CAG, for the purpose of sharing best practice and experience, discussing potential workstreams and solving problems common to all.

In particular, the group felt that the main benefit of the network group would be to optimise patient pathways where care is shared across centres for surgery and treatments. Improving communication between teams is an area for improvement that is often flagged in the National Cancer Patient Experience Survey (NCPES).

The group will also arrange CNS educational events to support those whose background knowledge may not be urology specific.

Resources for these events will be provided by the SWAG Cancer Alliance, as confirmed by the ACCEND Lead Liina Haythornthwaite and Managing Director Ruth Carr.

Actions: To arrange an educational update on erectile dysfunction — **Penile Cancer Specialist, NBT**

To send the date for the next CNS meeting and send content for the educational event. — **Michelle Syms/ CNS Team**

AGREED

To confirm a CNS co-Chair for the Urological Cancer CAG: Lucy Hamblyn

Lucy Hamblyn is an Advanced Nurse Practitioner who covers the Uro-Oncology Clinics in both BHOC and Weston, was previously a Urological Cancer CNS in Southmead and the BRI and is happy to represent the nursing element of Uro CAG going forward.

It was re-emphasised that Uro CAG is a platform to support all regional members of the multi-disciplinary team.

In Somerset there have been issues with the restructuring of the CNS team since the merger of Musgrove and Yeovil, which is probably why a representative could not attend the CNS meeting and why they may struggle to attend future educational events at present due to the reduced headcount. — **Workforce Shortage**

4. Clinical Guidelines

4.1 Focal Therapy for Prostate Cancer in the South West Region

Please see the presentation uploaded on to the SWAG website

Presented by Consultant Urological Surgeon Lucy Simmons

RUH Bath recently commenced a focal therapy service for the region, which was presented at a previous meeting when in set up.

Thanks were given to the group for the regional referrals and patience while embedding the focal therapy pathway which, at present, involves use of High Intensity Focal Ultrasound (HIFU) as the energy source. It is hoped to add additional energy sources in the future.

HIFU is used to treat prostate cancer in men who have unilateral or low volume contralateral disease with the aim to cure or downgrade surveillance.

The treatment has a lower risk of incontinence and erectile dysfunction in comparison with radical therapy.

It is not suitable for everyone and depending on individual assessment, radical treatment or surveillance would be recommended as an alternative. It has been necessary to provide counselling to a proportion of men who have been appropriately told by their local centre that radical treatment is the best treatment option, who have then sought a second opinion on the possibility for focal treatment and have had to be turned down.

Treatments started in November 2023 and, as of May 2025, 66 procedures have been undertaken. The service has grown from 2-3 referrals per month to approximately 12 a month.

The average age of patients is 65-66 with a Cambridge Prognostic Grouping (CPG) of 2 or above.

The average PSA drop post treatment is approximately 66%. It is possible for PSA levels to still be elevated for a few months following treatment prior to dropping, and then it can continue to drop over a long period of time.

Referrals have been received from throughout the SWAG region and beyond.

In terms of functional outcomes, a small number of men are using a safety pad once a day and 25% of men have had a reduction in erectile dysfunction but no complete impotence.

Anti-microbial prescriptions have been changed after a small run of infections, otherwise complication rates were within normal ranges.

RUH eligibility criteria has been slightly tweaked, but still reflects the practice undertaken in Imperial and UCL.

Optimising the referral pathways has been the biggest challenge, but a process is now in place so that once a Cancer Services IPT form plus all relevant background information is sent to the three email addresses documented in the presentation, the patient is listed for the focal therapy MDT. If not suitable, they are sent straight back to the referring MDT. If they are eligible, they will be sent a clinic appointment to meet with the focal therapy team.

Ideally, patients should be referred with an MRI reported no more than 12 months ago, and a histology report.

The HIFU follow up schedule is documented in the presentation, which mirrors national guidance.

Trial without catheter (TWOC) is undertaken locally wherever possible to avoid the need for patients to travel.

All men are informed that they are responsible to report their PSA results to the RUH secretaries and, to date, all men comply.

Concern had been raised about reporting the post focal therapy MRIs that are undertaken locally; these are all re-reported by the focal therapy MDT.

After two years follow up, it is hoped to repatriate patients to local centres for continued PSA monitoring up to 5 years.

Patients are to contact the RUH urology secretaries with queries about appointment dates and the RUH CNS team with any post-operative queries.

It is hoped to introduce Nanoknife next, which is better for treating prostate cancer in the anterior zone, to ensure that all treatment options are available in the South West.

Discussion:

Patients are well informed that they are consenting to a treatment option that is an alternative to standard care and data from the HEAT register is used to talk about recurrence rates, where 80-85% of men will continue to be fine for the next 10 years, but 15-20% will require further treatment.

Should a second focal treatment be required following assessment of the outcome of the first treatment, this is not considered to be a failed procedure and expected to occur in 1/5 men.

If any disease is left behind, it is made clear that the procedure has not been a cancer cure but has downgraded the disease.

A comprehensive HIFU leaflet has been developed that explains all the statistics.

A number of patients have been seen by the RUH service prior to being reviewed in their local centre. This is avoided wherever possible and the patients are referred back to their local centre so that all treatment options are explained to them.

Action: HIFU outcomes will remain a rolling agenda item for future CAG meetings. L Simmons

4.2 Management of Bone Protection for Prostate Cancer

Consultant Oncologists Serena Hillman and Emma Gray have developed a bone protection protocol for patients on long term androgen deprivation therapy (ADT).

There are local differences: Somerset has the capacity to Dexa-Scan all prostate cancer patients on ADT. For UHBW, there is an agreement with Rheumatology to complete a fracture risk assessment (FRAX) and only scan those flagged as amber or red risk. Patient Information on managing the risks of Osteoporosis is still provided to patients that fall into the green risk zone and these patients are advised to liaise with their GP.

The protocol will be circulated to see if it is possible to agree regional guidance, with local adaptations.

Action: To review within the CNS break-out meeting and assess equity of access to bone health practices across the region. CNS Team

A useful checklist for patients on ADT is available here:
Trends in Urology & Men's Health: Vol 15, No 3

4.3 SWAG Clinical Guidelines: Consensus view on optimal use of the PSA blood test in Primary Care

There is a cohort of patients referred to the prostate cancer pathway who are found to be benign and discharged with advice to Primary Care to have their PSA reassessed at intervals and re-referred if necessary.

Feedback from some sectors in Primary Care question why this should fall under the remit of the patients' GP.

The team in Great Weston Hospital have been following up many of these patients and have recently transferred this cohort back to Primary Care and will await feedback to see if this is feasible for GPs in the area.

It is a recognised problem in Somerset and Devon as GPs are not funded to undertake the tests and a document has been produced to try and establish a standardised process.

RUH have had pushback from some GPs, although not all, on providing PSA tests for patients on Active Surveillance.

NICE guidance (April 2025) includes how Primary Care should assess patients with suspected prostate cancer symptoms by Digital Rectal Exam (DRE), PSA testing, and refer on to the Suspected Cancer Pathway after taking into account the patient's preferences and comorbidities. A table on the age specific PSA thresholds is also included in the guidance.

Several papers have been published by BAUS that suggest removing DRE from the guidelines which may be considered in a future iteration.

Everyone is encouraged to look at the guidance on re-testing men over the age of 79 after 6 months to see if this aligns with local guidance.

GP/BNSSG ICB Representative Glenda Beard reports that there has been collective action from GPs in the region to raise awareness of the work that 'could' happen in Primary Care, but isn't currently funded; this includes PSA testing.

As Primary Care isn't funded on a Payment by Results (PBR) basis or based on the patient population for anything that sits outside the core contract, providing PSA testing would involve deciding to stop providing another service.

In other areas of the country, a Locally Enhanced Service (LES) have been agreed for PSA monitoring, but again, as there is no extra money in the system, this would involve moving funding from somewhere else.

The variation that exists between GP Practices is probably due to one deciding

to include a PSA test alongside another regular blood test and another declining to do so.

The other issue is having access to a robust system to track PSA surveillance.

GP/ Gloucestershire ICB Representative Sadaf Haque confirmed that GPs are happy to provide the one-off PSA screening to men who ask for the test, in particular for those with a family history or other risk factors, and in addition would generally provide an annual follow up PSA for those that have been through the suspected prostate cancer pathway, to manage patient anxieties.

Gloucestershire has PSA tracking software.

From the MS Teams Chat *Gloucestershire's PSA Tracker is only for those diagnosed with cancer, not for patients who are borderline for follow up.*

The hospital based phlebotomy services in Gloucestershire have been on strike for many months, causing problems for patients needing to access hospital blood tests.

A system-wide solution is required to standardise practice across the region.

The frequency of follow up could be safely reduced for the majority of patients to be discharged to Primary Care as the short term risk of harm from the disease is low.

The Government has taken the approach to put the onus for requesting PSA testing on to the patient rather than providing a screening programme, and this is where Primary Care needs to be supported.

Patients are also frequently referred in their 80's with a PSA of 7.5 and the appropriate management of these patients requires clarification.

Action: SWAG to collaborate with the Peninsula CAG to create a South West wide policy for PSA management that reflects national guidance. **Neil Trent / CAG and GP representatives**

The policy has already been drafted and reviewed by GPs in the Peninsula. It is due to be presented to the Devon and Cornwall team in July for ratification.

5. Coordination of patient care pathways / Quality indicators, audits and data collection

5.1 SWAG & GIRFT Days Matter Cancer Challenge

Please see the presentation uploaded on to the SWAG website

Presented by CA Managing Director Ruth Carr and Programme Manager Nicola Gowen

Members of Uro CAG from across the region have signed up to engage with the GIRFT 'Days Matter' Challenge, and supportive resources have been pulled together by the CA team in a very short time frame.

The challenge arose from a meeting between Professor Tim Briggs, who is the National Director of the Getting it Right First Time (GIRFT) Team and the SWAG Cancer Alliance, where it was highlighted that Cancer Waiting Times could be optimised in some of the cancer pathways. It was recommended to find ways to address this at pace for urology, colorectal and gynaecology.

It is recognised that a lot of hard work has already been undertaken to transform these pathways, but long waiting times do still occur and there is some variation across the patch.

Quarter 4 performance for urology was 50% overall, ranging from 40-60% across the SWAG Trusts.

A letter has been sent about the challenge to all Trust Chief Executives to request strategic and operational support from teams so that any ideas for transformation projects can be translated in to rapid action to improve CWT performance.

Data analysis will be undertaken to identify insights and information on potential service improvements from exemplar centres where performance is better and will be shared. Improvement plans will be drafted and outcomes measured to make sure any changes are successful and sustainable.

It is recognised that Trusts already have improvement plans in place, and this project is looking to do something in addition to these plans.

The pathways in exemplar Trusts are not different to those in SWAG, but the steps between each stage in the pathway are significantly shorter.

Action: To arrange meetings for the local Project Teams. Nicola Gowen

Resources will be provided by the Cancer Alliance to facilitate the meetings. These will include insight packs, play books (details of service improvements from other exemplar centres – for example Royal Surrey book LATP by Day 5) and Research and Innovation packs, which will be made accessible on the Futures Platform.

Regular communications will be arranged to steer any actions identified. Delivery timelines are tight, with the Cancer Alliance expected to feedback progress at Day 30, 60 and 90, with the aim to improve performance by 5% after 3 months and 10% by the end of the year.

Case studies are included in the presentation.

Uro CAG are invited to share potential opportunities for improvements.

Discussion:

The interaction between diagnostic workforce and workload and oncological treatment capacity needs to be calculated.

The Royal College of Radiology workforce census identified a 29% shortfall in clinical radiologists, and a 13% shortfall in clinical oncologists, with many oncologists planning to retire earlier than in previous years.

At present, it is not clear if any mutual planning agreements exist between the Southmead and BHOC sites.

Data for workload planning is also not available to the team in Somerset who have calculated that they currently have 24,000 hours of work to achieve within 18,000 hours of job planned time.

When a service has been chronically under-resourced over the course of many years and multiple recommendations have been made over that time for how services should be improved, proposal of a 90 day improvement project seems unrealistic.

Prostate AI is now available in pathology, but this is not expected to improve the speed of the patient pathway, but it does reduce the need for some tests.

Improving pathology capacity is recommended due to the significant workload increase caused by Waiting List Initiatives (WLIs). For example, a recent WLI resulted in 20 sets of cores over the course of 2 weekends, which is the equivalent of 3 weeks additional work for pathology with no notice.

Any ‘quick win’ solutions need to consider the effect on the downstream workload.

Opinions were mixed on whether IT solutions could help in the 'Days Matter' challenge time frame.

The majority of Trusts on the exemplar list are based in the South East (aside from Cornwall) which are known to receive more funding per head of population than the rest of the NHS Trusts.

The steps to expedite pathways are all well-known by all those involved. The problem is availability of appropriate colleagues to arrange the next step at the earliest opportunity; improving communication pathways is recommended.

It is difficult to pin down which step of the pathway is the main cause of delays as this fluctuates on a daily basis.

Gloucestershire has had multiple meetings with NHS E to try and optimise the prostate cancer pathway and has implemented a rapid prostate cancer diagnostic clinic, which was initially triaged by a dedicated CNS who has now left. Triage is now being arranged ad hoc by the Consultants, is less consistent, and means that the ring fenced MRI slots are either under or over utilised.

Training on LATP has been provided to ANPs, CNSs and Medical trainees to help with the workload.

Pathology is struggling, leading to outsourcing of cores. This again causes delays as the pathologists have to double report due to lack of confidence over the standard of the outsourced reports. A significant amount of work has been undertaken to reduce turnaround time (TaT) to an average of 11 days, but further resources are required.

MRI AI reporting is being investigated to help with the triage process.

Use of a Swedish company for outsourcing pathology is also being considered as they have a guaranteed TaT of 5 days.

There are also problems with estates, and the team are awaiting the opening of a new diagnostic assessment unit where everything is available in one place, which has been in planning over the last 3 years.

Yeovil team are in agreement with the feedback from Somerset. It is a difficult time to implement change in the current environment.

Plans are underway to implement regional image sharing which may be part of a solution, by helping to share the MRI reporting workload. This can be fed back to the regional imaging network group.

Although digital pathology has now been implemented in Severn Laboratory, it only came with short term funding and, in the long term, this has had an impact on staff numbers as an existing member of staff had to redirect their time to manage the system.

An additional OG pathologist and 2 locums have been appointed, which should help to reduce outsourcing from the lab, with funding used from other specialties; TaTs are not being achieved at present.

Action: A gap analysis is required to look at the current reporting capacity with the existing workforce and the increase in workload activity.	**Cancer Services / to be allocated**

From an NIMBC perspective, an additional sub-specialist Consultant is required.

Risk stratification of patient pathways at one-stop clinics and at the bladder scheduling meeting would help to maximise clinic time and maximise the use of TULA to save theatre time for high risk TURBTs.

It is important not to compromise on quality to meet the CWT targets as patients may require a specialised surgeon to be available for their particular TURBT procedure.

Same day pre-operative assessment would be a potential service development, although there is a resource implication. TULA team have a shortage in nursing support in the outpatient setting at present.

In RUH, it was not possible to retain the LATP nurse practitioner post holder as the role was not up-banded as expected. This is a common issue; it takes a significant amount of time to train an individual in this specialist task and retaining talent requires investment.

It is notoriously difficult to appoint to the non-medical LATP post, with the original advert only attracting one applicant and recent adverts attracting none.

TULA is also not available in RUH at present due to estate works limiting clinic space, nursing workforce, and wider discussions on where resources should be directed.

In NBT, the CNS workforce has changed over the past 4-5 years due to a change in the balance of long term experience. Progress was made with meeting the Faster Diagnostic Target (FDS) a few years ago by optimising provision of CTU but this was not sustainable in terms of consistent provision of administrative processes.

Dedicated administrative staff are required. It takes a significant amount of training to ensure staff are familiar with administrative requirements and

there is the need for staff that are available at key points in the day, such as at the end of the MDT on a Wednesday to book the relevant MDT outcome appointments.

Swindon CNSs triage all suspected urological cancer referrals. There is no dedicated urological cancer unit and the CNS team have no administrative support – there is a Trust wide recruitment freeze for admin at present.

Some members of the CNS team have been trained in TULA. It has not been possible to add LATP to the CNS skill set as it is not possible to fit this into the working week.

Changes were made to the pathway to improve compliance with FDS, but it is planned to change some elements of this back as it has a detrimental effect on the patient experience due to the limited face to face contact with the team. The shift for the majority of patients to go straight to test works well.

The discussion raises the opportunity for NBT Cancer Services to revise the approach to capacity and demand planning, which is usually undertaken at a specific point in time, doesn't reflect the peaks and troughs in activity, and generally results in a reactive approach to recovery that doesn't truly address the bottlenecks. The impact that falls outside the organisational boundaries will also need to be considered.

Cancer Services would welcome a shift from the current 12 month funding review model to help train and retain administrative support staff.

In Somerset, funding has been sourced from the Cancer Alliance to appoint the faster diagnosis CNS team, who triage the patient referral pathway for Urology, Colorectal, ENT, Gynae and Upper GI using a robust protocol, which works really well as an expedited pathway.

Frail patients are brought to clinic for assessment rather than inappropriately sent straight to test and over-investigated.

As there is a shortage of Consultants to manage clinics, the specialist nurses have been allocated additional tasks, including training three to perform flexi-cystoscopy.

Due to the shortage of space in the Trust, the only option is to run a theatre list for TURBTs on a Saturday.

MDT streamlining initiatives have already been put in place in one MDT and plans are in place to streamline the other.

Theatre lists are already booked solid for the next 5 weeks and so it would be unrealistic to try and improve performance within the next 30 days.

The closure of the maternity unit in Yeovil has freed up some theatre space and re-purposing this for urology is currently being investigated.

Improving performance by 5% in three months and 10% by the end of the year is felt to be very difficult to achieve and sustain.

Current funding is not sufficient to sustain performance as it is.
Gloucestershire has had a funding cut this year and treated more patients.

Learning will be sought from the Surrey Team on how Day 5 LATP is achieved.

Patient experience needs to be taken into consideration; some patients may well prefer to get results faster over the phone rather than drive in to see the hospital team, and the choice could be offered.

Action: Invites will be sent to BAUS colleagues in exemplar centres to share learning on pathway improvements at the project team meetings. **Jon Aning/Niki Gowen**

The priority for Uro CAG is to work collaboratively to deliver sustainable improvements while maintaining staff morale.

Resources available from the Cancer Alliance include Project Managers, who are pulling together the play books, and data analysis support to provide insights and track progress.

The Cancer Alliance has invested significant funding into improving Urological Cancer Services this year and hope to demonstrate resulting improvements in August 2025 by redirecting resources to prioritise the 'Days Matter' project.

A recurring theme across the Cancer Clinical Advisory Groups is to improve the quality of the information coming in to the MDTs in terms of information on Suspected Cancer Two Week Wait Referrals / MDT referral proformas and improving image transfer between centres.

Project Manager Nellie Guttmann is working on improving referral quality and conversations are underway with the Imaging Network to look at improving image transfer.

Now that sub-cutaneous Nivolumab is available, this has the potential to transform delivery of SACT by moving it out of Chemotherapy Day Beds and is an example of something that can make an immediate change in the pathway and provide a more positive narrative.

The Cancer Alliance team will contact the project teams early next week.

Opportunities identified:

- Increased provision of dedicated estates
- Share exemplar pathway case studies (ideally from outside the South East)
- Maximise the use of TULA to free up theatre space used for TURBT
- Broaden CNS skill set and up-band to improve staff retention
- Optimise one-stop clinics and incorporate same day pre-op assessments
- Improve communication pathways
- Provide administrative support with flexible hours to meet the needs of the MDT
- Optimising regional image sharing
- Backfill posts to support improvements
- Undertake workforce mapping to support demand growth
- Model recovery demand levels throughout the patient pathway, including through to oncology
- Remove or mitigate single points of failure
- Create standardised letter templates wherever appropriate
- Optimise straight to test pathways
- Incorporate patient views
- Resolve the one year funding model
- Improve MDT referral quality
- Improve IT support to mitigate the need to access multiple systems to pull together all the information required in a Consultation to maximise clinic efficiency.

6. Research

6.1 West Central Research Delivery Network (RDN) update

Please see the presentation uploaded on to the SWAG website

Presented by Study Support Service Manager Claire Matthews

National clinical trial recruitment from April 2025 to June 2025 shows that 2,244 patients have been recruited to urological cancer trials across 15 research networks. The majority were non-commercial and interventional.

The list of 15 prostate trials open in the SWAG region is documented within the presentation, as is a link to the 72 studies open across the nation.

Bladder cancer has 3 new trials that have opened since the last meeting.

A website is available where patients can proactively register their interest in participating in research: https://bepartofresearch.nihr.ac.uk

A campaign has been launched to increase the number of people registered and in particular increase the number of volunteers from under-represented

demographics.

Leaflets and posters are available to display in clinic waiting areas.

There is also e-learning for staff to help facilitate research conversations: https://learn.nihr.ac.uk/.

The NIHR 6-month Associate Principal Investigator (PI) scheme is still open to any interested clinician who doesn't have research in their current role. It allows associates to work alongside current PIs on studies (as documented in the presentation) signed up to the scheme.

The free 18 month Principal Investigator Pipeline Programme (PIPP) is also available for research delivery nurses or midwifes. The next cohort will open to applications later in the year.

NIHR website links and team contact details are available within the presentation. Dr Amit Bahl is the Research Lead for the CAG.

7. Clinical Opinion on Network Issues

7.1 South West Region Multi-Disciplinary Team Meeting Reforms

Please see the presentation uploaded on to the SWAG website

Presented by Consultant Oncologist Lucy Simmons

Several centres in the South West are using Prostate, Bladder and Renal Cancer 'Standards of Care' (SoCs), developed by Consultant Urologist Ben Lamb, to safely triage a proportion of patients to protocolise care and streamline MDT meetings.

This process has been adopted in RUH Bath, with job planned preparation time to undertake the triaging process now negotiated.

In NBT, Consultant Urologist Anthony Koupparis undertakes this process, but currently the patients are not removed from the list as there is not job planned preparation time for this to be achievable. Somerset are also using the SoCs, which have been published by BAUS, and the 2 Consultants have job planned preparation time.

A request had been sent to Chief Executives in 2019 from the MDT Leads and Cancer Alliance recommending that MDT Leads have MDT preparation time added to their job plans.

Action: To agree one version of the SoCs for use across the region within 30 days. **MTD Leads**

This approach would be supported by the Cancer Alliance Executive Board.

As radiology continue to report cases right up until the beginning of the NBT MDTM, it is not possible to streamline all cases prior to the meeting.

It is an ambition to optimise discussion of clinical trials and genomics in MDTMs, which would be helped by implementing the streamlining process.

MDTM streamlining is in the GIRFT recommendations and could be used as a lever to alter job plans. The argument can be made that one person's time is funded for this purpose for the benefit of the rest of the team and efficiency of the meeting. Somerset MDTM now runs to time and is highly efficient.

The MDT-Mode audit tool can be used to demonstrate the impact of any MDT streamlining interventions. Somerset MDTM has already been audited and the benefit of having the job planned time was clearly evidenced.

Action: To resend the recommendation to add MDTM preparation time to the NBT Consultant Urologists job plans. **Helen Dunderdale / Cancer Alliance Team**

8. Any other business

Regular meetings will be coordinated by Programme Manager Nicola Gowen, prior to the main CAG meeting again in 6 months.

Date of next meeting: To be confirmed

-END-