University Hospitals Bristol NHS
NHS Foundation Trust

Annual Report

Urology MDT

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Agreement and Approval

Urology MDT Lead Clinician Mark Wright

Date 24/09/2012 Signature (agreed via email)

Review Date

Annual Report Review Date: 01/07/13

Versions

Version	Date	Reason	Sign Off
1.0	28/05/10	Agreement of content by Lead Clinician and MDT at Annual General Meeting	
2.0	01/09/11	Draft revision for 2011 Peer Review	
3.0	May 2012	Revision for 2012 Peer Review	24/09/2012

1 Measure Checklist

Measure Number	Measure	Operational Policy	Annual Report	Work Plan	Supporting Information
11-2G-101	Lead Clinician and Core Team Membership	p8, p9			
11-2G-102	Level 2 Practitioners for Psychological Support	p15	p10		
11-2G-103	Support for Level 2 Practitioners	p15	p10		
11-2G-104	Team attendance at NSSG meetings		p7		
11-2G-105	MDT Meeting	p11			
11-2G-106	MDT agreed cover arrangements for core member	p8			
11-2G-107	Core member (or cover) present for 2/3 of meetings		p7-8		
11-2G-108	Annual meeting to discuss operational policy				p5-7
11-2G-109	Policy for all new patients to be reviewed by MDT	p11			
11-2G-110	MDT Agreement to Guidelines for the Management of High Risk Superficial Bladder Tumours	p16			
11-2G-111	MDT Agreement to Guidelines for the Management of Kidney Cancer	p16			
11-2G-112	Policy for communication of diagnosis to GP	p14, p19	p12	p9	
11-2G-113	Operational policy for named key worker	p15	p12-13	p9	
11-2G-114	MDT Agreement to Network/Supranetwork Follow up Guidelines	p16			
11-2G-115	Agreed Policy for Patient Access to MDT to Discuss Treatment Options	p16-17			
11-2G-116	Core histopathology member taking part in histopathology EQA	p18			
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11-2G-120	Extended Membership of MDT	p8			
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11-2G-124	Provision of written patient information	p14, p23			
11-2G-125	Regular Prostate Clinic	p16-17, p20-21			
11-2G-126	Regular Haematuria Clinic	p16-17, p20-21			

Measure Number	Measure	Operational Policy	Annual Report	Work Plan	Supporting Information
11-2G-127	Agree and Record Individual Patient Treatment Plans	p11			p11-15
11-2G-128	MDT Agreement to Network Clinical and Referral Guidelines for Kidney Cancer	p16			
11-2G-129	MDT Agreement to Network Clinical and Referral Guidelines for Bladder Cancer	p16			
11-2G-130	MDT Agreement to Network Clinical and Referral Guidelines for Prostate Cancer	p16			
11-2G-131	MDT Agreement to Network Clinical and Referral Guidelines for T2 Muscle Invasive Bladder Cancer and Organ-Confined Prostate Cancer	p16			
11-2G-132	MDT Agreement to Network Clinical and Referral Guidelines for Testicular Cancer - Diagnosis & Assessment	p16			
11-2G-133	MDT Agreement to Specialist Team Referral Guidelines for Testicular Cancer	p16			
11-2G-134	MDT Agreement to Network Wide Guidelines on Testicular Cancer - Defining Specialist Care for the Network	p16			
11-2G-135	MDT Agreement to Clinical and Referral Guidelines for Penile Cancer - Diagnosis, Assessment & MDT Discussion	p16			
11-2G-136	MDT Agreement to Network/Supranetwork Defined Specialist and Supranetwork MDTs	p16			
11-2G-137	Agreed Collection of Minimum Dataset	p18	p11	p6	
11-2G-138	Network Audit	p18	p12	p9	
11-2G-139	Agreed List of Approved Trials	p18	p18-19	p10	
11-2G-140	Joint Treatment Planning for TYAs	p12-13	p9		

2 Contents

3 Introduction

This Report relates to the operational period April 2011 – March 2012.

3.1 Key Achievements

- Maintaining a weekly high quality, high volume multidisciplinary team meeting (MDT) for 52/52 weeks for the year.
- Recruitment of the second Clinical Nurse Specialist (CNS)
- Development of the new diagnosis clinic into being nurse-led, majority of patients being offered an appointment within 1 working day of the MDT.
- Continuing recruitment and team commitment to clinical trials
- Promotion of High Does Rate Brachytherapy

3.2 Key Challenges

- Centralization of urology services to NBT.
- Loss of experienced band 7 CNS
- Loss of palliative care attendance as a core member of the MDT
- Achieving specified MDT attendance (in line with peer review criterion) alongside other trust commitments
- Completing the histopathology report on cancer register.
- Lack of operating theatre capacity (both UH Bristol and NBT) for urological malignancy.
- Not all cancer patients have access to CNS support due to large numbers of patients with new diagnoses.
- Time constraints for Urology MDT which discusses a large volume of cases each week. As Urology MDT follows on from an expanding Germ Cell MDT each week, complicated by the need of the Neuroendocrine MDT to start at 1130 once a month.

4 The MDT Meeting

4.1 Team Attendance at NSSG Meetings (11-2G-104)

The NSSG has had the following meetings during April 2011-March 2012, with the MDT represented as follows.

Meeting Date	Name	Job Title
20th May 2011	Amit Bahl Julia Hardwick Sue Brand	Oncologist CNS CNS
14th September 2011	Amit Bahl Mark Beresford*	Oncologist Oncologist
23rd March 2012	Raj Persad Julia Hardwick	Consultant Surgeon CNS
Overall % Attendance	**100**	

* - Member of the MDT at the time of meeting

Further details of the meetings can be found in the Network Annual Report

4.2 MDT Meeting Attendance (11-2G-107)

MDT attendance is captured on the Somerset Cancer Register. The MDT met on 52 occasions during the time period. A breakdown of the MDT meeting attendance for the year follows. It should be noted that attendance by role is excellent, well in excess of the peer review criterion of 66%. Individual attendance reflects the team approach taken in most areas i.e. one of several more suitably qualified representatives attends every meeting, sharing the work between them. The lower (but sufficient) CNS attendance reflects that there is currently no cover for the role; the post had been appointed to at the end of the review period.

4.2.1 Attendance by role

Role	Attendance
Two Urology Surgeons	96% (100% with at least one)
Oncologist(s)	90%
Radiologist(s)	90%
Histopathologist(s)	98%
Uro-Oncology CNS	78.85%
MDT co-ordinators	98%

4.2.2 Attendance by individual

Name	Role	Attendance
Tim Whittlestone	Surgeon	73.08%
Mark Wright	Surgeon	63.46%*
Raj Persad	Surgeon	48.08%
Amit Bahl	Oncologist	59.62%

Serena Hilman	Oncologist	38.46%
Janice Ash – Miles	Radiologist	57.69%
Julian Kabala	Radiologist	42.31%
Mohammed Sohail	Histopathologist	42.31%
Chris Collins	Histopathologist	53.85%
Julia Hardwick	Uro Oncology CNS	78.85%
Lucie Wheeler	MDT Co-ordinator	82.69%

*Mark Wright has a cancer operating list on alternate Friday mornings which clashes with the MDT and restricts his attendance. This was intended as a temporary measure to increase capacity prior to service centralisation to North Bristol, but due to delays in the centralisation project this has had a longer-term impact than expected.

4.3 Workload of MDT / Cases discussed

The following tables relate to the period 1 April 2011 to 31 March 2012

4.3.1 Diagnosed cancers by type

Diagnosis	Primary	Recurrence	Metastasis
C480 - Malignant neoplasm of retroperitoneum	2	0	1
C481 - Malignant neoplasm of spec parts of peritoneum	1	0	0
C488 - Malignant neoplasm of overlap lesion retroperit & peritoneum	2	0	0
C602 - Malignant neoplasm of body of penis	1	0	0
C609 - Malignant neoplasm of penis, unspecified	1	1	0
C61X - Malignant neoplasm of prostate	255	27	69
C620 - Malignant neoplasm of undescended testis	2	0	0
C621 - Malignant neoplasm of descended testis	48	0	0
C629 - Malignant neoplasm of testis, unspecified	6	0	0
C64X - Malignant neoplasm of kidney, except renal pelvis	66	0	14
C65X - Malignant neoplasm of renal pelvis	13	0	2
C66X - Malignant neoplasm of ureter	2	0	0
C67 - Malignant neoplasm of bladder	2	0	0
C671 - Malignant neoplasm of dome of bladder	2	0	0
C672 - Malignant neoplasm of lateral wall of bladder	8	0	0
C673 - Malignant neoplasm of anterior wall of bladder	1	0	0
C674 - Malignant neoplasm of posterior wall of bladder	6	0	0
C676 - Malignant neoplasm of ureteric orifice	6	0	0
C679 - Malignant neoplasm of bladder, unspecified	77	34	7
C749 - Malignant neoplasm of adrenal gland, unsp	2	0	1
C761 - Malignant neoplasm of thorax	0	0	1
C767 - Malignant neoplasm of other ill-defined sites	0	0	1
C780 - Secondary malignant neoplasm of lung	0	0	1
C795 - Secondary malignant neoplasm of bone and bone marrow	0	1	3
C798 - Secondary malignant neoplasm of other specified sites	0	1	0
C80X - Malignant neoplasm without specification of site	1	0	0

TOTAL	504	64	100

4.3.2 Number of MDT discussions

Please note this counts the number of discussions rather than the number of patients i.e. patients with discussions at multiple meetings will have each counted separately.

Month	Number of discussions
May 2011	243
June 2011	235
July 2011	262
August 2011	225
September 2011	316
October 2011	266
November 2011	266
December 2011	295
January 2012	248
February 2012	200
March 2012	356
	2912

4.3.3 TYA patients (11-2G-140)

One patient in the TYA age range (15-24) was discussed by the MDT during the review period. The patient was referred to the TYA MDaT as appropriate for agreement of the treatment decision.

4.4 Meetings to Discuss Operational Policies

The urology team has a well-structured process for meeting to review both operational and strategic developments. Once a month following on from MDT a number of the core members (surgeons, CNS, MDT co-ordinator) meet to discuss current issues and agree work streams as required, these meetings are extended to all core members and relevant others (waiting list office, outpatients, Assistant Divisional Manager etc). The monthly meetings allow for issues to be discussed and addressed as they arise.

In addition to the monthly meeting there is an Annual General Meeting for the MDT to which all members are formally invited and the activities of the team are reviewed. The AGM was held on March 16th 2012 and minutes are available in the supporting information.

5 Training

5.1 Advanced Communications Skills Training (11-2G-119)

The following core members of the urology MDT have attended the National Advanced Communication Skills training:

- Mark Wright, Surgeon and MDT lead, 12-13 September 2012
- Tim Whittlestone, Surgeon, 8-9 Feb 2012
- Raj Persad, Surgeon, 29 Nov-1 Dec 2011
- Amit Bahl, Oncologist, 7-9 December 2009
- Serena Hilman, Oncologist, 26-28 May 2010
- Janice Ash-Miles, Radiologist, 29 Nov-1 Dec 2011
- Julia Hardwick, CNS – 16-18 February 2009
- Rachel McCoubrie, Palliative Care – 29 April-1st May 2009

Two clinical core members with direct patient contact have yet to take the course, and have booked onto courses as follows:

- Julian Kabala – 11-12th December 2012
- Lucy Hamblyn, CNS (band 6) 17-18th October 2012

5.2 CNS Qualifications (11-2G-117)

Julia Hardwick has the following qualifications in relation to her role as CNS for the MDT.

- Bachelor of Science (second class Honours) in Cancer Care
- Module in Communication Skills (level II)
- National Advanced Communication Skills Training
- Dissolving Distress workshop (UH Bristol, Psychology Department, BHOC)

Lucy Hamblyn has the following qualifications in relation to her role as CNS for the MDT.

- Diploma in Cancer Nursing. (The Royal Marsden School of Cancer Nursing & Rehab)
- Advanced Assessment Skills in Patients with Cancer (London South Bank University)
- Breaking Bad News (UH Bristol) 26/6/2012

5.3 Clinical Supervision (11-2G-102,103)

Julia Hardwick completed the Trust's Network approved training in provision of psychological support at level 2, on 13th-14th December 2011. The Trust has secured funding to provide monthly supervision for CNSs with respect to this role with a level 4 clinical psychologist.

5.4 Other Training

Members of the Urology MDT Team undertake training and learning opportunities as appropriate to improve practice in the Unit.

6 Data Collection (11-2G-137)

The Team have agreed to adopt the Minimum dataset as defined within the NSSG guidelines, processes are in place to capture both the national cancer waiting times standards and the BAUS data items. The Somerset Cancer Register is used to facilitate this, improvements have been made in the number of core team members accessing the register and entering data directly onto the database – this includes the use of the surgical fields for the collection of operative details, although slow and sporadic across the team this remains a key activity in the work program to improve the timeliness of data capture.

During 2011/12, and particularly in early 2012, work has been ongoing to audit and improve data collection in key fields across all cancer sites. For Urology the results of the audit are as follows:

- 100% patients had diagnosis code, date, and tumour status at diagnosis recorded
- 100% patients receiving surgery as a first treatment had a surgery date, treatment intent and procedure name recorded
- 25% patients receiving surgery as a first treatment had a pathology report date on the cancer register and 49% had a SNOMED code recorded on the register
- 100% patients receiving radiotherapy had a treatment intent and treatment start date
- 100% patients receiving chemotherapy had a treatment start date, and 22% had a treatment intent (improving over the year with 40% in quarter 4).
- 12% patients had a contact with a CNS recorded, however this should be considered in light of the single-handed CNS. Significant improvement was seen across the year with 30% in quarter 4.
- 24% patients had a complete final TNM stage entered.

Work is underway to improve the data completeness and significant progress has been made during the year. Issues have been identified across all sites with lack of clarity on where data should be entered, meaning data entry is often performed but then does not ‘count’. The Somerset Cancer Register was upgraded in March 2012 and a new data entry guide is in development, to help ensure data entry is in the right place. Better monitoring of data quality is also being put in place. The improvements achieved in a relatively short space of time in early 2012 are a positive sign.

7 Audit

7.1 Network Audit (11-2G-138)

The MDT is participating in the current Network SSG audit, 'High Dose Rate and Low Dose Rate Brachytherapy Practice for Prostate Cancer Patients. The period for data collection ends in January 2013, or when 20 patients in each category have been found, if earlier.

7.2 Local Audit

7.2.1 GP Notification within 24 hours of diagnosis (11-2G-112)

The notes of 20 patients with urological cancers diagnosed between 01/04/2011 – 31/03/2012 were selected at random to audit whether GP fax notification had been sent.

Findings

Of the 20 sets of notes reviewed 1 patient was from out of town and not diagnosed at UH Bristol therefore the GP Fax notification does not apply.
In the 19 sets of notes considered 4 had GP Fax notifications present, totalling **21%.**

Evaluation.

The number of GP Fax notifications of new urology cancer diagnoses is significantly below the Peer Review standard, reasons identified for this include;

- The majority of GP Faxes are completed by the Nurse Specialists.
- For the audit period (2011/2012) only one specialist nurse was in post. This explains the decrease in the number of faxes sent as in 2010/2011 there was a team of two nurses.
- Lack of awareness of rationale for the GP Fax being sent.
- GP Fax document not readily available in out-patient clinics.
- Difficulty in finding and filing in notes once fax has been sent.

Actions.

- Increase awareness of the importance of the GP Fax notification for newly diagnosed patients.
- Letter to all explaining that it is the responsibility of the person giving the diagnosis to complete the GP Fax and to hand this to the medical secretaries with their Dictaphone after clinic. (SM)
- A blank GP Fax document to be put in notes at MDT. (All)
- Medical secretaries to fax document to GP's. Fax to be filed in patients notes. Fax receipt to uro-oncology Nurse Specialists for their records. (secretaries)
- Present findings of audit to urology MDT and to ensure that members of the team are aware of action plan. (LH)
- To re-audit the number of GP Faxes in patients notes to evaluate if actions are improving numbers. (LW LH)

7.2.2 Key Worker (11-2G-113)

The notes of 20 patients with urological cancers diagnosed between 01/04/2011 and 31/03/2012 were selected at random to audit whether a Key Worker sticker was present.

Findings.

Of the notes reviewed 7 out of 20 had Key Worker stickers present, resulting in **35%.**

Evaluation.

The percentage of Key Worker stickers present in patients' notes has fallen from the years 2010/2011 to 2011/2012. Reasons for this have been identified as;

- A Key Worker is not allocated at the time of diagnosis.
- The majority of Key Worker stickers that are present have been entered by the Nurse Specialist.
- During the audit period (2011/2012) only one specialist nurse in post compared to 2 specialist nurses in 2010/2011.
- Uro-oncology CNS team unable to see every patient at diagnosis due to large number of patients.

Actions.

The aim is to identify a Key Worker for 100% of newly diagnosed patients. To achieve this, the uro-oncology MDT will;

- Allocate a Key Worker for all new patients in the weekly MDT meeting. (LW)
- The name of the Key Worker will be entered on the MDT outcome for each patient by MDT co-ordinator. (LW)
- Review referral criteria to CNS team to aid allocation of Key Worker (e.g. consultant, CNS). (JH LH)
- Present findings of audit to urology MDT at next business meeting and to ensure that members of the team are aware of action plan. (LH)
- To re-audit to evaluate if actions have increased the percentage of allocated key workers. (LH LW)

7.2.3 Other Audits

An audit of 'Renal Cancer Diagnosis' was undertaken by Mark Wright, Tim Whittlestone, Julia Hardwick, and Lucie Wheeler. The aims were to investigate quality assurance of the patient journey and investigate if information was getting through to GPs. Patients with a new diagnosis of Renal Cell Carcinoma from 01/09/2011 to 31/01/2012 at UH Bristol were included in the audit. There were 28 patients for whom 23 had paper notes accessible by the audit team.

The audit findings were as follows:

- 96% patients had written information in the medical notes at the time they were seen
- 65% had a copy of the GP letter in the notes detailing the cancer diagnosis episode.
- 96% had documented evidence that a discussion of diagnosis and implications for the patient had taken place
- 91% had documented evidence of treatment options having been offered to the patient
- 96% had a documented follow-up plan
- 91% had previously been discussed at the UH Bristol urology MDT (the others were discussed at MDT elsewhere)

- 56% had evidence that a fax was sent to the GP within 24 hours of the diagnosis being given to the patient

Discussions and actions:

There was good documentation of diagnosis, options, and follow-up for newly diagnosed patients with renal cell cancer. Fewer patients had evidence of a GP letter in their notes or evidence that the GP was notified within 24 hours of the diagnosis. This is thought to be more likely to be due to failure to file the information rather than actual failure to send the letter, although this cannot be proved. Actions are:

- Further audit availability of copies of clinic letters in notes and GP notification process to identify where problems are occurring

- Consider electronic notification of GPs rather than faxing, as this is significantly faster and more efficient for the staff involved

- Consider electronic checking of letters by clinicians, as this may speed up turnaround time and therefore likelihood of notes being available to file final letter, as well as improving timeliness of communication

7.3 EQA Audit (11-2G-116)

Pathology services has full CPA accreditation across its labs. The Pathology services manager has confirmed the participation of both core histopathologists in a relevant EQA scheme.

8 Patient and Carer Feedback and Involvement (11-2G-123)

A local survey of patients attending the nurse-led prostate cancer clinic has been undertaken. The survey consisted of nine questions and a free text option to add any other comments or concerns relating to the patient's experience.

1. Were you given your diagnosis by a:
Doctor
Clinical Nurse Specialist
Can't remember/not sure

2. When you were given your diagnosis of prostate cancer do you feel this was done with:
Great sensitivity
Some sensitivity
Little sensitivity
No sensitivity
Can't remember
2a. Additional comments

3. Were you given the opportunity to ask questions?
3a. Additional comments:

4. Were you made to feel at ease enough to ask questions?
4a. Additional comments

5. Do you feel that you had adequate **verbal** information about your diagnosis?
5a. Additional comments

6. Were you given adequate **written** information about prostate cancer?
6a. Additional comments

7. Overall, do you think you had enough time at your appointment to talk about your diagnosis?
7a. Additional comments

8. Were you given a contact number for the:
Clinical nurse specialist
Bristol Prostate Cancer Support Group

9. After your appointment were you clear about any planned investigations and future appointments?
9a. Additional comments

10. Finally, if you have any other suggestions on how we can make what can be a difficult time for you any easier, please write these in below

- The response rate of 58% was fair.
- The majority of patients (78%) were seen by the CNS
- The majority of patients felt that they had been given their diagnosis either with great sensitivity (78%) or with some sensitivity (22%).
- 94% of respondents felt able to ask question and 100% felt at ease enough to ask questions.
- 100% of respondents stated they had adequate verbal information and 94% that they felt they had adequate written information.
- 100% of patients who responded felt they had enough time at their appointment and they were clear about proceeding investigations and future appointments.

- When asked if they'd been given contact with the CNS (one respondent chose not to answer) but 88% of respondents said they had, with a further 12% unable to remember.
- 83% of patients stated they were given details of the local support group with 17% unable to remember.

There was some other useful information gained in the 'additional comment' sections of the questionnaire, (see end of document).

Comments
This patient satisfaction survey represents a small sample; however the overall group is not large due to the nature of the clinic. Future surveys could be run over a longer period to obtain a broader viewpoint. Overall the comments are positive.

> "I have been very pleased with my treatment with the BRI the only concern I had was that my initial PSA test was wrong. That was corrected and I do feel that I will get the best treatment for my condition with the BRI."

Of those who responded to the survey the right amount of information offered seem to be adequate with one exception that felt overwhelmed. The absence of the clinicians name on the appointment letter was highlighted by one respondent. One concerning comment made was that one respondent was unsure that they had been diagnosed with cancer.

Action
- Improve prominence of the contact details of the CNS on the CNS leaflet.
- Maintain importance of judging patient information needs at the time of diagnosis.
- Ensure clinicians name visible at the outpatient clinic.
- CNS to follow up the one patient who is unclear about their diagnosis

The MDT also reviews the outcomes of the National Cancer Patient Survey and implements actions as a result. As a result of the 2010 survey the Trust implemented a number of actions including improving information for patients on financial support and benefits, installing Macmillan information points throughout the Trust, and reviewing written information around operations.

The 2012 survey results were published shortly before the self-assessment and a full analysis is taking place prior to an action plan being decided. Results for prostate cancer and other urological cancers are reported separately and the results differed between the two. Areas for improvement in prostate are:

- Q16. Patient's views definitely taken into account by doctors and nurses discussing treatment
- Q68. Patient offered written assessment and care plan
- Q56. Staff definitely did everything to control side effects of radiotherapy
- Q15. Patient given a choice of different types of treatment

Strong areas compared to the national average for prostate were:

- Q25. Hospital staff gave information on getting financial help
- Q11. Patient told they could bring a friend when first told they had cancer

- Q26. Hospital staff told patient they could get free prescriptions

Areas for improvement for other urological cancers are:

- Q61. Waited no longer than 30 minutes for OPD appointment to start
- Q68. Patient offered written assessment and care plan
- Q44. Patient did not think hospital staff deliberately misinformed them

Strong areas compared to the national average for other urological cancers were:

- Q26. Hospital staff told patient they could get free prescriptions
- Q25. Hospital staff gave information on getting financial help
- Q12. Patient felt they were told sensitively that they had cancer
- Q56. Staff definitely did everything to control side effects of radiotherapy

9 Research and Trials

The Urology MDT has a strong and varied portfolio of clinical trials, adopting not only those agreed by the NSSG but the MDT also has a varied portfolio of additional clinical trials.

The NSSG lead for Clinial Trials is Amit Bahl who is the Core Oncology Member of the MDT and thus the MDT review their recruitment to trials on a regular basis

9.1 Clinical Trials (11-2G-139)

The below table is an extract from the clinical trials report submitted to the NSSG, showing recruitment against the NSSGs list of agreed trials or comments if not open at UHB.

	MDT **estimate** for recruitment (2011/12) **Not provided**	**Actual** MDT recruitment (2011/12)	Trial Status (April 12)	MDT annual estimate of recruitment for 2012/2013	MDT actions and comments for 2012/13 (endorsed trials) If no actions required please state 'no actions required'.
SSG endorsed NCRN trials 11/12:					
Bladder - BOLERO			Not open	n/a	Study not opening at this site (open at NBT)
Prostate - RADICALS (MRC PR10)		**5**	Open	5	No actions required
Prostate - Stampede		**3**	Open	6	No actions required
NCRN trial recruitment 11/12:					
Bladder - BOX-IT		**7**	Open	0	Study closing to recruitment on 31/07/12. Study patients from UH Bristol will need to be transferred to NBT when reconfiguration occurs
Bladder - LaMB		**1**	Open	1	No actions required
Bladder - SUCCINCT			Closed		
Prostate - EDVART		**42**	Open	30	No actions required
Prostate - INDEX		**0**	Open	6	Study opened 08/03/12
Prostate - TERRAIN		**0**	Open	4	Study opened 02/12/11

Prostate - UKGPCS		**20**	Open	5	No actions required
Renal - Cosak		**2**	Open	2	No actions required
Renal – NCRN281 - GOLD		**1**	Open	2	No actions required
Renal - NCRN118 - RECORD 3		**1**	Closed		
Renal - SORCE		**2**	Open	4	No actions required
Renal - Surtime – EORTC 30073			In set up	4	No actions required
Renal – TRANSORCE		**2**	Open	4	No actions required
Testis - 111 Trial (formerly BEP 111)		**3**	Open	2	No actions required
Testis - TRISST (TE24)		**10**	Open	8	No actions required
Testis - UKGTCS - (Testicular Genetics)		**194**	Open	100	No actions required

MDT actions - to be **completed** at **MDT meeting:**
MDT to maintain compliance with GCP
MDT to continue to routinely discuss and identify trials

The above actions were agreed by the MDT on 13/07/12 in the presence of Dr Amit Bahl