South Yorkshire and Bassetlaw
CANCER ALLIANCE

Right Test, Right Pathway, Right Time:

Improving Urology Referrals Across Prostate and Bladder Cancer

Mr Aidan Noon
Consultant Urological Surgeon, Sheffield Teaching Hospitals NHS Trust
Chair of the Urology Clinical Delivery Group SYB Cancer Alliance

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ITV

https://www.itv.com › watch › news › prostate-cancer-patient-urges-men-to-get-tested-after-

Prostate cancer patient urges men to 'get tested' after cells ...

28 Aug 2025 ... Prostate cancer patient urges men to 'get tested' after cells spread to his bones and lungs · Catch up on ITV News West Country (South West) ...

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IMPARTIAL NEWS + INTELLIGENT DEBA

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BIG READ I have i cancer - if I lived I'd have a drug to life

SIMON KELNER

I used to agree with my doctor about

CANCER SCREE

NEWSLETTER (£) Si

Chris Hoy cancer battle leads to referral spike

PA MEDIA

Sir Chris Hoy revealed in October 2024 that his cancer diagnosis was terminal

Alison Stephenson, LDRS and **George Thorpe**, BBC News, South West

1 June 2025

Sir Chris Hoy's cancer diagnosis has led to an increase in referrals - and subsequent treatment backlogs - at a Devon hospital, figures have revealed.

A performance report presented to the University Hospitals Plymouth (UHP) NHS Trust Board said there had been a 55% rise in prostate cancer referrals since November last year.

Sir Chris Hoy's terminal cancer diagnosis prompts near sevenfold increase for prostate cancer advice

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Prostate cancer

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Prostate Cancer Testing Saves Lives | Our campaign | What is the PSA test? | Why

23 October 2024

Cancer

Visits for prostate cancer symptoms advice on the NHS website rose by 672% following Sir Chris Hoy's announcement about his terminal prognosis.

New figures from NHS England show that in the 48 hours after the six-time Olympic champion revealed his cancer was incurable, there were 14,478 visits to the page on prostate

Health › Conditions › Cancer

The Telegraph's call for a screening programme for prostate cancer to save men's lives

Prostate cancer kills more than 12,000 men a year, it's time we caught it earlier

PROSTATE CANCER TESTING SAVES LIVES

Lauren Shirreff.
Emily Craig

Related Topics

This article is more than **2 months old**

The silent epidemic: the pros and cons of screening for prostate cancer

Surprising reasons olive oil now costs more than a decent bottle of wine

SEE PAGE 26

PROSTATE SCANS THAT COULD CUT DEATHS BY 40 PER CENT

By Kate Pickles
Health Editor

THE UK is leading a prostate cancer revolution which could prevent four in ten deaths from the disease.

The biggest prostate cancer trial in a generation will test the effectiveness of diagnosis techniques, with a national screening programme almost certain to follow.

In a major victory for the Mail's End Needless Prostate Deaths campaign, the results of the £42 million trial are expected to 'transform' practice, saving thousands of lives a year.

Doctors say it will also create a 'treasure trove' of data, samples and images that will help in the global fight against the disease, which kills 12,000 Britons every year.

Professor Hashim Ahmed, chairman of urology at Imperial College London, described it as the 'biggest, most exciting trial in prostate cancer screening and diagnosis'.

One of six experts who are leading

Daily Mail CAMPAIGN
END NEEDLESS PROSTATE DEATHS

Turn to Page 4

Suburban sword rampage leaves boy, 14, dead PAGES 8-11

Nightmare on the streets: The suspect yesterday

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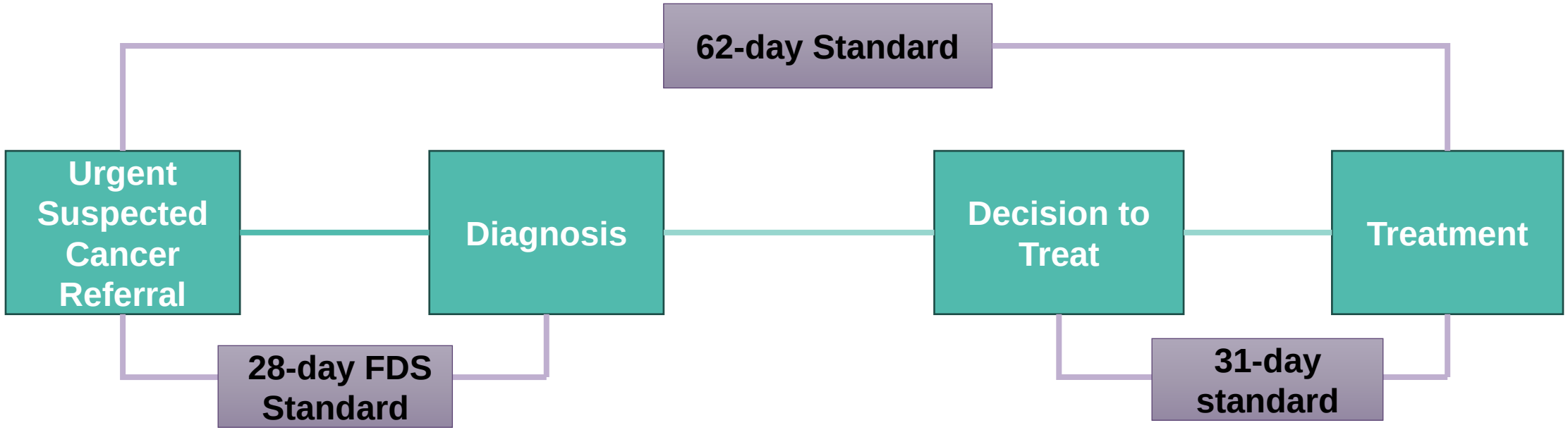
How is cancer performance measured?

- 28-Day Faster Diagnosis Standard (FDS) (previously 2 week wait)
- 31-Day Decision to Treatment Standard
- 62-Day Diagnosis to Treatment Standard



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Best Practice Timed Pathway – Prostate

28-day best practice timed pathway

This is a straight to test pathway using mpMRI.

Day -3 to 0	By Day 3	By Day 14			By Day 21	By Day 28
Primary care	**Local diagnostic centre**					
Urgent GP referral[1] Including locally mandated information[2]	**Clinical triage**[3] Based on local protocol Men with UTI/ positive MSU to be informed and referred to non-cancer routine pathway	**Straight to mpMRI** before biopsy	**Prostate biopsy** (by day 9)[8]	**Further investigations** (if required for staging)	**MDT**[10]	**Outpatient clinic**; **Discuss treatment options** and Personalised care and support plan with MDT input; assess fitness +/- pre-op assessment; patient optimisation and support[11]
Patient information Provided in primary care[1]	**Patient information** Provided in consultation or OPA/clinic[4]	**Cancer likely/diagnosed** Clinic review; **Communication with patient and discussion with CNS.** Record FDS when patient is informed that they have cancer[5] OR **No suspicious lesions reported**[7] **or negative biopsy:**[9] **Cancer ruled out and communication with patient** Patient informed; referred to other secondary care service if possible. Record FDS when patient informed that cancer has been excluded[6]				

Patient information

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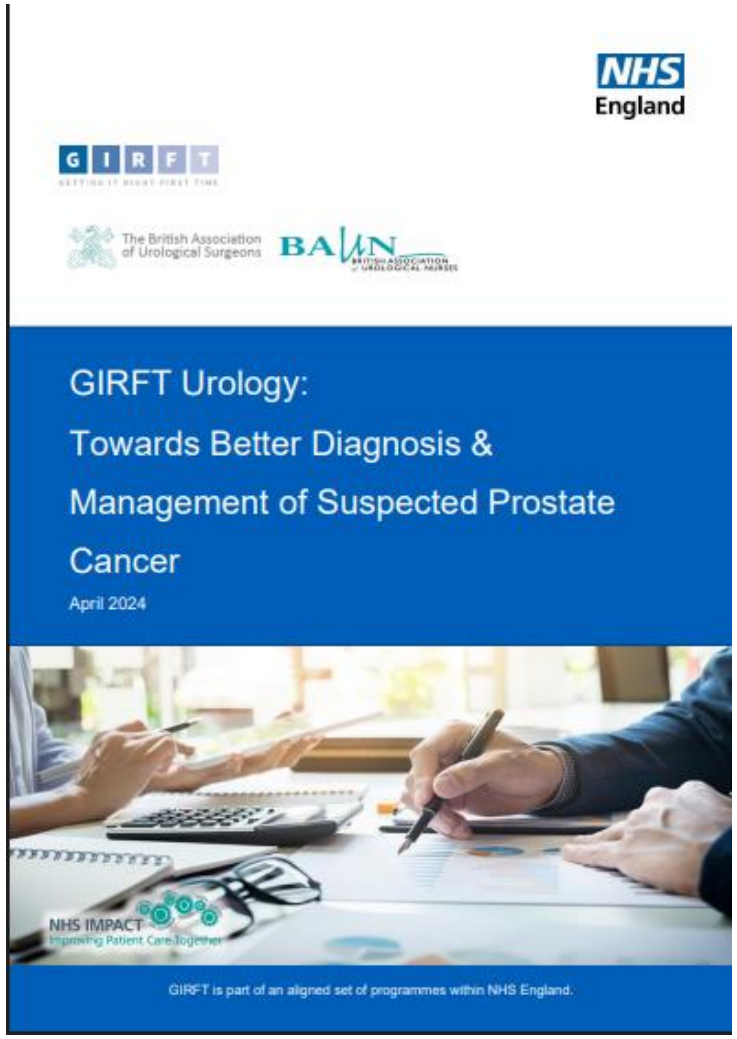
GIRFT – Prostate Guidelines



•Men at higher risk (for example: men of Black or mixed-Black heritage, family history of prostate cancer) should be offered a discussion about PSA testing.

•In asymptomatic men aged over ~80 years (or with significant comorbidity/limited life expectancy) routine PSA testing is **not recommended** unless symptoms suggest metastatic disease

•Identify patients who are fit and likely to proceed with radical treatment, so they can be triaged directly to Straight-to-Test (STT) MRI

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Primary Care: Key Actions

- <u>When you order a PSA test and the result is elevated:</u>

  - Check for a urinary infection (via urine test) and recent catheterisation or other plausible cause of PSA rise. When investigating a symptomatic patient.

  - If the PSA is elevated, a DRE in primary care is *not routinely required* before referral.

  - If you *have done* a DRE and found an abnormal result (even if PSA is within “normal” limits) → refer on the urgent suspected cancer pathway.

  - If PSA is very elevated (e.g., > 20 ng/mL), referral via the urgent suspected cancer pathway is required, even if other causes might explain a rise.

  - Do **not** routinely repeat a raised PSA unless there is a plausible reversible cause (infection, catheterisation etc) delaying referral may harm

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Specific Scenarios Worth Noting

- If a symptomatic man has an abnormal DRE (even with “normal” PSA) → refer.

- If an asymptomatic man aged 50–69 has a PSA ≥ 3 ng/mL (per the Prostate Cancer Risk Management Programme) then referral may be considered. **Shared decision discussion needed.**

• If the urology/secondary care team discharge back to primary care with a set PSA re-referral threshold (often based on PSA density, MRI findings) – **What does this mean**???

•For men under surveillance (active surveillance) or after radical treatment: primary care may be asked to perform annual PSA tests if secondary care deems it safe – **Probably controversial!**

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Referral Optimisation

- Adopted GIRFT Guidance around the management of prostate cancer
- Developed a separate prostate USC referral form
- 10 safety questions (developed by the ICB MRI Group)
- Reviewed by MRI Group at the request of the Urology CDG to see if these could be rationalised

(Balance between not being time consuming to complete V the need to triage and send patients STT MRI)

- Now have 5 questions – Cancer Alliance Primary Care CDG in early Dec

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The new MRI safety questions

Does the patient have any implanted active medical devices (e.g. Pacemaker, CRT-D, Loop Recorder, Neurostimulator, Implantable infusion pump etc.)?

If yes, please give details including implanting hospital and date. *Make and model details will be required before the patient can have a scan.*

Does the patient have any passive implanted medical devices (e.g. orthopaedic implants, breast implants, penile implants, heart valves, shunts, surgical clips, endoscopy clips, stents etc.) or have they had any surgery?

If yes, please give details including implanting hospital and date.

Does the patient have retained metal fragments in any part of their body e.g. pellets or shrapnel? Have they ever had metal penetrate their eyes?

If yes, please give details.

Has the patient ever had a pill cam or BRAVO pH capsule? When?

Does the patient have:

a. Any allergies
b. poor kidney function
c. claustrophobia
d. epilepsy
e. diabetes?

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Urgent Suspected Prostate Cancer Referral form

South Yorkshire and Bassetlaw Integrated Care System
CANCER ALLIANCE
Working with Derbyshire

PROSTATE

Urgent Suspected Cancer (USC) referral

Please refer via e-Referral Service

Disclaimer: It is not always possible to provide a yes/no diagnosis of prostate cancer. Some patients may require ongoing follow-up and surveillance.

The clinical information requested is essential to ensure your patient receives the most appropriate streamlined care. Your patient may be triaged to be on a straight to test pathway, which could include mpMRI, CT, Bone scan & biopsy.

Patient details			
Patient Name	${firstname} ${surname}		
Address	${patientAddress} ${postcode}		
DOB	${dob}	NHS No.	${nhsNumber}
Home Tel. No.	${home}	Gender	${gender}
Mobile Tel. No.	${mobile}	Ethnicity	${ethnicity}
Preferred Tel. No.	${preferredNumber}	Email Address	${email}
Main Spoken Language	${language}	Interpreter needed?	Yes ☐ No ☐
Transport needed?	${transportNeeded}	Patient agrees to telephone message being left?	☐ Yes ☐ No
Communication requirements	Sensory impairment (e.g. hearing, visual impairment): ☐ Any mobility requirements? ${mobilityRequirements} Other disability needing consideration: (please specify) ${otherDisability} Dementia: ☐		

	Communication difficulties other: (please specify) ${communicationDifficultiesOther}
Safeguarding concerns?	${safeguardingConcerns}
The patient has the capacity to make their own decision?	Yes ☐ No ☐ If no, please give details and indicate whether a mental capacity assessment is required: ${mentalCapacity}
Learning disability?	${learningDisability}
Date of Decision to Refer	${createdDate}

Registered GP details			
Practice Name	${practiceName}		
Registered GP	${usualName}	Usual GP / Referring GP	${referringClinical}
Registered GP Address	${practiceAddress}		
Tel No.	${main}	Fax No.	${fax}
Email	${gpEmail}	Practice Code	${practiceCode}

Patient engagement	
The patient has been informed that the reason for referral is to rule out or rule in Cancer.	☐
Supporting information (USC leaflet) provided or directed to the infopool website https://www.theinfopool.co.uk/	☐
The patient has been informed that they may go straight to a diagnostic test at hospital	☐
The patient has been screened for a UTI There is no need to repeat a raised PSA unless there are other probable causes of a raised PSA for example a urinary tract infection or recent catheterisation. A second PSA test should not be a requirement for further investigation, except where the patient has had a UTI found at the time of the first raised PSA. Requiring a second test can lead to a delay of between 2 – 6 weeks in a patient's referral, while the second test is being arranged and completed. If UTI present, treat and repeat PSA no sooner than 6 weeks later, refer if PSA remains elevated.	☐
Does the patient want a relative present at the appointment	☐ Yes ☐ No

Patient or Carer Concerns/ Support Needs at the point of referral:

${carerConcernsOrSupportNeeds}

Referral criteria	
Symptomatic	
Raised age-specific PSA	☐

Age (years)	Prostate-specific antigen threshold (mcg/L) – NICE 2021
Below 40	Use clinical judgement
40 - 49	More than 2.5
50 - 59	More than 3.5
60 - 69	More than 4.5
70 - 79	More than 6.5
Above 79	PSA >20mcg/L or PSA >7.5mcg/L AND there are symptoms suggestive of metastatic disease (bone pain and/or fatigue and/or significant unintended weight loss)

PSA ≥ 20.0 ng/ml	☐
Malignant feeling prostate on Digital Rectal Examination	☐

Men treated with Finasteride/ Dutasteride have a median reduction of PSA of 50% after 6 months of continuous treatment. A rise of PSA of 2ng/mL or more from their nadir value should be considered significant. An approximate rule of thumb is to double the PSA level if nadir PSA level not available.

Standardised by C the Signs
SYB ICS Cancer Alliance working with Derbyshire: Prostate Pathway [Version 1.3]
[Implementation Date: March 2025 Review Date: March 2026]

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The Prostate 3Ds

Prostate Cancer 3D's
Diagnose,
Disclose,
Decide.

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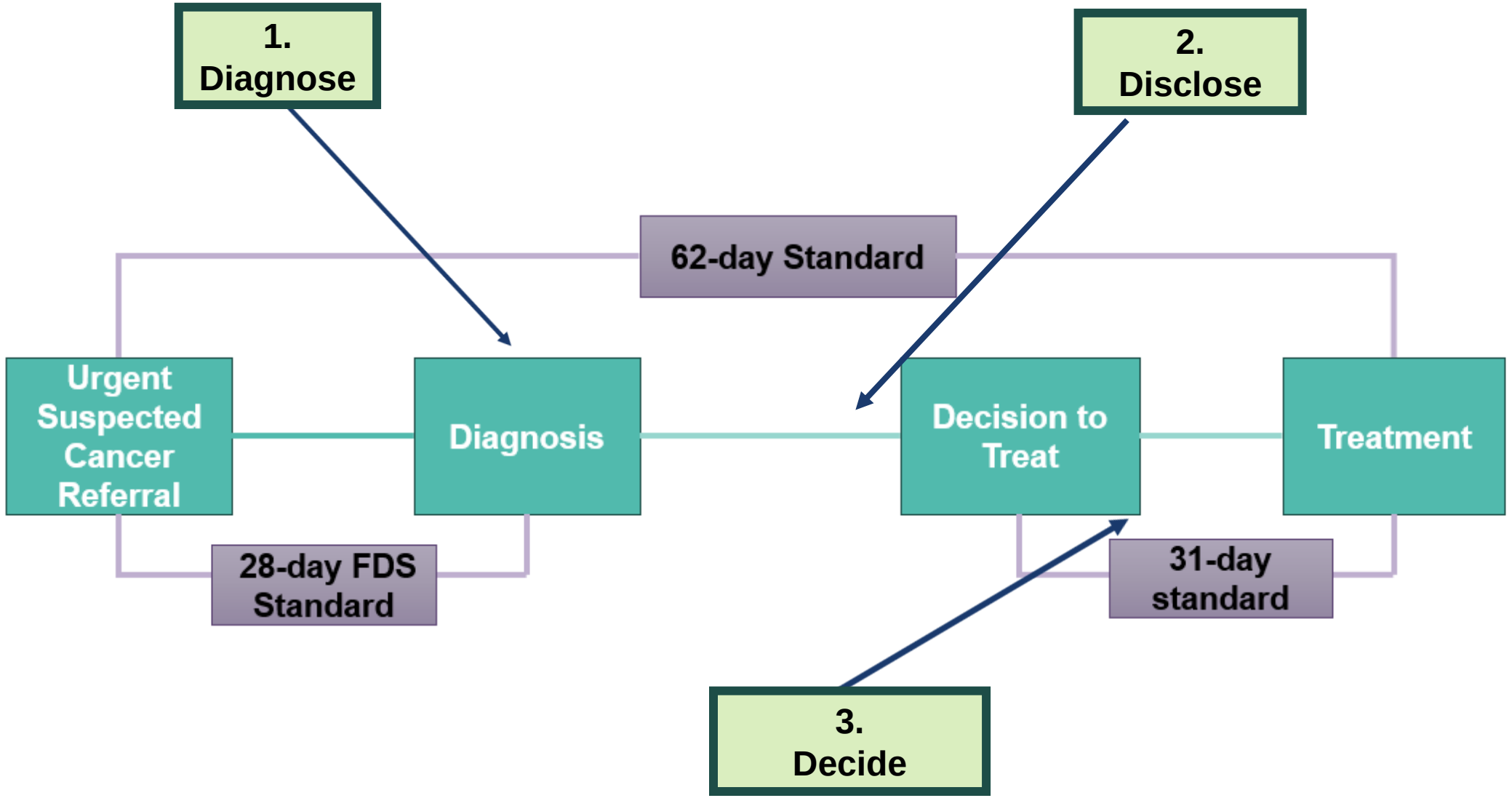
The Prostate 3D's – Diagnose, Disclose, Decide



Prostate 3Ds - Diagnose

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Prostate 3D's Diagnose, Disclose, Decide.

- Work continues to develop the diagnostic pathway:

More emphasis on:	Less emphasis on:
MRI and going to straight to MRI (not having an outpatient appointment first	Digital Rectal Examinations (DRE) (previously patients underwent a minimum of 3 DRE's)
Biopsies – ensure this happens at the right time, and it's reported in a timely way	Surgeons and oncologists
More tests / investigations carried out by other healthcare professionals	

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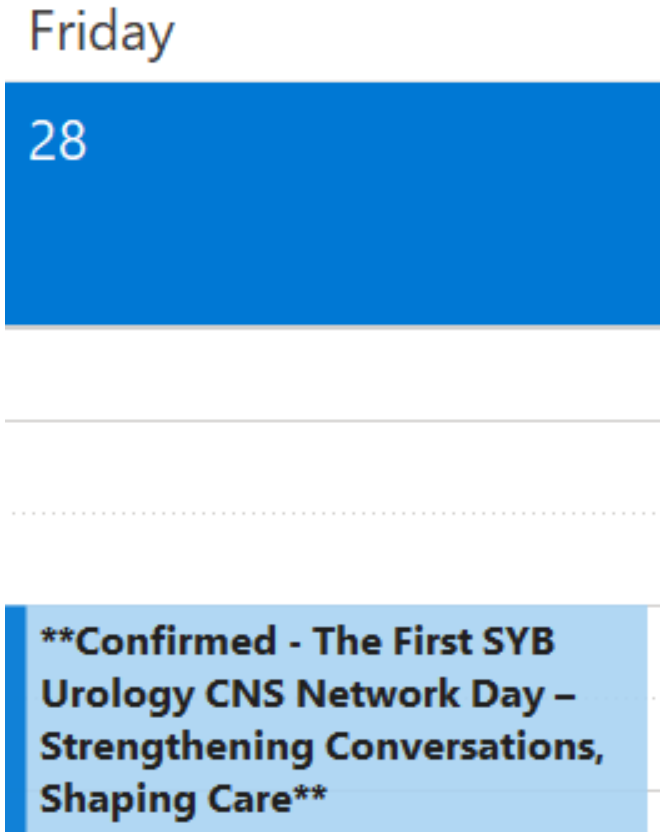
Prostate 3Ds - Disclose

Prostate 3D's
Diagnose, Disclose, Decide.

- Have the news communicated with empathy and clarity by a Clinical Nurse Specialist (CNS)
- Remove any bias
- Use of scripts / prompts to help the CNS team across the region deliver consistent information and the use of non - frightening language, ensuring the right language is used
- 1st regional Urology CNS network day at the end of November
- Training requirements of teams
- Development of competency documents
- Clarity around how to refer for treatments available outside of SYB



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Prostate 3Ds - Decide

Prostate 3D's Diagnose, Disclose, Decide.

- We are developing:
- Podcasts about all the different treatments available & how to make decisions about your treatment
- Animations (short)
- Branding and logos – to get engagement from our clinical teams
- Standardise the information that patients receive across SYB

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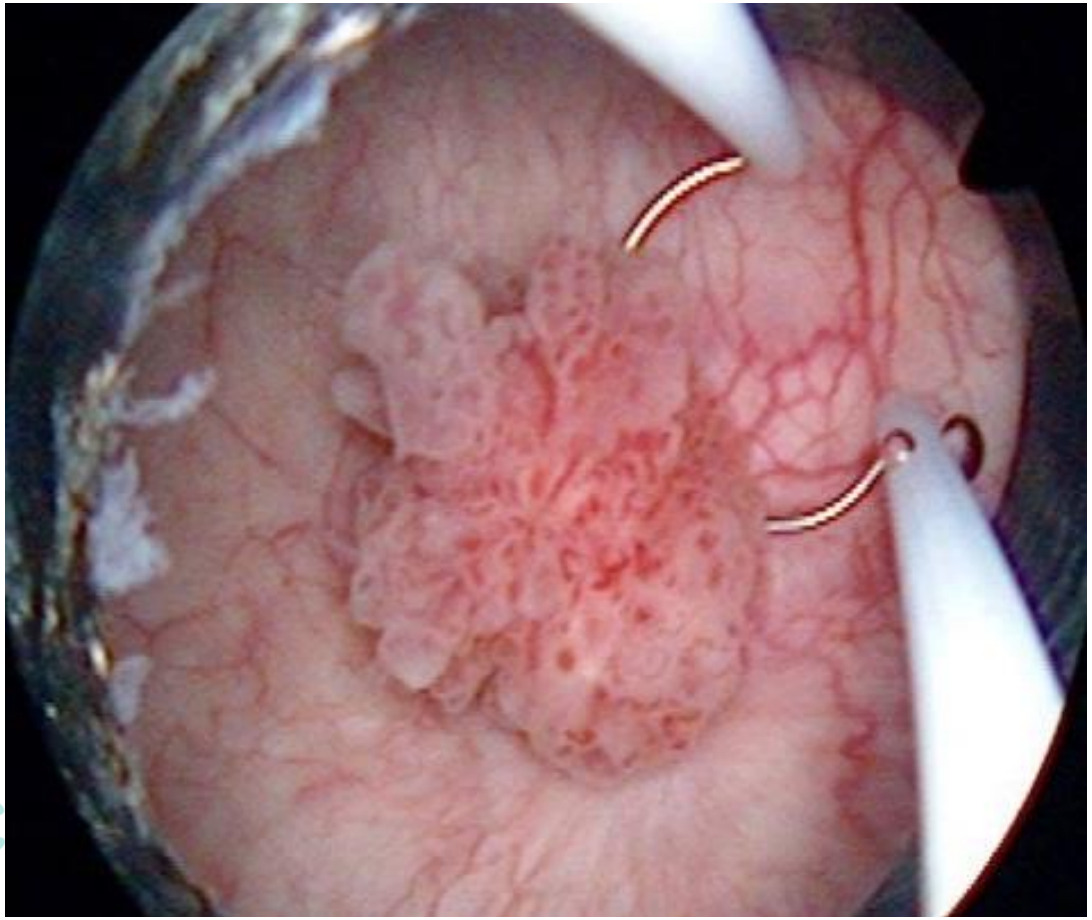
Help from Primary Care

- Help advise patients on potential outcomes after referral
- Different types of prostate cancer – not all “spread to the bones”
- Many prostate cancers will be safely observed

Suspected Bladder Cancer



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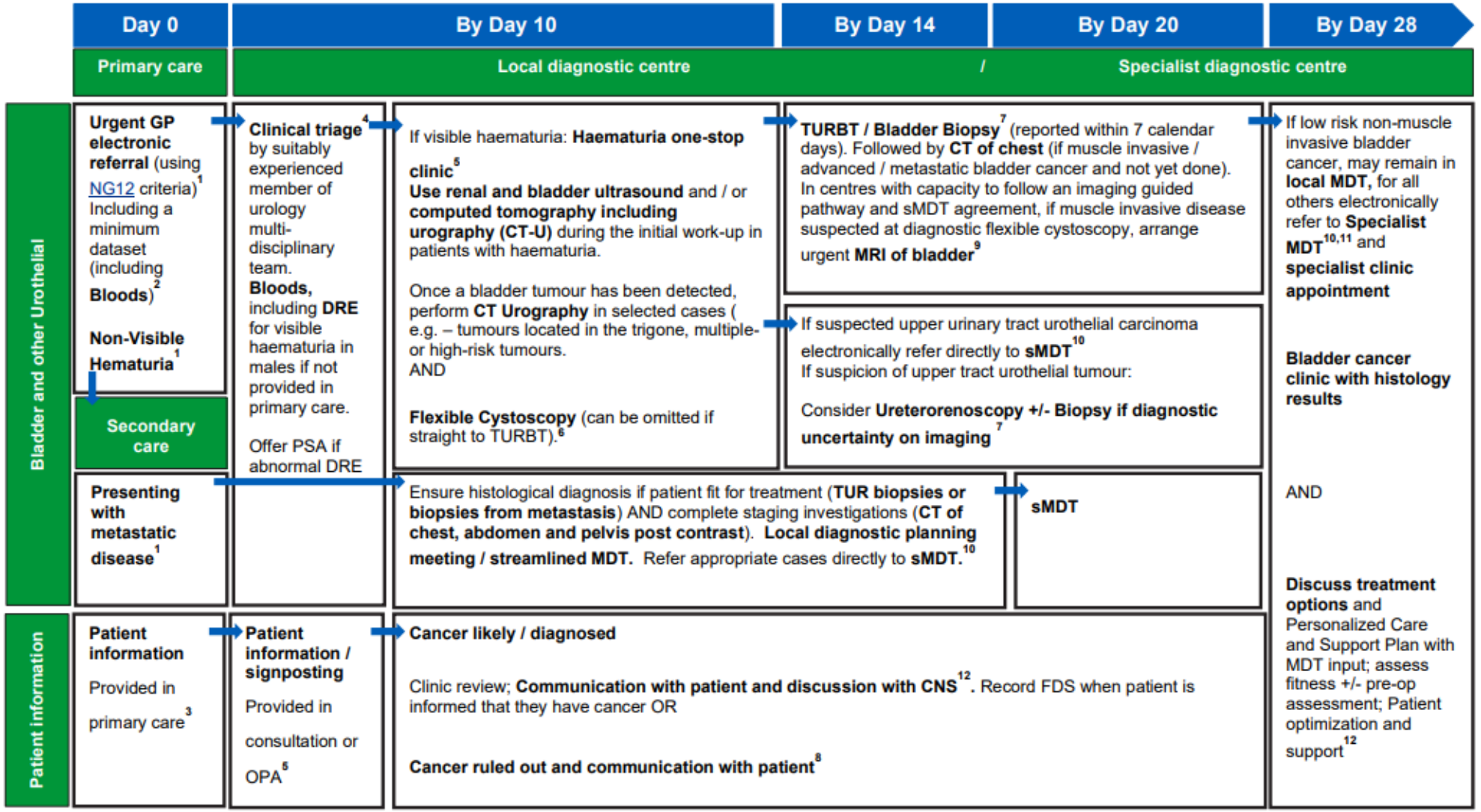
Best Practice Timed Pathway – Bladder

Bladder best practice timed pathway



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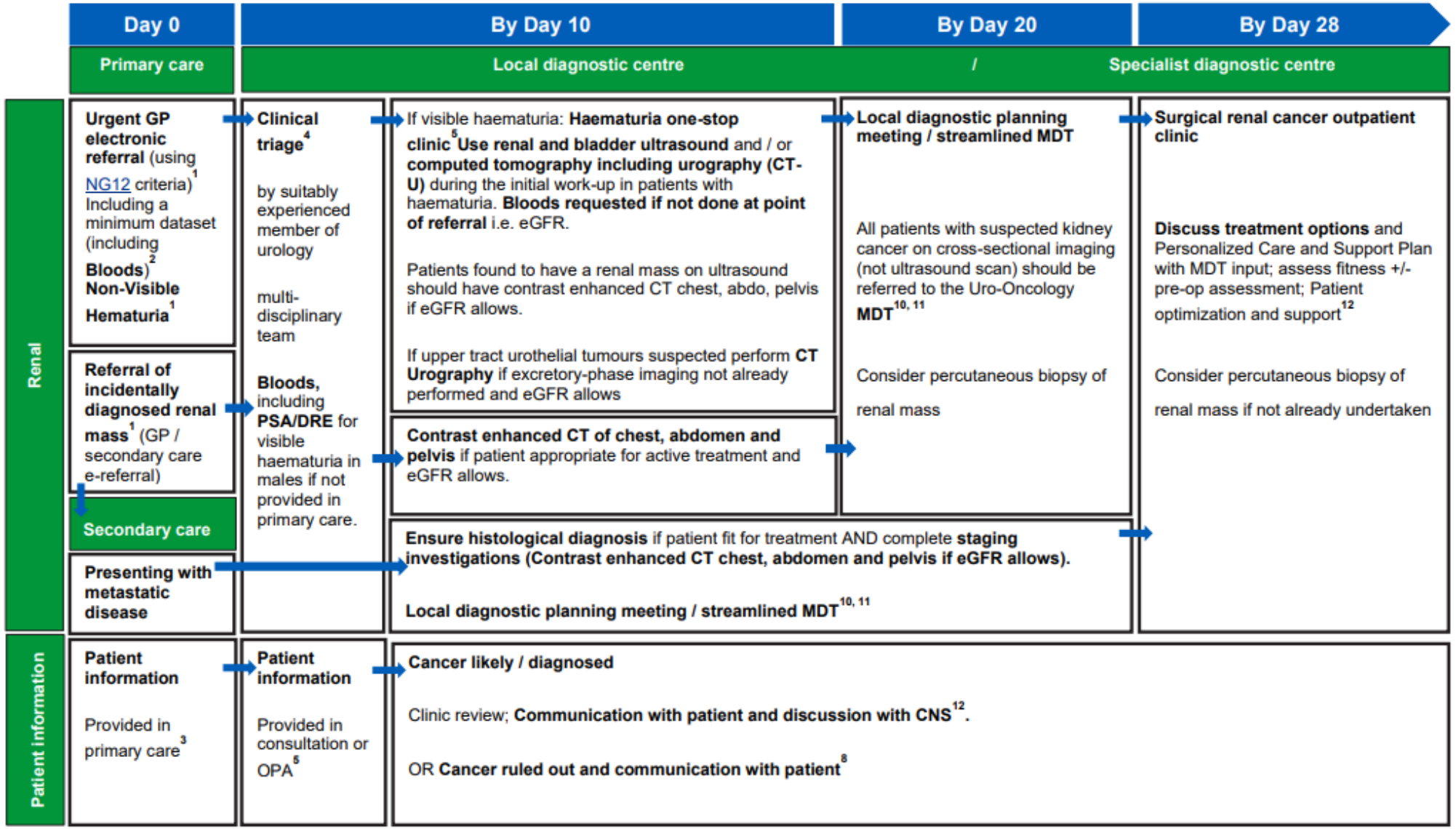
Best Practice Timed Pathway – Renal

Renal best practice timed pathway



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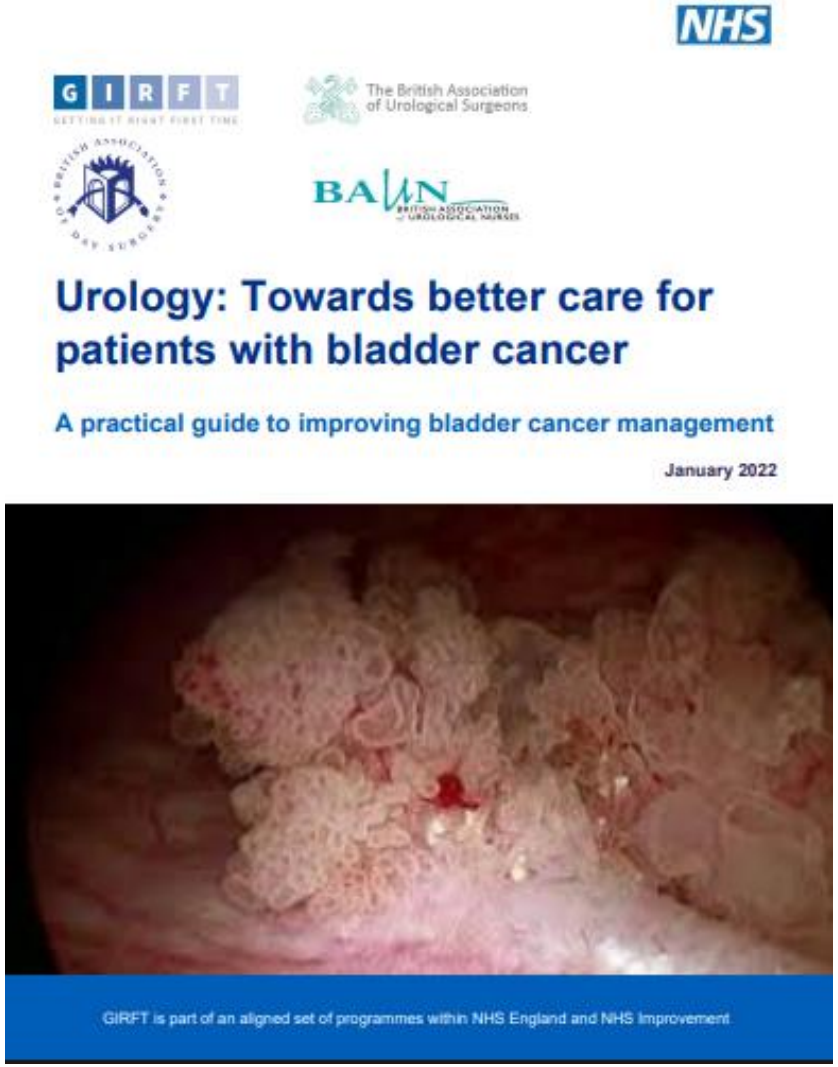
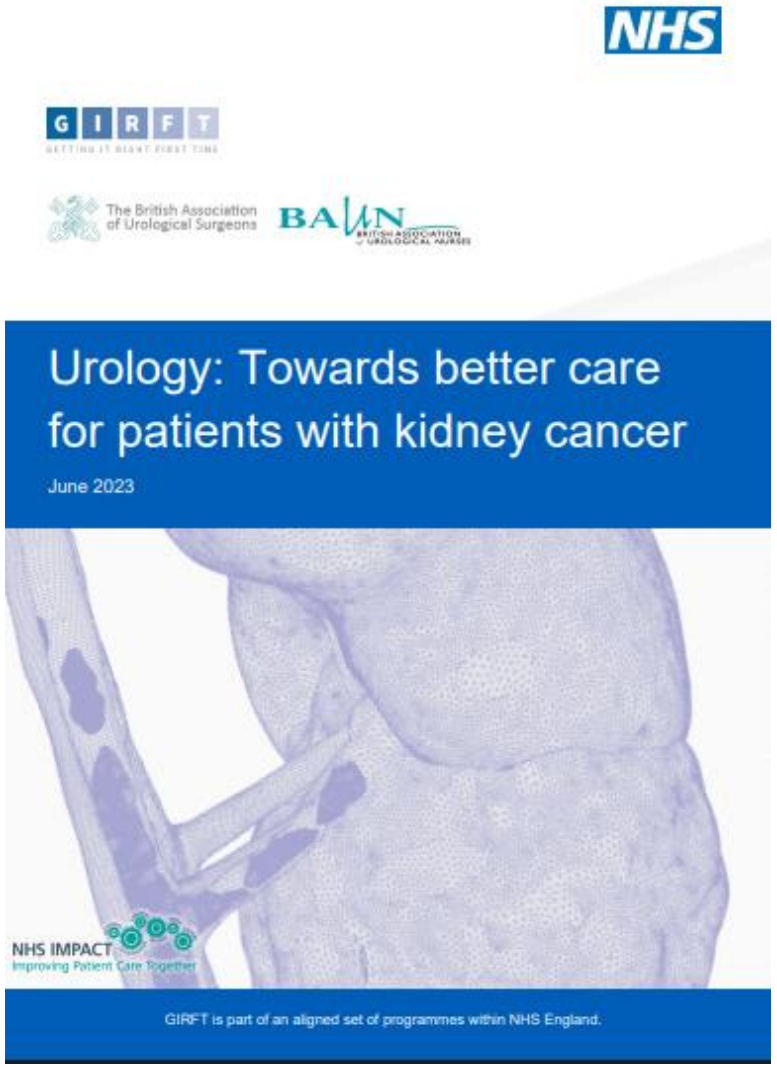
GIRFT Guidelines





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Bladder / Renal Referral Guidelines

Visible Haematuria	**Aged ≥ 45y with unexplained visible haematuria without UTI** Please ensure that a U&E has been taken within one month of referral (for CT Scan) and include the result if available
Visible Haematuria	Aged ≥ 45y with unexplained visible haematuria that persists or recurs after successful treatment of UTI Please ensure that a U&E has been taken within one month of referral (for CT Scan) and include the result if available
Non-visible Haematuria	Aged ≥60y with unexplained non-visible haematuria and either: • Dysuria • Raised blood white cell count Please ensure that a U&E has been taken within one month of referral and include the result if available
Mass on Imaging	Mass in the kidney or bladder on USS or CT

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Routine referral

Non-visible Haematuria (A trace of blood on urine dipstick is not considered to be of significance)

All patients 60yrs and under:

- If proteinuria or raised creatinine – refer to renal physician
- If no proteinuria and normal creatinine – refer to a urologist

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GIFT Bladder Cancer – key messages

•Visible haematuria (blood in urine) in patients aged ≥ 45 yrs (or as per local urgent suspected cancer guidelines) should prompt urgent referral.

•For non-visible haematuria (microscopic), in older patients (typically ≥ 60yrs) with additional risk factors (e.g., dysuria, raised inflammatory markers) referral should also be considered.

•Don't assume benign causes without evaluation—while many haematuria cases are non-malignant, bladder cancer is not rare and delays in diagnosis worsen outcomes.

•Before referral or testing, exclude reversible causes of haematuria such as urinary tract infection (UTI), recent instrumentation/catheterisation.

•Send urine dipstick/microscopy, culture if indicated; consider whether the haematuria is visible vs non-visible and risk stratify accordingly.

•When referring, provide full relevant history: age, haematuria type (visible/non-visible), LUTS symptoms, smoking history, occupational exposures, prior UTIs or instrumentation. This helps proper triage.

•Do *not* delay referral simply to obtain a full array of tests if there is a strong suspicion of bladder cancer: the pathway emphasises timeliness

Professionals Area SYB Cancer Alliance Website – Urology Library

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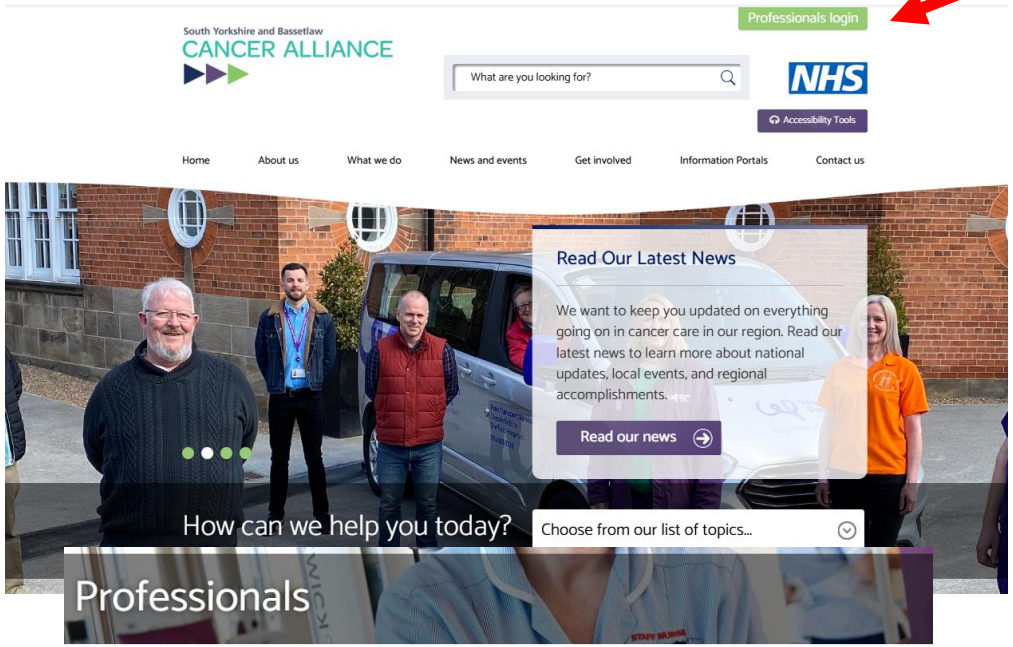
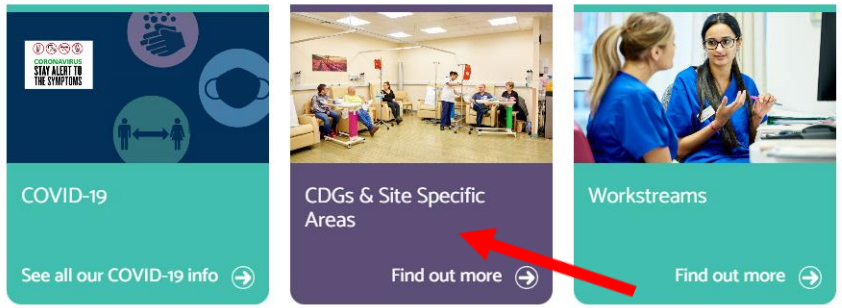


Welcome to the professionals area of the South Yorkshire and Bassetlaw (Working with Derbyshire) Cancer Alliance website.

While we are still building the site, we are also looking to continuously develop and improve it. If you have any feedback, please email us at **sybndcancer.alliance@nhs.net** with your suggestions and comments.

If you are looking for SYB Cancer Alliance Urgent Suspected Cancer Forms - please access suspected cancer referral proformas via the CtheSigns Clinical Decision Support Tool



- Catch up on previous CDG meetings
- Quality Standards and Guidelines
- Genetic Testing
- Prostate Treatment Options (Outside of SYB)
- Urology Standards of Care
- Prostate Specific Information
- Kidney Specific Information
- Bladder Specific Information
- Testicular Specific Information
- Penile Specific Information
- CNS Specific Information

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Thank you