Delivering stratified follow-up in primary care for Prostate Cancer Patients
- The NCL Approach

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Background

“patients stable at 2 years after radical treatment and patients who are undergoing “watchful waiting” are offered follow-up outside of hospital in an appropriate setting”

NICE Prostate Cancer CG175 2014

NHS Five Year Forward View

“Over the next five years the NHS must drive towards an equal response to mental and physical health, and towards the two being treated together...we have a much wider ambition to achieve genuine parity of esteem between physical and mental health by 2020.”

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Project Aim:

Transforming Cancer Services Team for London, in association with Prostate Cancer UK and Croydon CCG, developed and tested a holistic follow-up service led and delivered in primary care for patient cohort outlined by NICE. The model enables principles outlined in the FYFV, Cancer Taskforce and further supports cancer commissioning strategy for London.
Objectives

Enhance patient experience and outcomes by providing care closer to home and improving access to support services.

Resource primary care to provide support and holistic care for stable prostate cancer patients within a safe governance framework

- Produce a clinically safe service specification

Streamline the discharge process and improve transfer of information about patient care from secondary care to primary care

- Reduce variation and across CCGs and Trusts

Appropriate patient information to enhance knowledge of late effects and enable self-management.

Increase urology outpatient capacity by moving care of stable prostate cancer patients from secondary to primary care
• Decision to implement a primary care led follow-up model was agreed at NCL Cancer Board in July 2016

• Service specification developed with input from London Cancer - Urology Board, TCST and five NCL CCG Cancer Leads
  • CCG Commissioning Managers
  • GPIT
  • CSU
  • LMC

• Collaborative working across Secondary and Primary Care
  • Service Specification discussed and agreed by the Urology board
  • Pathways discussed with Clinicians and Operational colleagues at the 4 Acute Trusts
North Central London Stratified follow-up pathway for stable prostate cancer

**Diagnosis and Treatment**

- **GP Support** - Includes cancer care review within 6 months of diagnosis and referral back to specialist team, as required
- **Secondary Care Admin**
  - Process referral
  - Entry onto cancer IT system and remote monitoring database
- **Medical**
  - Investigations and diagnosis
  - MDT
  - Treatment decision / Treatment / End of treatment clinical OPA with: discussion of future surveillance tests, support information and healthy living advice
  - Treatment summary completed
- **Patient**
  - Patient info. describes follow-up options
  - Discuss follow-up options with patient
  - Holistic Needs Assessment
  - Patient actively engaged as a partner in their care throughout pathway.
- **CNS**
  - Holistic needs assessment reviewed as needed
- **Support services**
  - Health and well-being events AND additional support services (sexual functioning, continence, psychological/emotional support, rehab, diet and nutrition, physical activity, peer support)

**End of treatment & living beyond cancer**

- **Preparation of Treatment Summary and invitation to aftercare appointment**
  - Once PSA stable, Stratified follow-up OPA to be scheduled with clinician.
  - HNA completed
  - Treatment Summary reviewed and updated as required.
  - HNA and TS given to patient and sent to GP.
  - Discharge to Primary Care for all eligible individuals.
  - Urgent referral back to secondary care as per triggers outlined on Treatment Summary
  - GP Led Follow Up: Welcome appointment: with signposting or referral to relevant services. Annual holistic needs assessments are offered and PSA testing conducted every 6-12 months as per the individuals’ surveillance schedule
  - Ongoing support and helpline for patients
Exclusion criteria

- Is on active surveillance
- Is being treated with brachytherapy
- Is at high risk and has had radical radiotherapy or surgery
- Is being treated with focal therapy

For individuals participating in clinical trials, follow-up will be determined by the clinical trial protocols. All individuals taking part in trials will still access and benefit from the end of treatment clinical OPA (outpatient appointment) and health and wellbeing events.

Eligibility Criteria

Definitions of stable have been developed and agreed per treatment. They are as follows:

- Localised Prostate Cancer – Watchful Waiting: All patients after 1 year of diagnosis who are willing and able are to be considered for self-management.
- Patients who have had curative radical prostatectomy: All patients 1 year after treatment and have undetectable PSA.
- Patients who have radical radiotherapy: All patients 2 years after treatment and PSA is less than 2 ng/ml above nadir. This is within the context of normal testosterone levels.
- Patients being treated with hormonal treatment only for locally advanced disease: All patients 1 year after treatment whose PSA is less than 2 ng/ml.
Patient is identified as suitable for primary care led follow up

**Secondary Care**

- Continuing regular follow up by specialist service
  - Treatment summary sent; arrange rehabilitation services. Virtual or face to face follow up by specialist as per local follow up schedule
  - Regular follow up with PSA testing every 6-12 months.
  - Specialist review

**Primary Care**

- Discharge letter and Treatment Summary to GP with detailed individualised follow up advice
  - GP / Practice nurse appointment; holistic assessment; prostate care plan; arrange prostate review and rehabilitation services. Care is integrated with other long term conditions
  - Regular GP/ Practice nurse follow up appointments as per follow-up schedule.
Quality and Safety Netting

• Primary Care Prostate Cancer Register
  – Read coding – 8Hgg2
  – Active recall for appointments

• Secondary Care
  – Agreed urgent re-referral routes back to secondary care
  – Email contacts for advice
  – Audit by each Trust to monitor list of patients discharged and reconcile with primary care registers

• Patient Empowerment
  – Same information given to patients at transfer from secondary to primary care
  – Patient information leaflets to explain the service
  – Patients know what to expect from primary care
Next Steps

• CCG Implementation in progress
  – CCG sign off, Primary Care templates, central reporting

• Sign off of final service specification

• Start Date across all 5 CCGs and 4 Trusts

• Primary Care Education and Engagement Events
• Many thanks to:
  – Professor John Hines, Sharon Cavanagh and London Cancer Urology Board
  – Sarita Yaganti and the TCST team
  – Barnet CCG Commissioning team
  – Clinical Lead colleagues

ANY QUESTIONS?