

London Cancer:
**Prostate Cancer Stratified
Follow-up Pathway Guidelines**

December 2015

Final Version 2.0

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2. Introduction and Purpose of this Guideline

The *London Cancer* Urology Pathway Board formed a sub-group to develop a stratified follow-up pathway for the future delivery of prostate cancer. The sub-group met during the period between February 2015 and May 2015 and delivered its final proposed pathway to the Urology Pathway Board on 14th May 2015. The pathway board, as the ultimate source of prostate cancer expertise and leadership for *London Cancer* ratified the stratified follow-up pathway on 4th February 2016.

This guidance describes a secondary care led follow-up process but it can be adapted for a primary care led solution. It is anticipated that trusts will engage with local Clinical Commissioning Groups (CCGs) to discuss if a secondary or primary care led model is best for their local population and services. For definitions, please refer to **Appendix I**.

These guidelines have been produced to ensure that:

- All individuals diagnosed with prostate cancer receive personalised information and appropriate support to enable them to live actively and well following the end of their cancer treatment.
- A safe, robust and transparent system is utilised to manage prostate cancer surveillance and ongoing care/support.
- Timely, safe and appropriate systems back into specialist services are in place in the event that a concern arises.
- Each individual is provided with verbal and written guidelines about exactly when and who to contact if they have any concerns in the future.

This stratified pathway meets the expectations of the National Cancer Survivorship Initiative, NHS Improvement (Cancer) and NICE guidance for the management of prostate cancer. It is an accompanying document to the *London Cancer* Pathway Specification for Urological Cancers document.

3. Stratified Follow-Up: Overview of the pathway

The redesigned stratified follow-up pathway for individuals with prostate cancer is outlined in **Appendix II**. The pathway is described from the point of diagnosis, through treatment until living with and beyond the disease or the transition to end of life care.

The pathway has 3 strata of follow-up:

- **Supported self-management pathway (SSMP):** Patient led follow-up where the individual receives support and interventions to empower them to self-manage their health. They receive surveillance tests but do not have routine clinic appointments

- **Personalised clinical follow-up:** Clinician led follow-up. Clinic appointments are scheduled as per individual need
- **Supportive/end of life care services:** Clinician led with palliative care input as required.

The individual will receive personalised clinical follow-up until their disease is deemed stable. If they have unstable or advanced disease, they will continue to have personalised clinical follow-up or will transition to supportive/end of life care (as per their clinical/individualised needs).

Once an individual has stable disease they will be reviewed by the clinical team and stratified onto the supported self-management pathway – or remain on the personalised clinical follow-up pathway if they are unable to self-manage. Detail of the ‘Stratified Pathway for Stable Prostate Cancer’ pathway is provided in **Appendix III**. They will be monitored on this pathway for approximately **three years**. Those who are on the SSMP will then be discharged into primary care. Individuals receiving personalised clinical follow-up will be reviewed and their needs for ongoing support by secondary care will be reviewed by the Multidisciplinary Team (MDT).

4. Eligibility for Entry onto Supported Self-management Pathway

All stable prostate cancer patients will be considered for entry onto the prostate supported self-management pathway unless the individual:

- Is unable to self-manage due to physical, cognitive or emotional reasons
- Chooses not to enter the supported self-management pathway
- Is on active surveillance
- Is being treated with brachytherapy
- Is at high risk and has had radical radiotherapy or surgery

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.

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

- 1. Localised Prostate Cancer – Watchful Waiting:** All patients who are willing and able are to be considered for self-management.
- 2. Patients who have had curative radical prostatectomy:** All patients 1 year after treatment and PSA is <0.1 ng/ml above nadir.
- 3. Patients who have radical radiotherapy – aim PSA <0.1:** All patients 2 years after treatment and PSA is <2 ng/ml above nadir and no complications.
- 4. Patients being treated with hormonal treatment only for locally advanced disease with or without metastases:** All patients 1 year after treatment whose PSA is less than 4 ng/ml.
- 5. Patients who have received focal treatment:** All patients 1 year after treatment and no complications. Consultant will set individualised ceiling for PSA at this time.

Patients will have their suitability for entering the supported self-management pathway considered in the MDT. Those who are not eligible will be recorded as not appropriate for SSMP on their MDT proforma within the cancer IT system and will receive personalised clinical follow-up. A printed copy will be placed in the patient notes as appropriate.

5. Stratified Follow-Up: The Process

5.1 Diagnosis and treatment:

- All men diagnosed with prostate cancer will receive information about the treatment they will receive and how they will be supported:
 - During and following the end of treatment
 - Once their disease and PSA are stable
- This will include a description of both personalised clinical and supported self-management follow-up options with emphasis placed on the fact that they may move between pathways if their needs change during the follow up period.
- Individuals will receive a holistic needs assessment around diagnosis. This will be reviewed whenever their needs change.

5.2 End of treatment

- At the end of first definitive treatment or at the end of a defined set of treatments, all individuals will receive an **'end of treatment clinical outpatient appointment'**. This is an appointment between the patient and the Consultant in which the individual will have their holistic needs reviewed and they will receive personalised information to support them at this transitional point in the pathway. It is recommended that the patient be provided with verbal and/or written information regarding the following:
 - Explanation of their personal plan for future surveillance tests. This will include a description of the process for having blood tests and receiving results
 - Alert symptoms that require contacting the specialist team to discuss
 - Possible treatment toxicities/consequences of treatment
 - Contact name and phone number of the urology specialist team and trust helpline
 - Advice on healthy eating
 - Advice on physical activity – keeping active
 - Upcoming Health and Wellbeing Events
 - Any local self-help groups and useful phone numbers (e.g. Macmillan Cancer Support, Prostate Cancer UK)
- A treatment summary will be generated by the medical team and placed in the individual's written/electronic hospital notes. Copies of the treatment summary will also be sent to the patient if they have opted to receive clinical documents.

- It is recommended that the GP is sent copies of the same information that is given to the patient. This will enable the GP to support the individual in the primary care setting.
- A schedule of personalised future clinical appointments will be booked and dates will be given to the individual.

5.3 Living with or Beyond Cancer – Stratification

Once the individual has stable disease, their eligibility for entry onto supported self-management pathway (SSMP) is to be established. The final decision regarding the most appropriate pathway for the individual is conducted in collaboration with the patient. Therefore if they are eligible, it is advised that a '**stratified follow-up OPA**' is arranged to discuss follow-up options – with a focus on encouraging entry onto the SSMP.

During this appointment, the individual will also receive:

- A review of their holistic needs assessment
- A personal plan for future surveillance tests - including an explanation of the process for having blood tests and receiving results
- Alert symptoms that require contacting the specialist team to discuss
- Possible treatment toxicities/consequences of treatment
- Contact name and phone number of the urology specialist team and trust helpline
- Advice on active and healthy living – nutritional advice and physical activity
- Information on upcoming Health and Wellbeing Events
- Contact details on any local or national support groups or information services (e.g. Macmillan Cancer Support, Prostate Cancer UK)

Individuals who are eligible and choose the **supported self-management pathway**:

- Can contact their Urology CNS as needed with any concerns
- Will have six-monthly PSA tests for 3 years with the results sent to them
- If on hormone therapy, they will have six-monthly PSAs on an ongoing basis and will receive bone health monitoring as per national and local guidelines
- Will not have routine outpatient appointments

At any point during the follow-up pathway, individuals may be contacted and offered access to any relevant clinical trials that may become available.

The individuals who choose the **personalised clinical pathway** or who are **not eligible for the supported self-management pathway**:

- Will receive follow up surveillance tests and outpatient appointments as per their clinical and individual needs
- During each OPA, the individual's eligibility for entry onto SSMP to be revisited

5.3.1 Health and Wellbeing Events

All patients will be offered a health and wellbeing event. Health and wellbeing events are patient education and support sessions which aim to provide individuals with the information and confidence they require to lead as normal and active life as possible after their cancer treatment. They also aim to increase awareness of the local facilities, supportive care and opportunities that are available to them and their families.

The Health and Wellbeing events may be delivered as:

- **1:1 appointments** conducted with individuals at the end of treatment
- **Rolling programmes** (such as the 6-weekly Macmillan HOPE events)
- **Group events** which are scheduled at regular intervals throughout the year and which individuals may have an open invitation to attend if they choose to do so. They give opportunity for interaction between patients and carers, clinicians, clinical nurse specialists, allied health professionals, and complementary therapists. These might also include market stalls of local health promotion services or voluntary agencies

It is recommended that the core content of Health and Wellbeing events is as follows:

- Expert advice on **health promotion** – to minimise risk of recurrence and support healthy living. Specifically this will include: being physically active, nutrition, healthy weight management, and smoking cessation. To include information/support to effect behavioural change
- **Support** to ensure that individuals have the confidence and skills to manage their condition themselves as far as possible – i.e. referral to rehabilitation and psychological support services and signposting to local groups or buddying services
- Advice on **adjusting to life after treatment** – addressing fears of cancer recurrence
- Information on **signs and symptoms of recurrence** and **potential consequences of treatment**. All events should clearly convey and reinforce the methods to activate fast-track access back into the system if there are any concerns regarding new symptoms or recurrent disease
- Information and access to **financial and benefits advice**
- **Specific issues relevant to the individual's type of cancer**. For example continence issues – early detection and management, body image & sexual functioning
- **Vocational rehabilitation**

The end of treatment appointment with the Consultant/CNS may be tailored to fulfil the function of a health and wellbeing event. However, evidence from National Cancer Survivorship Initiative health and wellbeing pilot sites revealed that many patients benefited from group sessions¹. Specifically the pilots demonstrated that:

¹ Palin, J. Ryrie, I. Smith, L. Khanna, M. Pralat, R. (2011) **Evaluation of Health and Wellbeing Clinics: Final Report**

- The **informal atmosphere** of group events enhanced the delivery of the Health and Wellbeing messages
- The **combination of using professionals and volunteers at the Health and Wellbeing group sessions** was effective
- Participants valued the **group discussions** – this assisted to address issues of isolation and to validate what is ‘normal’ to experience and feel for a person affected by cancer. This differentiates the clinics from traditional forms of follow-up such as outpatient appointments

5.3.2 Discharge from the Stratified Follow-up Pathway

At the end of 3 years from the point of entry onto the stratified follow-up pathway, it is recommended that the individuals on the:

- **Self-management pathway** – are reviewed in a virtual MDT to update any ongoing treatment regimes in light of latest evidence. Discharge into primary care to be effected as appropriate.
- **Personalised clinical follow-up pathway** – are reviewed every three years in a virtual MDT meeting to establish suitability of being discharged to primary care or moved to self-management pathway.

Any plans from the virtual MDT review will be actioned and a letter will be sent to both the patient and the GP to inform them of any recommendations for ongoing treatment or stating that the individual has been discharged from the trust stratified follow-up pathway. Patients will continue to have annual PSA measurements for the length of time indicated by their Consultant.

6. Surveillance Investigations

All patients will have their surveillance investigations recorded on the cancer IT database. This database will hold the information required to manage follow up investigations – ordering of tests and results recording/checking. From a clinical perspective, it is recommended that the IT system provides data that demonstrates PSA results numerically and graphically over time as increases in PSA levels, even if levels are within tolerance, can indicate recurrence of disease.

- 6.1 PSA tests will be conducted on a six monthly basis unless otherwise indicated by the consultant. PSA surveillance requests will be recorded and scheduled on the cancer IT database.
- 6.2 A safe and robust system of checking PSA tests needs to be implemented. It is recommended that the electronic database generates a monthly list of patients requiring a PSA test. The PSA requests will then be made and an appointment sent to the patient.
- 6.3 Results will be reviewed by a clinician and recorded on the cancer IT database. They will then be sent directly to the GP. If the results are normal, a letter will be sent to the patient informing them of this. If the results indicate further investigations required, the patient will be recalled into an OPA within 2 weeks of the results being reviewed.

- 6.4 Other surveillance such as for bone health will be recorded and managed on an individual basis.
- 6.5 Patients will be aware of due date for their PSA tests from information included within their end of treatment clinical OPA and on their treatment summary. Individuals will be advised to contact the specialist team if they do not receive a request for the PSA test by the end of the month that it is due.
- 6.6 It is recommended that the trust has a system in place to outline which team members will have the responsibility to resolve issues regarding missed PSA results or to follow up DNAs.
- 6.7 After 3 years of being on the SSMP, patients on the self-management pathway will be discharged to primary care. It is recommended that PSA testing responsibilities transfer to primary care at this point.

7. Clinical Governance

Over the 3-year duration of the stratified follow-up pathway, the clinical governance responsibility for patients on the personalised clinical follow up and supported self-management pathways lie with the Urology MDT. Clinical governance responsibility for those on the SSMP will then move to primary care once they are discharged into the care of their GP.

8. Re-accessing Specialist Services as required

All patients and their GP's will be aware of how to access the specialist team if concerns arise. Safe robust systems will be in place to facilitate this.

- 8.1 Patients and their GP's will have written contact numbers and guidelines about when and how to access further support. Access will be via the Urology CNS whilst the individual is on either of the stratified pathways and thereafter via a GP referral.
- 8.2 If a patient is on the SSMP and is required to have further investigations following their routine PSA testing, they will be recalled for an urgent OPA within two weeks of their investigations being reported. It is recommended that trusts identify a clinic for these patients to attend to ensure rapid access when required. Patients will be informed of this possibility at their end of treatment clinical appointment. Patients on the personalised clinical follow-up pathway will be seen in clinic for a review within 2 weeks and further investigations ordered as required.
- 8.3 **Triggers for re-referral (by treatment)**

Localised Prostate Cancer – Watchful Waiting: 2 consecutive rises in PSA is predominant trigger. A member of the Urology MDT should review men with localised prostate cancer who have chosen a watchful waiting regime and who have evidence of significant disease progression (rapidly rising PSA or bone pain) as per NICE guidance (2014)

Patients who have had curative radical prostatectomy: PSA > 0.1 ng/ml, or 2 consecutive rises in PSA, or PSA of Nadir + 1

Patients who have radical radiotherapy - aim PSA <0.1 ng/ml: PSA of Nadir +2

Patients being treated with hormonal treatment only for locally advanced (or metastatic) disease: 3 consecutive rises in PSA, or PSA of Nadir +2

Patients who have received focal treatment: 2 consecutive rises in PSA, or if PSA ceiling reached

9. Evaluation

- 9.1 It is recommended that user feedback is conducted by postal questionnaire which is sent to all patients 3 months post the stratified follow-up OPA. The aim of the questionnaire is to establish if the patients' needs have been met. (Refer to **Appendix IV** for an example of a patient questionnaire)
- 9.2 Baseline measures/process mapping: Establishing baseline measures prior to implementation is critical to enable measurement of improvements at a later date. Recommended data for collection includes:
- **New cancer diagnosis : Follow up ratios** for prostate patients
 - Number of **Surgical** outpatient clinics per week
 - Number of **Oncology** outpatient clinics per week
 - Number of **cancer patients** seen at each outpatient clinic
 - Average number of new **cancer patient** slots per clinic
 - Average number of follow up **cancer patient** slots per clinic
 - Number of **telephone clinics** to follow up cancer patients. Average number of cancer patients reviewed at each telephone clinic.
 - Number of **virtual clinics** to follow-up cancer patients. Average number of cancer patients reviewed at each virtual clinic.
 - **Readmission rates** for cancer patients
- 9.3 On-going measures: Establishing the data collection and measures to be utilised to demonstrate effectiveness also needs to be agreed prior to implementation. Data on all or some of the following would be useful:
- Reduction in outpatient attendances
 - Patient Reported Experience Measures (PREMS)
 - Patient Reported Outcome Measures (PROMS)
 - No. of calls to helpline or Clinical Nurse Specialist from patients being followed up on the SSMP
 - No. of Holistic Needs Assessments completed
 - Cancer waiting times
 - Number/ % of patients with a care plan

- Number/% of patients who receive a Treatment Summary at end of treatment
- Number of patients enrolled onto the supported self-management pathway
- Patients' narratives/stories

9.4 It is recommended that measurement of the health related quality of life and wellbeing of prostate cancer patients is assessed approximately one year post entry onto the stratified model of follow-up. PROMS tools to consider:

- **EORTC QLQ-C30**
Description: A questionnaire which assesses the quality of life of cancer patients. It comprises 30 questions which focuses upon functional (physical, cognitive, emotional, and social); specific symptom (fatigue, pain, and nausea and vomiting); global health and quality-of-life domains. A tumour specific module is also available as required.
Permissions/Licencing: Permission required. There is no fee for academic use. Permissions obtained via the EORTC website.
Website: <http://groups.eortc.be/qol/eortc-qlq-c30>
- **FACT G:** A general quality of life instrument intended for use with a variety of chronic illness conditions. It assesses the functional status of patients with specific cancer diagnosis. The sub-scales included within the questionnaire are as follows: physical, social/family, emotional, and functional well-being. Originally validated in a general cancer population, it has condition-specific subscales to complement it, including one for prostate cancer (**FACT-P**).
Permissions/Licencing: Permission for use is obtained by completing a user agreement on the FACIT website. There is no fee for use of the tool.
Website: <http://www.facit.org/>
- **EQ-5D-5L:** A standardised instrument for use as a measure of health-related quality of life and of health outcome. The measure has 5 dimensions: mobility, self-care, usual activity, pain/discomfort, and anxiety/depression. The instrument comprises 2 parts: respondents rate their health on the dimensions/levels as well as record an overall assessment of their health on a visual analogue scale. Results able to be utilised to calculate quality adjusted life years (QALYs) to inform economic evaluation.
Permissions/Licencing: Requires written consent of the EuroQol Executive Office. Registration form able to be completed electronically via the EuroQol website.
Website: <http://www.euroqol.org/>

10. Guideline Monitoring

It is recommended that auditing occur three months following the implementation of these guidelines at trust level – and on an annual basis provided there are no significant adjustments required.

11. References

Armes, J. *et al.* (2009) **Patients' supportive care needs beyond the end of cancer treatment: a prospective, longitudinal survey.** *J. Clin. Oncol.* **27**, 6172–6179

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London Cancer (2014) **Health and Wellbeing Event Implementation Event Guidance**

London Cancer (2012) **Pathway Specification for Urological Cancers**

Maddams, J. Utley, M. and Moller, H (2012) **Projections of cancer prevalence in the United kingdom, 2010-2040.** *Br J. Cancer* **107**, 1195-1202

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NHS Improvement Cancer (2012) **Innovation to Implementation: stratified pathways of care for people living with or beyond cancer. A “how to guide”**

Palin, J. Ryrie, I. Smith, L. Khanna, M. Pralat, R. (2011) **Evaluation of Health and Wellbeing Clinics: Final Report**

12. Acknowledgements

Thank you to all of the sub-group members (named in Appendix V) who assisted in the development of this new stratified follow-up pathway. We acknowledge the input and expertise of all the members of this sub-group and the Prostate Pathway Board whom participated in the development process.

Appendix I: Definitions

Cancer IT System: The local cancer database (Somerset or Infoflex).

CNS: Clinical Nurse Specialist

Eligibility Criteria: An agreed description of the safety and appropriateness of entry onto the supported self-management pathway for individuals with prostate cancer.

OPA: Outpatient appointment

Personalised clinical follow-up pathway: The follow-up pathway in which individuals with cancer have face to face, phone, or email contact with the specialist team as part of individualised continuing follow up.

PSA: Prostate specific antigen. A test for PSA may be used to screen for cancer of the prostate and to monitor treatment of the disease.

Supported self-management pathway (SSMP): The follow-up pathway in which patients are empowered with the knowledge and skills to self-manage their condition. They are given information about the symptoms to look out for and who to contact if they notice any of these alert symptoms, future scheduled tests, and how to contact the specialist prostate team if they have any concerns. They do not receive any further OPA unless further investigations or support is required.

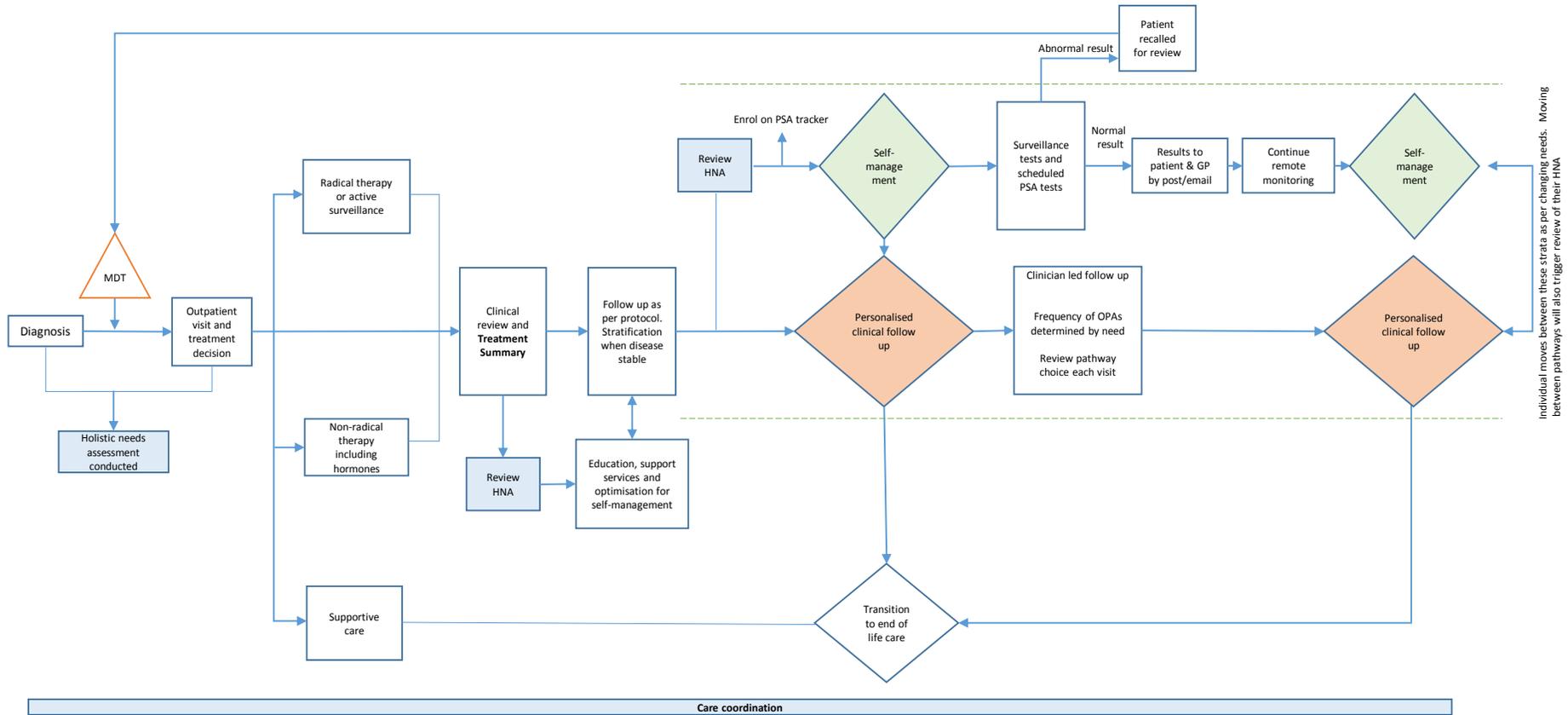
Stratified Follow-up: A model of follow-up in which the clinical team and the person living with cancer make a decision about the best form of aftercare based on the individual's clinical and personalised needs. Individuals enter either a personalised clinical follow-up pathway or a supported self-management pathway. The stratified follow-up pathway extends 5 years from the point of diagnosis.

Treatment Summary: The NCSI treatment summary template is completed by the medical team at the end of primary treatment. It includes information on possible treatment toxicities and /or consequences of treatment, signs and symptoms that require referral back to a specialist team, an ongoing management plan, and a summary of information given to the individual about their cancer and future progress and any required GP actions to support the patient. Copies are sent to the GP and provided to the patient when they are discharged.

The treatment summary can be automatically generated on the two main cancer information systems Somerset and InfoFlex.

Appendix II: Stratified Follow up Pathway for Prostate Cancer

Stratified Follow up Pathway for Prostate Cancer

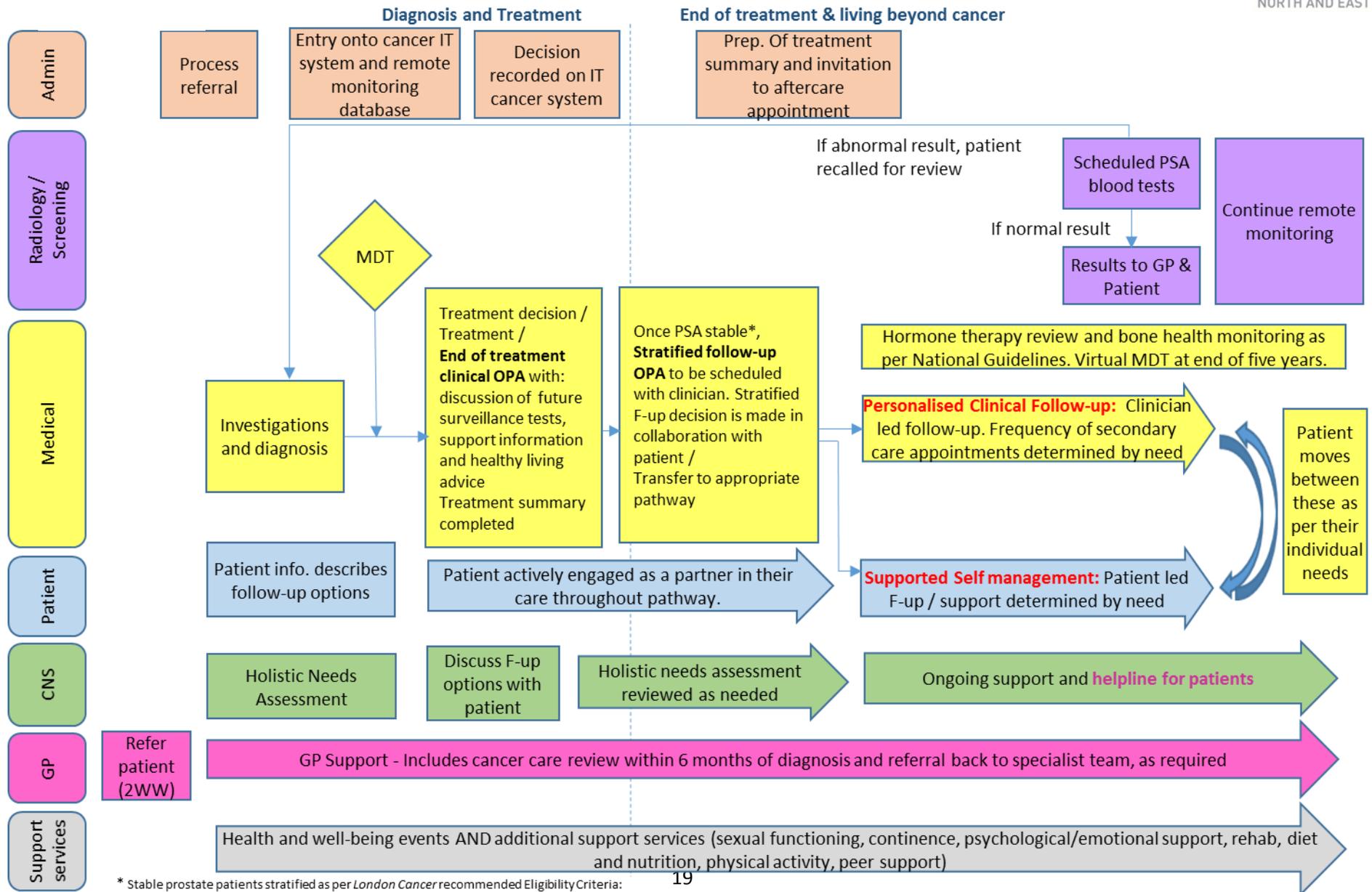


----- Area within the green lines is expanded in the 'Stratified follow-up pathway for stable prostate cancer' diagram overpage

Appendix III: Stratified Follow up Pathway for Stable Prostate Cancer

Appendix III

Stratified follow-up pathway for stable prostate cancer



* Stable prostate patients stratified as per London Cancer recommended Eligibility Criteria:
 All stable prostate cancer patients will be considered for entry onto the stable prostate supported self management pathway unless:
 • The individual is unable to self-manage due to physical, cognitive or emotional reasons
 • The individual chooses not to enter the supported self-management pathway
 NB: For individuals undertaking clinical trials, follow-up to be determined by clinical trial protocols
 For definition of stable, please refer to London Cancer Prostate Cancer Stratified Follow-up Guidance document.

Appendix IV: Patient Questionnaire Example

Patient Questionnaire about follow up, after treatment ends, for prostate cancer patients cared for by insert trust name

At the insert trust name, we are changing how we care for individuals who have prostate cancer once they have completed their treatment. These changes are in line with national guidelines (NHS Improvement Cancer and the National Cancer Survivorship Initiatives) and with what cancer patients have reported best meets their needs. It is important to us that we receive feedback from you to determine if we are meeting your needs - and what we need to do to continue to improve the care we give.

Please could you take a few minutes to complete this questionnaire?

Your answers will remain anonymous and will only be used by the trust to guide service improvements.

1. Do you have the contact details for your Urology Clinical Nurse Specialist (CNS)?
Yes No

2. After your end of treatment clinical review outpatient appointment with the doctor or Prostate CNS, did you receive a letter detailing your diagnosis, treatment and what scans or treatment you will need in the future?
Yes No

3. Do you feel you were given an adequate explanation of this letter by the doctor?
Yes No

4. Have you had the opportunity to discuss this letter in your aftercare appointment with your Urology CNS?
Yes No

5. Please comment about the contents of this letter below, if you feel able to.

6. Did you receive a holistic needs assessment with your Urology CNS at your aftercare appointment?

Yes No don't know

7. Do you feel the holistic needs assessment was useful for you?

Yes No don't know not applicable

8. Please comment about the holistic needs assessment below, if you feel able to.

9. Over the past six months, how many times have you contacted your GP practice for advice or support with issues relating to your cancer, or your treatment for cancer?

Not at all 1-2 times 3-5 times 6-10 times More often

10. How confident do you feel about managing your health?

Very Confident

Fairly Confident

Not very confident

Not at all confident

Don't know

11. Do you have all the information, advice or support you need to help you manage your health?

Yes No not sure

12. What other information, advice or support do you need to help you manage your health?

13. Do you have all of the information and advice that you need about the effects of your treatment?

Yes No not sure

14. How confident do you feel about who to contact if you have a query or concern, if at all?

Very Confident

Fairly Confident

Not very confident

Not at all confident

Don't know

13

15. Were you offered the opportunity to be on the supported self-management pathway?

Yes No I don't know

16.If yes to question 15 then did you choose to go on the supported self-management pathway?

Yes No I don't know not applicable

If you feel able, please could you share any further comments or thoughts you have about the end of treatment information and appointment with your Urology CNS?

Thank you for taking the time to complete this questionnaire, we value your comments and they will be used to guide service improvement in the future.

(Questionnaire adapted from Parapet Breast Unit at Heatherwood and Wexham Park Hospitals NHS Foundation Trusts)

Appendix V: Prostate Cancer Stratified Follow-Up Subgroup Members

- Sharon Cavanagh (Chair) – Living with and Beyond Cancer and AHP Lead, *London Cancer*
- John Hines – *London Cancer* Urology Pathway Director and Consultant Urologist, Barts Health NHS Trust
- John Sandell – Patient Representative
- Jane Smith – Patient Representative
- Katie Sutton - Macmillan Project Lead-Cancer Follow-Up Redesign, University College of London Hospital NHS Foundation Trust
- John O’Neill – Prostate Cancer Nurse, Whipps Cross Hospital
- Kate Kavanagh - Cancer Commissioning Manager (BHR & West Essex) NEL Commissioning Support Unit
- Alex Clayton-Jolly - Consultant Radiologist, Barking, Havering and Redbridge University Hospitals NHS Trust
- Paula Wells – Consultant Clinical Oncologist, University College London Hospitals NHS Foundation Trust
- Ros Crooks – Consultant Prostate Radiologist, Whittington Hospital NHS Trust
- Philip Lunn - Divisional Operations Director, Homerton Hospital
- Wade Norcott, Assistant Service Manager, Princess Alexandra Hospital
- Karen Sennett, GP/CCG Islington Board member, Islington Cancer Lead, Islington CCG
- Christine Moss, Epping GP and Clinical Director of west Essex CCG