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**Service Specification for Prostate Cancer Follow-up/Monitoring**

**Period: 1st April 2017 to 31st March 2018**

**Date of Review: Annual**

**Introduction**

All practices are expected to provide essential and those additional services they are contracted to provide to all their patients.

This specification outlines the more specialised services to be provided. The specification of this service is designed to cover the enhanced aspects of clinical care of the patient, all of which are beyond the scope of essential services.

No part of the specification by commission, omission or implication defines or redefines essential or additional services.

**Background**

The service will enable GPs to provide prostate follow up monitoring for patients with stable PSA who have no significant treatment complications and monitor those patients within the agreed limits.

There are likely to be 3 categories of patient suitable for community monitoring of prostate disease:

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| --- | --- |
|  | Localised prostate cancer: |
|  | * Radical Radiotherapy. Stable disease at 2 years post treatment, with controlled therapy side effects can be discharged to community care follow up.
* Radical Prostatectomy. Stable disease at 2 years post treatment, with controlled continence and potency.
* Brachytherapy.
* Active surveillance. Hospital based follow up until active treatment decided upon
* Patients in a trial will be followed up in hospital care
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|  |  |
|  | Locally advanced prostate cancer:* Radical Radiotherapy. Stable disease at 3 years post treatment (+/- adjuvant ADT) maybe discharged to community care at the discretion of the oncologist
* Radical Prostatectomy. Stable disease at 2 years post-surgery may be discharged to community care at the discretion of urological surgeon.
* Watchful Waiting. Where a joint decision to start ADT at a later time with symptoms or rising PSA; it is appropriate for community care to follow up men with 6/12 PSA and refer back to Hospital care when PSA reaches 40, or local urinary symptoms or signs of metastatic disease become apparent.
* Androgen deprivation therapy. Stable disease for more than five years with a PSA that has responded to ADT
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|  |  |
|  | Metastatic prostate cancer:* Androgen Deprivation therapy. (Bilat orchidectomy, LHRH analogues or antagonists, Anti-androgen) Men who have an initially elevated PSA, stable disease with a documented PSA fall towards a nadir, and minimal side effects are safe to be followed up in community care.
* Trials. All men in a trial will be followed up in hospital setting
* Men with metastatic disease that do not show a response to ADT; with no PSA response are not appropriate to discharge to community care.
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| (see Schedules) |

**Aims**

The overall aims of the service specification are to:

Provide a community based follow up service for those patients identified by secondary care clinicians as suitable for primary care monitoring of prostate disease.

The implementation of this specification will result in the following outcome for NHS Doncaster CCG:

* Care closer to home
* Increased patient satisfaction
* Reduced travel for patients
* Expanding patient care in Primary Care
* Potential for some longer term financial efficiencies

**Service Outline**

After the appropriate investigation/treatment in secondary care, the consultant looking after the patient will send their GP a letter with the following information in preparation of transfer of care:

* Diagnosis
* Investigations to date (with summary findings)
* Any presence of known metastatic disease
* Current PSA & Care Plan
* Purpose of monitoring

In addition, the consultant will identify triggers requiring consultant review e.g. increase of PSA above 8, Increase of PSA by greater than 50% over baseline, development of obstructive symptoms, symptoms suggestive of metastatic disease etc. The frequency of PSA monitoring will also be advised. This information will be provided in a standard letter format for clear identification of appropriate guidance on a Community PSA Monitoring Transfer Form (attached below).

If the GP accepts the monitoring proposal, he should sign the proposal, keep a copy in the patient’s notes and return a signed copy to the consultant. If the GP does not accept responsibility for monitoring the patient, it is their (the GP’s) responsibility to inform the consultant team of this fact so that secondary care can arrange appropriate follow-up.

The GP will monitor these patients within the agreed limits. The GP will arrange PSA tests for each patient at the required intervals. The GP will refer to the initial agreement on receipt of any PSA results and, if any of the “triggers” occur, the GP will refer directly back to the original consultant, via a “2 week wait” appointment. The review of results and decisions made are the responsibility of GPs within the patient’s practice and will not be delegated to other staff members without prior agreement of the CCG.

Therefore GPs will:

* Receive referrals from DBHFT of patients who are identified as appropriate for Follow up in Primary Care by DBHNHSFT.
* Establish and monitor appropriate recall systems within the practice to ensure safe and consistent monitoring.

Arrange for the patient to attend for an appropriate PSA blood test at the practice and arrange a clinical assessment at a time when the test results will be available.

Undertake a clinical assessment of the patient including:

* Review of the PSA blood test results
* Perform a rectal examination where this has been requested as part of the transfer of care arrangement.
* Enquire about bone pains and changes in urinary symptoms
* Review care plan
* Make a decision whether a specialist opinion is required based upon the triggers outlined by the secondary care consultant in the transfer of care arrangement with the: involvement of the patient and refer the patient under the 2ww scheme if this is deemed appropriate.
* Record the outcome of the follow up.

**Accreditation**

No additional training required. The practice will implement appropriate recall systems within the practice to ensure safe and consistent monitoring.

**Performance and Payment**

Activity data should be submitted on a monthly basis to the CCG

The practice will be required to submit audit information on request.

Activity should be submitted within 14 days of month end for activity undertaken in month.

Activity for March 2018 should be submitted within 7 days of month end. DCCG reserve the right to withhold payment on activity not received within these time scales

**Schedules**

**NSSG Guidelines** - Community based follow-up of Prostate Cancer.

Following diagnosis, investigation, staging and treatment of prostate cancer, North Trent NSSG suggest the following men with prostate cancer are appropriate to be followed up in Community Care. Based on a number of years experience with shared care agreements for follow up; and NICE guidelines (Feb 2008) that recommend:

**“After at least 2 years, men with stable PSA and who have had no significant treatment complications should be offered follow up outside hospital (eg primary care).....unless they are taking part in a clinical trial that requires more formal clinic based follow up. Direct access to the urological cancer MDT should be offered and explained.”**

LOCALISED PROSTATE CANCER.

* Radical Radiotherapy. Stable disease at 2 years post treatment, with controlled therapy side effects can be discharged to community care follow up.
* Radical Prostatectomy. Stable disease at 2 years post treatment, with controlled continence and potency.
* Brachytherapy. Leeds guidelines awaited (DJS to chase)
* Active surveillance. Hospital based follow up until active treatment decided upon.
* Patients in a trial will be followed up in hospital care

At discharge to community care, a clinical summary will be given from the discharging consultant with local contact details. It is expected that 6 monthly review will be undertaken in the community with symptom and serum PSA review (a DRE is not required). A rising PSA from previous nadir, deteriorating urological symptoms or local/systemic symptoms suggestive of recurrent disease would generate an URGENT NEW PATIENT referral back to the local Urology MDT team.

LOCALLY ADVANCED PROSTATE CANCER.

1. Radical Radiotherapy. Stable disease at 3 years post treatment (+/- adjuvant ADT) maybe discharged to community care at the discretion of the oncologist
2. Radical Prostatectomy. Stable disease at 2 years post surgery maybe discharged to community care at the discretion of urological surgeon.
3. Watchful Waiting. Where a joint decision to start ADT at a later time with symptoms or rising PSA; it is appropriate for community care to follow up men with 6/12 PSA and refer back to Hospital care when PSA reaches 40, or local urinary symptoms or signs of metastatic disease become apparent.
4. Androgen deprivation therapy. Stable disease for more than five years with a PSA that has responded to ADT.

At discharge to community care, a clinical summary will be given from the discharging consultant with local contact details. It is expected that 6 monthly review will be undertaken in the community with symptom and serum PSA review (a DRE is not required). A rising PSA from previous nadir, deteriorating urological symptoms or local/systemic symptoms (including obstructive renal failure) suggestive of progressive disease would generate an URGENT NEW PATIENT referral back to the local Urology MDT team (not 2ww).

METASTATIC PROSTATE CANCER.

1. Androgen Deprivation therapy. (Bilat orchidectomy, LHRH analogues or antagonists, Anti-androgen) Men who have an initially elevated PSA, stable disease with a documented PSA fall towards a nadir, and minimal side effects are safe to be followed up in community care.
2. Trials. All men in a trial will be followed up in hospital setting
3. Men with metastatic disease that do not show a response to ADT; with no PSA response are not appropriate to discharge to community care.

At discharge to community care, a clinical summary will be given from the discharging consultant with local contact details. It is expected that 6 monthly review will be undertaken in the community with symptom and serum PSA review (a DRE is not required). A rising PSA from previous nadir, deteriorating urological symptoms or local/systemic symptoms suggestive of recurrent disease would generate an URGENT NEW PATIENT referral back to the local Urology MDT team.

Chesterfield Urology dept with GP/CCG involvement have developed a pilot for community care follow up. NT NSSG document our thanks to Nicola James and local GPs who have led this initiative. Their practice is documented in appendix 2 and local units following discussion with CCG/GP groups should base their practice on this pilot.

This document should now be discussed locally with Urology departments, their local CCG/GP groups to finalise arrangement to allow the follow up of men with prostate cancer in the community.

A revision of these guidelines will occur when the NICE guidelines on Prostate Cancer are released.

##### Community PSA Monitoring Transfer Form

##### Patient Details (or sticker)

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Surname |   |   |  Date of birth |   |
|   |   |   |   |   |
| Forename |   |   |  Sex |  M 🞏 |
|   |   |   |   |  F 🞏 |
| Address |   |   |
|   |  |  |  |  |
|   |   |   |  |  |
|   |   |   |  |  |
| NHS Number |   |   |   |   |
|   |   |   |   |   |

##### Patient Category: Please tick one of the following:

Unconfirmed diagnosis – no biopsy 🞏

Unconfirmed diagnosis – negative biopsy 🞏

Confirmed localised prostate adenocarcinoma – “watchful waiting” 🞏

Treated metastatic prostate adenocarcinoma – monitoring for relapse 🞏

CURRENT PSA LEVEL : WITH DATE agreed

##### Monitoring advised:

*Please tick all the appropriate boxes below and complete the subsequent guidance:*

#### Please arrange a PSA test every …………… months for 1 year.

#### If stable, please continue to monitor the PSA every …………. months after 1 yr .

#### Please refer back to clinic if PSA rises above ………… ng/ml.[[1]](#footnote-1)

#### Please refer back to clinic if PSA increases by more than …………% within a 12 month period.[[2]](#footnote-2)

#### Please refer back to clinic if there are 2 consecutive rises in PSA.

🞏 Please perform a rectal examination every …………..months.

At each review, please enquire about any new bone pains or urinary symptoms.

# In the event of any new patient concerns, queries regarding monitoring, or worries about treatment please contact \*\*\*\*\*\*\*\*\*\*\*\*\*\* on \*\*\*\*\*\*\*\*\*\*\*\* for advice.

**Signed:**

*(consultant responsible)*

Print name …………………………………………. Date ………………..

1. 20ng/ml suggested [↑](#footnote-ref-1)
2. 20% suggested [↑](#footnote-ref-2)