Greater Manchester
Cancer Alliance

Personalised Stratified Follow up for Prostate Cancer

Document Control

Written by	**Developed by a subgroup of the Greater Manchester Urology Pathway Board and take into account NICE clinical guidelines: Prostate cancer: diagnosis and management [NG131].[i] In 2002** **Revised after GM Wide review 2023**
Signed off by	**GM Cancer Urology Pathway Board**
Date of review	**April 2024**
Version Number	**1.1**
Date for next review	**April 2025**

Version number	Date	Revision Author	Status	Revision Made
0.1	2022		Original version	
1.1	October 2023	GM Trusts	Draft	Discussions after meetings held with all Trusts
1.1	November 2023	A Webber	Draft	Uploaded onto protocol template
1.2	April 2024	A Webber	Final	Added reference to accountabilities for PSFU document

1. Purpose

This document provides local guidance for Personalised Stratified Follow Up (PSFU) within the GM Prostate cancer pathway. It is for the management of patients who have had radical treatment (radiotherapy or surgery) for localised or locally advanced prostate cancer.

It applies to all Greater Manchester local units and specialist centres involved in the treatment of patients with a prostate cancer. This model of care is aligned with the NHS Long Term Plan for Cancer, British Association or Urological Surgeons (BAUS) guidelines, NHSE Personalised Care for Cancer Initiative. Phase 3 COVID Recovery Planning, the GM Cancer Plan and NHS 22/23 and 23/24 priorities and operational planning guidance.

This protocol does not override the individual responsibility of healthcare professionals in making decisions appropriate to the circumstances of the individual patient.

2. Introduction

The overall aim of PSFU is to improve patient experience and outcomes with tailored aftercare and supported self-management. It is intended to meet the wider needs of a cancer survivor than is possible by routine clinic follow up alone. It reduces the frequency of hospital-based outpatient appointments but must be supported with rapid access to clinical review if symptoms of recurrence are reported.

Prostate cancer is the most common cancer in men in the UK. The majority (84%) of men diagnosed with prostate cancer live beyond 10 years. The incidence and prevalence of prostate cancer continues to increase.[ii]

This improvement in survival means that cancer services must adapt to managing prostate cancer as a long-term condition. Indeed, it is estimated that 70-80% of people living with long-term conditions can learn to be active participants in their own care with the right support. There is a growing body of literature supporting the effectiveness of self-management interventions for cancer survivors. Reviews of interventions, specifically for men with prostate cancer have shown evidence of a consistent, positive effect on distress, and sexual and urinary functioning.iii Extensive work in this area has been undertaken by the National Cancer Survivorship Initiative, which in 2013 published: “Innovation to Implementation: Stratified pathways of care for people living with or beyond cancer - A “how to guide””.[iv]

The NHS Long Term Plan states that the traditional model of outpatient follow up is outdated and unsustainable and aims to redesign services so that patients avoid unnecessary face-to-face outpatient visits; putting them in charge of their own survivorship with all the necessary assurances in place regarding re-entry to specialist care when absolutely necessary.[v]

It is incumbent on all teams looking after men who have undergone radical treatment for prostate cancer to find a way to commission and facilitate a safe remote follow up strategy with the necessary governance and support structures in place to assure patients are appropriately safety-netted at all times and have access back into specialist uro-oncology services in a timely manner. This is in line with NICE guidance[i] and the commitment made by NHS England to implement Stratified Follow-Up pathways for prostate cancer by 2021.[vi]

3. PSFU Process

PSFU describes the delivery of personalised ongoing care to cancer patients that supports them towards self-management based on individual risk stratification, needs and preferences rather than the traditional clinic based follow up.

To care self-care effectively, patients must have good knowledge, skills and confidence about their condition.

All newly diagnosed prostate cancer patients should receive information about their diagnosis, treatment options and subsequent follow-up pathway at the end of treatment, including PSFU. This will include a description of the re-entry process, the support, and tools available to enable self-management and explanation of the ongoing surveillance and screening that will occur during follow up period up to 5 years.

All patients will be transferred onto the jointly agreed follow-up pathway at the end of treatment following discussion between the clinician and patient.

To ensure patients are fully informed about their PSFU decision, they should be given specific written information about PSFU for prostate cancer. All patients should be given time to decide if they need to reflect on the information and reassured that they can convert to traditional clinic follow up at any time if they so wish.

4. Eligibility Criteria

Suitability is determined by the patient, the treating team and at MDT and should be assessed using the following criteria.

- Patients with non-secreting tumours or rare tumours (such as small cell) are not suitable for remote surveillance.

Patient must:

- Have completed primary treatment for prostate cancer and be clinically well
- Not be on active or maintenance treatment.
- Have no diagnosed recurrent disease.
- Have no significant treatment related side- effects.
- Not be on a clinical trial.

- Have the capacity to consent to PSFU.
- Have no physical, cognitive or emotional issues affecting their ability to self-manage.
- Have the ability to communicate their concerns. (Are they able to identify any signs or symptoms that would need further investigations, as detailed on his post treatment summary, and contact the clinical team?)
- Be willing and able to access healthcare. (Can this patient arrange to have his PSA checked in response to reminder letters?)
-

- Not be deemed inappropriate by the MDT because of oncological concerns or non-engagement.

Trusts will also complete an Equalities Impact Assessment for PSFU which will include specific cohorts of patients with protected characteristics that should be included with reasonable adjustments made or excluded. The EIA should be read alongside this protocol.

5. Groups and schedules

	Post Radical Radiotherapy (including men who have had salvage radiotherapy following a radical prostatectomy)	**Post Radical Prostatectomy**
Treatment summary	Sent within 4 weeks of last fraction of radiotherapy	Sent within 4 weeks of discharge from hospital
Post treatment review	----------	6-8 weeks post-op. Wound review, PSA check and final histology result discussion
CNS appointment	At 6 months post radiotherapy at the treating Trust	At 3 months post radical prostatectomy at the treating Trust
If not deemed suitable for PSFU at first CNS appointment another appointment to be offered at:	12 months post radiotherapy (or earlier if specific circumstances dictate) at the treating Trust	At 6 months post radical prostatectomy (or earlier if specific circumstances dictate) at the treating Trust
Location of PSA checks whilst on PSFU	Any Christie outreach phlebotomy clinics	Local phlebotomy centre

5.1 CNS appointment

- To take place face to face, by telephone or by video-conferencing depending on patient preference
- Completion of a Holistic Needs Assessment
- Completion of a personalised care and support plan completed which includes health and wellbeing signposting
- Review of end of treatment summary (treatment summary templates on GM Alliance website). Ensuring the patient understands the symptoms of side effects of treatments and what the alert symptoms of reoccurrence are.
- Clarification of the duration of androgen depravation therapy (ADT) where applicable

- Discussion on toxicity, including pelvic effects, ADT effects and functional assessment as appropriate
- Opportunity for the patient to ask questions
- Latest PSA result assessed to ensure it is adequately suppressed
- Discussion about personalised stratified follow up and written information provided

If the patient is not felt to be suitable for remote surveillance at this stage then a further appointment with a urology CNS will be made. If at that point the patient is deemed suitable, the patient will move onto the remote follow up pathway.

5.2 Responsibility for patient whilst on PSFU

The document 'Defining Accountabilities for Personalised Care Interventions: End of Treatment Summaries & Personalised Stratified Follow-Up in Prostate' lays out which Trust is responsible for PSFU patients and was ratified by Pathway Board in March 2024.

5.3 Remote Surveillance Schedule

Patients will be sent a reminder letter asking them to get a PSA check at the appropriate time points.

		Time (months)								
		0	**3**	**6**	**12**	**18**	**24**	**36**	**48**	**60**
Post Radical Radiotherapy	Assumes PSA remains adequately supressed, ≤4.0 µg/L	Completion of treatment	----------	CNS appt and PSA check	PSA	PSA	PSA	PSA	PSA	PSA
Post Radical Prostatectomy	Assumes PSA remains undetectable	Completion of treatment	CNS appt and PSA check	PSA	PSA	PSA	PSA	PSA	PSA	PSA

5.4 PSA outside of assumed level

Radical radiotherapy - If the PSA is >4.0µg/L then urology CNS team will liaise with the responsible Clinical Oncology Consultant and contact the patient with a plan.

Radical Prostatectomy - If the PSA is ≥0.025µg/L then a member of the urology CNS team will liaise with the patient to request a repeat test in 3 months. If the repeat test remains elevated, then the urology CNS team will liaise with the operating surgeon and contact the patient with a plan.

If at any point the patient contacts the team with any signs/symptoms that could be related to disease progression or recurrence, the case should be discussed with one of the urology CNS team and escalated to the responsible Clinical Oncology Consultant if required.

Patients may be removed from a stratified pathway at any point during follow up. This decision will be taken by the clinical team and/or MDT and the patient.

6. Re-accessing the Urology specialist team as required

- All patients and their GPs will be aware of how to access the Urology Specialist Team if concerns arise within the surveillance period. These concerns may be signs or symptoms related to disease progression or symptoms related to toxicity of the treatment. Safe robust and sustainable open access systems will be in place to facilitate this.
- Patients and their GPs will have contact numbers and guidance about when and how to access further support. Access will be via the Urology Specialist Team through an open access system.
- To deliver a robust rapid re-entry pathway, it is essential to ensure there is appointment capacity with the existing urology and oncology clinics.
- Access for treatment side effects is detailed in Section 8

7. After Five Years Follow Up

After five years being followed up by the hospital team it is envisaged that the vast majority of men will no longer require secondary care follow up and will feel empowered to continue follow up in primary care. Many men may have PSA rises that do not significantly impact their overall clinical condition or life expectancy.

- Men should continue to have an annual PSA check for as long as they are well enough to attend for blood tests and their fitness levels are such that they would benefit from further intervention if required.
- If there is a PSA rise (radical radiotherapy patients) or PSA becomes detectable (surgical patients) then the PSA should be repeated again in 6 months rather than waiting for a further 12 months.

Urgent contact of the local urology team

The local urology team should be contacted on an urgent basis in the following instances.

- If there is a second PSA rise. It is recognised that not all men will require specialist urological input at this stage but an opinion should be sought to help guide further management. (The surgical team should be contacted for radical prostatectomy patients)
- If the patient complains of any signs/symptoms that could be related to disease progression or recurrence,
- If the patient complains of any signs/symptoms that could be related to toxicity from treatment.

8. Issues arising post radiotherapy or surgery

Issue	Post Radical Radiotherapy	Post Surgery
Erectile Dysfunction	Local ED services	Local ED services
Intractable urinary incontinence	Christie Team/Pelvic Floor Physio/Local urology team	Operating surgeon /Pelvic Floor Physio
Urethral Stricture	Christie team/Local urology team	Operating surgeon
Psychological Distress	Christie Psycho-oncology Service	Local psychology service
Haematuria or other lower urinary tract symptoms	Local urology team	Local urology team
Troublesome haematuria despite local review	Local urology team	Local urology team
Rectal bleeding	Local GI team	_____
Troublesome rectal bleeding despite local review	Dr Caroline Henson GI Consultant MFT or local colorectal team	_____

9. Responsibilities and Governance

Role	Responsible person
Responsibility for the installation and security of the digital system, and ensuring its suitability,	Caldicott Guardian, Cancer Lead Clinician and Cancer Lead Nurse of the Provider
Identifying patients suitable for remote follow up and referring to support Worker for registration (must be documented in notes)	Urology CNS
Sending reminders to patients who have missed surveillance investigations or are overdue	Cancer Care Coordinator
Reviewing surveillance investigation results and taking appropriate action	Cancer Care Coordinator + Clinical Nurse Specialist via “virtual clinic”
Reviewing incoming messages and questions/concerns from patients	Cancer Care Coordinator and Clinical Nurse Specialist
Ensuring patient and GP are informed of results of investigations	Cancer Care Coordinator
Monitoring compliance with protocols and reviewing deviations from the pathway	Lead Clinician

[i] https://www.nice.org.uk/guidance/ng131

[ii] https://www.cancerresearchuk.org/health-professional/cancer-statistics/statistics-by-cancer-type/prostate-cancer

[iii] https://pubmed.ncbi.nlm.nih.gov/20119934/

[iv] https://www.england.nhs.uk/wp-content/uploads/2016/04/stratified-pathways-update.pdf

[v] https://www.longtermplan.nhs.uk/wp-content/uploads/2019/08/nhs-long-term-plan-version-1.2.pdf

[vi] https://www.england.nhs.uk/wp-content/uploads/2018/12/nhs-operational-planning-and-contracting-guidance.pdf