South Yorkshire, Bassetlaw and North Derbyshire

Living With And Beyond Cancer Programme

Prostate Cancer Risk Stratification Guidelines
# Document Information

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# Document History

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<th>Version</th>
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<tr>
<td>1</td>
<td>2017</td>
<td>1&lt;sup&gt;st&lt;/sup&gt; draft</td>
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These guidelines should be seen as a living document to be updated and refined as necessary, and at least annually.
1.0 Introduction

Risk stratified follow-up pathways improve aftercare services for people living with or beyond cancer by matching the level of support on offer, to individual patients’ holistic and clinical needs, whilst also addressing the likelihood of treatment related side effects and the risks of recurrence.

Three tumour specific groups were set up to engage with multidisciplinary team (MDT) leads, cancer nurse specialists (CNSs), and representatives from radiology and pathology, commissioners and primary care, meeting every quarter. The groups have advised on the refreshing and implementation of stratified follow up guidance for breast, colorectal and prostate cancer patients across the Cancer Alliance to reduce variation in cancer care.

Refreshed stratified follow-up guidance for prostate cancer were agreed in June 2018 and support put in place to implement this guidance across the Alliance. Two CCGs are now introducing stratified follow-up for prostate patients in primary care for the first time, for certain groups of men affected by prostate cancer. Some CCGs and Trusts are currently reviewing how the guidance is applied. While the guidance doesn’t suggest that all men on watchful waiting are suitable for a remote monitoring pathway, this is something that some trusts are currently investigating.

Stratified follow-up pathway guidance is linked to a crucial understanding of a patient’s needs along with the clinical likelihood of suitability for self-management follow-up. Follow-up care and support is individualised. The majority of patients receive health and wellbeing information as part of their HNA and care planning process. Some men also access health and wellbeing information through support groups.

This document has been drafted based on:
- Four clinical delivery group meetings during 2017/2018, involving clinicians from secondary and primary care, managers and commissioners from across the programme footprint.
- Further conversations outside the meetings with clinicians, managers and commissioners.
- Local experience of risk stratification in prostate cancer to date.
- Research into models and approaches to risk stratification in prostate cancer both regionally and nationally.
- Regional and national policy and guidance on prostate cancer and risk stratification.
2.0 Background and current Risk Stratification of Prostate Cancer

The Living with a beyond cancer programme has been working with commissioners, providers and local stakeholders in a programme approach across the cancer alliance since April 2016. The aim of the programme is to implement the nationally specified “Recovery package” and “Risk Stratified Pathways”.

The aims of this programme are to
• Tailor post treatment care to individual patients according to their needs and risk of developing further problems.
• Support and empower patients to manage their own follow-up where appropriate.
• Ensure follow-up pathways are efficient and value for money, without compromising patient care.

In 2016, the Yorkshire and Humber Clinical Network convened a series of meetings for steering groups to develop High Value Pathways (HVP) for the management of prostate cancer across Yorkshire. Based on the best available evidence, they recommended:
• At diagnosis, men with Prostate cancer should, if clinically appropriate, be assigned to the relevant risk stratified follow up pathway.
• Commissioners and providers should review existing resource commitment and adapt and implement risk stratified follow up for stable prostate cancer.

Other relevant policy and guidance supporting risk stratification includes:
• Living With or Beyond Cancer a ‘how to guide’.
• Implementing the cancer taskforce recommendations: commissioning person centred care for people affected by cancer (2016).

Why stratify?
• Many outpatients follow up appointments offer little value to the patient. Large proportions are scheduled simply to convey a test result.
• Demand is increasing by at least three per cent per year due to increased incidence and improved survival rates. Additional resources are not available to meet this increasing demand.
• Effective risk stratification releases capacity, which in turn can be used to deliver:
  o timely initial diagnosis and treatment.
  o and supporting those with metastatic and complex disease.
• Needs change as patients move along the pathway demanding a more tailored approach to care in place of the current ‘one size fits all’ approach.
• The personal cost of follow-up can be significant for patients particularly those with other conditions and illnesses who need to attend other departments. Where the patient cost of care can be reduced it should be.
• Technology is offering many new alternatives to face-to-face follow up.
• Existing clinics are often overbooked and ensuring access times for new patients and urgent follow ups can be challenging.
3.0 Current Risk Stratified Pathways for Prostate Cancer

Locally commissioned arrangements are already in place in some of our localities:

<table>
<thead>
<tr>
<th>CCG Locality</th>
<th>Prostate</th>
<th>Comment</th>
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<tbody>
<tr>
<td>Bassetlaw</td>
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<td>Barnsley</td>
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<td>Doncaster</td>
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<td>Primary Care – limited activity at this stage</td>
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<td>Hardwick</td>
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<tr>
<td>Sheffield</td>
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<td>Primary Care – some Hormone drugs</td>
</tr>
<tr>
<td>Wakefield</td>
<td>X</td>
<td>Primary Care – significant activity +/- 2000 pa</td>
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Arrangements for hormone injection therapy to take place in primary care existed across all eight CCGs. A degree of risk stratified follow-up for prostate cancer patients had also been implemented across six of these CCGs, but variation existed in the rates of men followed-up in primary care.

There is a variable system of follow-up in place currently which broadly includes:
- Face to face contact (Acute and or Primary care)
- Other contact eg: telephone
- Surveillance investigations
- Holistic needs assessment (ad hoc), with onward signposting and referral
- Health & wellbeing events/groups

In 2014 Wakefield (364,000 population) implemented seven pathways to support the Risk stratification of men affected by Prostate cancer. Wakefield already had Anti-Androgen Injection pathway in place since 2009. From evaluation (below) 1935 primary care follow ups were provided in 2015/16, with the majority (85%) being injection therapy. Patient experience is very positive with most patients rating their care as excellent or good.

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<th>Pathway</th>
<th>FU</th>
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<th>Housebound</th>
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<tr>
<td>Injection Therapy</td>
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<td>150</td>
<td>131</td>
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<tr>
<td>Oral Hormone Therapy Radiotherapy - Intermediate/Locally Advanced</td>
<td>14</td>
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<td>Persistently Raised PSA</td>
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<tr>
<td>Radical Prostatectomy</td>
<td>38</td>
<td>15</td>
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<tr>
<td>Radiotherapy - Post External Beam</td>
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<td>Radiotherapy - Primary</td>
<td>5</td>
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<td>Watchful Waiting</td>
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<td>17</td>
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<tr>
<td>Total</td>
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<td>208</td>
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<tr>
<td>Grand Total</td>
<td>1,935</td>
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4.0 Who is suitable for Risk Stratification

Shared principles in the delivery of follow up care

No matter who or how follow up care is provided there are shared principles we would expect. Tailoring follow-up to individuals will require more than one approach to the delivery of follow-up pathways in the future. Some patients will have less direct secondary care contact, whilst retaining the same level of care and support. Effective risk stratification will be dependent upon the presence of other key components of the pathway. These include:

- a system to ensure on-going surveillance tests happen at the right time
- effective holistic needs assessments that identify and address any outstanding needs and ensure the patient has the knowledge and confidence to self-manage; *person centred conversation with a meaningful shared care plan*
- good communication between specialist and primary care teams; and
- a system that allows timely re-access to the specialist team if needed
- **pathway choice is a joint decision between the individual and the clinician**
- expectations need to be clear at the start – patients and clinicians should be clear on how long they may be followed up in a particular setting, this may be earlier, but it will be based on their needs.
- follow-up after treatment for prostate cancer comprises two key elements
  - Clinical care / Psychosocial support
  - Surveillance tests to look for recurrence of disease
- These two elements are not necessarily interdependent. Some patients may not be appropriate for surveillance monitoring, but may require ongoing review for clinical or psychosocial concerns. Conversely, many patients in an active surveillance programme will not require regular clinical review.

Patients suitable for risk stratified follow up including surveillance for recurrence

- Following treatment, patients should be assessed for suitability to participate in post treatment surveillance programmes based on clinical factors and patient choice.
- Post treatment surveillance does not require regular clinical contact with patients and can be delivered remotely or via primary care, as long as a robust system is in place to ensure that tests are being correctly requested and reviewed.
- The risk of developing recurrence varies with known risk factors and a stratified approach to surveillance tests is appropriate.

There are five groups of men who are suitable for risk stratified follow up:

1. Adjuvant Anti Androgen Injection
2. Long Term Anti Androgen Treatment
3. Radical Prostatectomy
4. Radiotherapy
5. Watchful wait
1. **Adjuvant Anti Androgen Injection** - Anti Androgen Hormone Injections are prescribed by Secondary Care Clinicians and can be delivered to the patient in Primary Care. In some cases these patients remain under secondary care as receiving other treatments. The duration of hormones and the frequency of GP review including PSA as specified in management plan. Considered from 3 months post treatment. Where men remain under secondary care they may be suitable for remote PSA monitoring. **Red flags** - A rising PSA as specified in individual management plan, Significant or deteriorating IPSS, Haematuria or recurring UTI, GP Concern, Cardiac Event

2. **Long Term Anti Androgen Treatment** – (As above) The treatment is for men who have been diagnosed with prostate cancer and the progression is stable. The duration of hormones, the frequency of GP review including PSA is specified in management plan. Considered from 3 months post treatment. **Red flags** – Advice: PSA doubling time of less than 6 months, Significant or deteriorating IPSS, GP Concern, Acute admission: Urinary retention, Bone pain and concern of spinal cord compression, 2 week wait: Haematuria or recurring UTI

3. **Radical Prostatectomy** - Radical prostatectomy is used in men with localised or locally advanced prostate cancer. Men should generally have a 10 year life expectancy. Shared care with Primary care would be for men who have a stable PSA<0.05ng/ml. They would have no ongoing post-operative problems requiring secondary care input. Consultant review at 3 and 6 months, if stable, Nurse Led follow-up for 18 months. The secondary care team may also choose remote PSA surveillance from 6 weeks. From 2 years GP can provide 6 monthly reviews up to 5 years following date of treatment, including PSA testing and then annual GP reviews ongoing including PSA testing. **Red flags**: Advice: PSA 2 consecutive rises and PSA >0.1ng/ml, LUTS, Increase in urinary incontinence, GP Concern, Acute admission: Urinary retention, Bone pain and concern of spinal cord compression

4. **Radiotherapy** -
   a. **Intermediate/Locally Advanced** - External beam radiotherapy along with adjuvant androgen deprivation therapy is used in the management of intermediate and locally advanced non metastatic prostate cancer. It influences both local control and has a small survival benefit in patients of appropriate performance status and life expectancy from co morbidities. Management of PSA rise is expectant, with re introduction of androgen deprivation therapy as the mainstay of treatment. These patients are not usually suitable for other prostate directed therapies. Acute hospital review for 3 years in total, who may choose remote PSA surveillance from 6 weeks. From year 4 or 5 GP can provide annual reviews up to 10 years following date of treatment, including PSA testing. **Red flags**: Advice: 6 month doubling time of PSA, GP Concern, PSA > 10, Acute admission: Urinary retention, Bone pain and concern of spinal cord compression

   b. **Post Salvage External Beam Radiotherapy** – Out with the current Radicals trial, patients undergo salvage radiotherapy plus or minus androgen deprivation therapy for post operative PSA rise. The purpose of follow up is to detect toxicities and longer term PSA rise which may warrant systemic therapy. Acute hospital review for 5 years in total. The acute trust may also choose remote PSA surveillance from 6 weeks. From year 5 GP can provide 6 monthly reviews up to 15 years following date of treatment, including PSA testing and then annual GP review from year 15.
Red flags: Advice: PSA >0.4, GP Concern, Acute admission: Urinary retention, Bone pain and concern of spinal cord compression

c. Primary Radiotherapy of Brachytherapy or External Beam Radiotherapy - External beam radiotherapy or brachytherapy is used in men with early stage prostate cancer. Men should generally have a 10 year life expectancy. Shared care would be for men who have a stable PSA <2ng/ml. They would have no ongoing post radiotherapy problems requiring secondary care input. These patients may be suitable for salvage prostate directed therapies preferably within clinical trials.
Acute hospital review for 2,3 or 5 years depending on risk. The acute trust may also choose remote PSA surveillance from 6 weeks.
‘Low risk’ patients can be discharged back to GP at years 2 or 3; if the locality has an arrangement in place with Primary care. The onus has been on CCG/localities to communicate with Oncologists when this is set up. GP can provide 6 monthly reviews up to 5 years following date of treatment, including PSA testing and then annual GP reviews ongoing Including PSA testing.
‘High risk’ are discharged at year 5 for annual PSA.
Red Flags: Advice: 3 consecutive rises in PSA, PSA >2, GP Concern, Acute admission: Urinary retention, Bone pain and concern of spinal cord compression

5. Watchful Waiting - Watchful waiting involves the conscious decision to avoid treatment unless symptoms of progressive disease develop. Often for older men or those with significant co-morbidities and thought unlikely to have significant cancer progression.
Patient can be transferred to shared care with Primary Care with an individual management plan or the acute trust may also choose remote PSA surveillance.
Patient will require blood tests at 6 months whether followed up remotely or via Primary care.
Red Flags: Advice: PSA of 50 or doubling of 6 months or less, Significant or deteriorating IPSS, GP Concern, Acute admission: Urinary retention, Bone pain and concern of spinal cord compression, 2 week wait: Haematuria or recurring UTI

Supporting the whole person - the Recovery package

- All patients should be reviewed face to face post-surgery/completion of treatment to determine a follow-up/care plan
- A Holistic needs assessment should be performed around the time of diagnosis and following treatment to detect concerns that may require addressing. Where patients do raise concerns a care plan will be developed and appropriate signposting/referral will be made.
- Patients without any on-going clinical or psycho-social concerns do not require regular clinical contact with the secondary care team as long as a robust system is in place to identify problems and allow patient to access back to the secondary care team as needed.
- All patients should have a Treatment summary and an individual management plan if care is to be shared with primary care.
Management of Late Effects (LE)

Over the past two decades, increasing attention has been given to understanding the long-term and late effects experienced by cancer survivors as a result of their cancer diagnosis or treatment. Long-term (side) effects caused by cancer or its treatment that are present during treatment and may persist for months or years may be physical or psychosocial in nature.

In contrast, late effects of the cancer or cancer therapy may occur months or even years after a cancer diagnosis and again may include second cancers, physical problems, or psychosocial issues. Along the cancer continuum, there are at least three distinct phases: from diagnosis to the end of initial treatment, the transition from treatment to extended survival, and long-term survival. While clinical practice guidelines exist for diagnosis and treatment, there are few evidence-based clinical care guidelines for posttreatment care.

The ever increasing number of cancer survivors living posttreatment poses a challenge to oncology and primary care clinicians to provide ongoing optimal clinical follow-up care. To meet this demand, it is important to equip primary care clinicians with the necessary resources to recognize and manage the health risks and maximize quality of life (QoL) of cancer survivors.


How late effects care can be integrated into the risk stratified pathway

The purpose of follow-up for some clinicians can focus on clinical care, psychosocial support and surveillance tests to check for recurrence of disease. It is therefore imperative that late effects screening and management is specifically detailed.

The risks of late effects increase with disease and treatment intensity so it is linked to risk stratification. The risk stratified model recommends an MDT approach to complex cases. This includes management of late effects.

In relation to late effects when implementing this risk stratification guidance patients should be categorised into 3 groups:

**Low risk (disease)**

Low risk patients who are deemed fit for self-management – common late effects associated with treatment should be communicated a) with the patient at diagnosis b) on the treatment summary along with the necessary screening required and the frequency of screening for GPs to do C) as part of a scheduled meaningful conversation at the end of or approaching the end of definitive treatment.

**Medium Risk**

For patients who are medium risk and are on nurse led follow-up – the same common late effects (and specific where necessary, clinically appropriate) associated with treatment a) with the patient at diagnosis b) on the treatment summary along with the necessary screening required and the frequency of screening for nurses to do C) as part of a scheduled meaningful conversation at the end of or approaching the end of definitive treatment.
**High / complex risk**

For complex cases who will stay under the care of a MDT - the same common late effects associated with treatment plus specific late effects according to treatment a) with the patient at diagnosis b) on the treatment summary along with the necessary screening required and the frequency of screening for physician/surgeon to lead on/facilitate C) as part of a scheduled meaningful conversation at the end of or approaching the end of each treatment line.

**Core commonality in current practice across the LWBC programme (August 2018)**

- The treatment summary and in particular end of treatment summary includes information around the consequences of treatment / late effects.
- All patients have dialogue with the clinical teams about possible early and late side effects prior to treatment in the decision making process. Including the possibility of radiation induced malignancy in appropriate patients.
- All high risk patients are referred to the STHFT LE clinic when necessary.
- Most patient’s post DXT may be under PSA surveillance remotely, rather than nurse led clinics.
- From an oncology perspective for all patients having Radiotherapy (RT) there is the possibility when they are considering treatment options.
- All patients are asked about toxicity treatment during RT (to pick up and manage acute toxicity) and at every follow up appointment to ensure acute toxicity is settling, to pick up late toxicity and manage any toxicity.
- Any possible late effects of RT on bowel, urinary and sexual function (and acute toxicity) are discussed by the oncologists.
- After RT patients are asked about possible late toxicity at every appointment and manage accordingly.
- Some trusts have routine access to DEXA scanning and the metabolic bone teams are really helpful. The aANTELOPE trial is ongoing and looking specifically at the effect of ADT on bone density. This would happen for every patient, regardless of the risk stratification.
- For high grade / locally advanced disease, radiotherapy is still potentially a curative treatment and in that setting discussions around LE are sought.
- For intermediate risk of disease if someone develops a 2nd malignancy the oncologists may suggest surgery (unless major anaesthetic risk) – might not be the case if there are other significant comorbidities.
- Patients are supported with the consequences of treatment via various ways; from information to referral to support resources to address physical symptoms to additional information within the newly designed Treatment Summaries.
• ALL patients are advised to contact cancer teams if they have any concerns.

• The recommendations for the End of treatment (EOT) appointment are being delivered by the CNS at the EOT Holistic Needs Assessment (HNA), which all our patients are offered.

• At the diagnosis/treatment discussion with the Consultant and CNS all potential late effects are discussed by the surgeon and CNS, and documented in the patient pathway booklet, inc bowel function, hernia, sexual dysfunction etc. so the patient is aware of potential consequences of the treatment.

• In nurse-led cancer follow up clinics the HNA tool is to identify consequences of treatment and produce an action plan or deal with the issue there and then. The physical late effects are more often related to the position of the primary rather than the risk of recurrence; psychological obviously depends on the individual but again a low risk patient can struggle as much as high risk. Any on-going consequences of treatment are summarised on the Discharge Summary/Transfer of care document.

• Teams communicate about consequences of treatment from a patient's first diagnosis appointment and this is via a 'meaningful conversation' at every opportunity (this can include pre-assessment appointment/oncology appointment/whilst inpatient/via telephone/stoma + consultant clinics).

• At each surveillance appointment using the HNA or just through conversation we discuss and often identify consequences of treatment. This varies how this is delivered.

• Patients encourage contacting via telephone at any time throughout their pathway if a concern arises.

• Fortunately, most side effects of radical treatment (surgery and RT) are early and predictable, should be addressed before discharge from tertiary care to primary care.

• Patients with advance and symptomatic disease will be under the care of the acute trust teams.

• Bowel, bladder, sexual dysfunction – are recognised early and referred on.

• Bowel side effects of RT, oncologists will normally refer to colorectal team to rule out other path as well as help with management. Bladder toxicity is normally referred to us either from oncologists or GP.

• Endocrine / bone effects of long term hormonal therapy needs to be recognise first. There are treatments but most important is recognition. The teams willing to take over long term hormonal treatment will have to be aware of them and take responsibility for knowing and assessing such symptoms.

• The endocrine / bone and bladder LE can be very non-specific and there are massive cross over with other pathologies/ age related symptoms.

• LEs which are complex and extreme (like fistulae or uncontrolled, intolerable side effects of hormonal therapy) will need to be escalated to MDT discussion after assessment by urologist / oncologist and if standard measures have been attempted. This is to get a consensus on extreme measures (like withdrawal of treatment or palliative surgery etc).
• Patients who are already known to have severe / uncontrolled LEs should remain under treating team and not be discharged before symptoms have been controlled or difficult decisions have been made.

To note – the Holistic Needs Assessment (HNA) is not a tool for identification, assessment or monitoring of late effects.
# Managing complications of treatment

## Urinary symptoms
- Offer men experiencing troublesome urinary symptoms before treatment a urological assessment.
- Ensure men with troublesome urinary symptoms after treatment have access to specialist continence services.
- Refer men with intractable stress incontinence to a specialist surgeon for consideration of an artificial urinary sphincter.
- Do not offer injection of bulking agents into the distal urinary sphincter to treat stress incontinence.

## Bowel symptoms
- Ensure men with signs or symptoms of radiation induced enteropathy (RIE) are offered care from a team of professionals with expertise in RIE.
- Tell men there is a small increase in the risk of colorectal cancer after radical external beam radiotherapy for prostate cancer.
- Carry out full investigations, including flexible sigmoidoscopy, in men who have symptoms of RIE to exclude inflammatory bowel disease or malignancy of the large bowel and to ascertain the nature of the radiation injury.

## Sexual dysfunction
- Ensure men have early and ongoing access to specialist erectile dysfunction services.
- Offer phosphodiesterase type 5 (PDE5) inhibitors to men who experience loss of erectile function.
- If PDE5 inhibitors fail to restore erectile function or are contraindicated, offer a choice of intraurethral inserts, penile injections, penile prosthesis, vacuum devices.

## Endocrine
- **Hot flushes**
  - Offer medroxyprogesterone (20mg daily) initially for 10 weeks. Evaluate the effect at the end of the treatment.
  - Consider cyproterone acetate or megestrol acetate (20mg twice a day for four weeks) if medroxyprogesterone is not effective or not tolerated.
  - Tell men there is no good quality evidence for the use of alternative therapies.
- **Gynecomastia**
  - Offer men starting long term bicalutamide monotherapy (>6 months) prophylactic radiotherapy to both breast buds within the first month of treatment. Choose a single fraction of 8 Gy using orthovoltage or electron beam radiotherapy.
  - Consider tamoxifen if radiotherapy is unsuccessful in preventing gynecomastia.
- **Fatigue**
  - Tell men who are starting androgen deprivation therapy that fatigue is a recognised side effect of this treatment.
  - Offer men who are having androgen deprivation therapy supervised resistance and aerobic exercise at least twice a week for 12 weeks to reduce fatigue.

## Preventing osteoporosis
- For men having androgen deprivation therapy.
  - Consider assessing fracture risk in line with Osteoporosis Frailty Fracture Risk (NICE clinical guideline 146)
  - Do not routinely offer bisphosphonates to prevent osteoporosis.

## Managing osteoporosis
- For men having androgen deprivation therapy.
  - Offer bisphosphonates.
  - Consider denosumab if bisphosphonates are contraindicated or not tolerated.

*The nature and treatment of radiation-induced enteropathy should be included in the training programmes for oncologists and gastroenterologists.*
**Delivering risk stratified follow up**

The programme is working towards the ICS/Cancer Alliance integration level (ii) *Single system level commissioning framework to improve connectivity with contracting and delivery at place (ACP)*. Therefore if the same outcome is achieved, the delivery method does not need to be the same in each local place. It is also clear that when considering the different options for the delivery of risk stratified follow up there will be local place based issues/needs which require consideration.

The need for regular clinical follow-up in secondary care (“face to face” or “phone”) is not dependent on risk of recurrence or site of disease, but whether patients have ongoing issues to address. i.e. decision based on:
- Clinical issues
- Persons individual needs, identified through a Holistic needs assessment
- General fitness
- Functional problems
- Psycho-social issues

Patients and health professionals need to have confidence in ongoing care and surveillance whoever is providing that care. Consequently, a defined period of follow-up after which patients would be discharged if there are no current issues is recommended.

Currently, no trust has a system in place whereby surveillance tests can be requested remotely (i.e. independently from patient follow-up) with the full confidence that no patient will be lost to follow-up. Without such a system, it is likely that patients in surveillance would need ongoing regular face to face contact with secondary care for the first two years on average.

However from the work undertaken to date it is clear that there is the opportunity for a joint model of care provided by both secondary and primary care. Based on the five groups of men suitable for risk stratified follow up we can say in general terms to maximise the benefits of risk stratification for Prostate cancer there is scope in:
- **Secondary care** for remote PSA surveillance combined with clinical led follow up as necessary
- **Primary care** for shared/discharged follow up care including PSA testing and Hormone injections

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<tr>
<td>3 months</td>
<td>6 months</td>
<td>year 1</td>
<td>year 2</td>
<td>year 3</td>
<td>year 4</td>
<td>year 5</td>
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* 2, 3, or 5 years depending on risk
Sample pathways/protocols for both are available;

**Secondary care** remote PSA surveillance from Wessex University Hospital. Many hospitals now use remote monitoring systems based on either additional software in systems like Infoflex or recording a PSA range within the current system. Bloods can be taken in primary care and the PSA result goes directly to the secondary care clinical team. The results are reviewed often by band 4 ‘support worker’ with any deviation from the individual patients’ normal range being highlighted to a clinician for action.

**Primary care** shared care from Wakefield can be found in Appendix 1 - where primary care is currently commissioned the tasks required, the quality standards and monitoring requirements are detailed in a service specification.

**Recommendations & Actions**

1. All clinical teams in acute provider trusts, across the LWABC programme footprint should adopt the guidelines in Section 2 - Who is suitable for risk stratification.

2. For those localities where they already have local arrangement in place, the programme will support local commissioners and providers evaluate their current approach to risk stratification for prostate cancer and explore the opportunities to maximise the benefits of risk stratification based on this guidance.

3. For those localities where they don’t currently have local arrangements in place the programme will support local commissioners and providers to agree the appropriate delivery model for risk stratification for prostate cancer in their locality based on this guidance.

4. Local commissioners should include this guidance in commissioning intentions for 2019/20 contracts (August 2018), which will be commissioned within provider contracts in 2019/20.
Appendix 1 - Primary care shared care specification Wakefield

Wakefield - Prostate Cancer Share Care Fc

NICE prostate Guidelines

NICE prostate cancer full-guideline-1