



Transforming Cancer Services Team for London

September 2015

Local Incentive Schemes (LIS) for prostate cancer follow-up: frequently asked questions for commissioners

What would stratified follow-up in primary care look like?

A primary care stratified follow-up pathway in primary care comprises of a number of elements: monitoring of PSA and symptoms to detect signs of recurrence, detection and management of the consequences of treatment through holistic assessment and care planning, and support to patients to self-manage.

Why would the CCG pay for an incentive scheme for this patient group if secondary care is discharging them anyway?

The Croydon project has been testing a primary led pathway and will be evaluated from October-November 2015. From preliminary data and feedback, the project team believe that a local incentive scheme is necessary to promote provision of a safe, robust, high quality follow-up service for this patient group.

How much does the follow-up of stable patients after radical treatment/ watchful waiting pathways cost?

The cost of secondary care based follow-up appointment has been averaged to £85 per consultation. The Croydon Local Medical Committee provided the following costing of a primary care delivered appointment: £50 for an initial 30 appointment in primary care, £43 for subsequent 20 minute follow-up appointments. If a patient is seen 6 monthly the saving will be £ 33/ patient in the first year and then £ 84 each year. For a population of 500 patients, whose care has been transferred to primary care, this will save £16,500 in year one, then £42,000 per year. It would be anticipated that the transfer of patients would be a gradual managed process, the savings would be realised gradually. Data from the Croydon project demonstrated that 40-45 % of patients with prostate cancer are suitable for primary care follow-up based on NICE criteria (Prostate Cancer CG175, NICE 2014)

What are the benefits for patients?

Patients have expressed their support for their care to be delivered in primary care once they are stable after treatment or on a watchful waiting pathway. Care is provided closer to home by clinicians that know them and are managing their other long term conditions so care is less fragmented. Gaps in the provision of Clinical Nurse Specialists and of holistic needs assessments in secondary care mean that patients are often discharged with unmet supportive needs. The use of standardised information packs, clinical templates and targeted prostate cancer specific holistic needs assessment tools enable men's supportive needs to be met in a primary care setting.

What are the benefits for the health system?

Preliminary feedback and data suggest that a robust pathway into primary care enables the smooth transfer of patients with both secondary and primary care providers fully engaged with facilitating Sandra Dyer, TCST Project nurse lead Sandra.dyer1@nhs.net



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the process. Capacity within secondary care is increased by the transfer of stable patients. The provision of a clear mechanism for advice or transfer back to secondary care in turn makes the patient's cancer journey smoother and safer.

How do we know this pathway is clinically sound and safe for patients?

NICE 2014 advise that patients on watchful waiting and those who are stable two years after treatment are suitable for care outside of the hospital setting. The Croydon project tests the safety and robustness of a primary care delivered pathway. Secondary care clinicians retain clinical responsibility for the risk stratification of patients to ensure that only suitable patients are transferred. The use of a prostate cancer register in each GP practice as a requirement of the LIS helps mitigate against the risk of patients becoming lost to follow-up. In addition the use of IT based solutions for prompting follow-up (for example the adaptation of QOF alerts software) could further safeguard clinical safety.

The use of clinical templates on EMIS, VISION or System One enables standardisation of follow-up and ensures each patient has their medical and holistic needs met. The use of templates would also enable the provision of care in networked or federated models.

The provision of high quality transfer information from secondary care provides important guidance to patients and clinicians about their follow-up care. This enables clinically safe decisions to be made about their PSA results and any symptoms men may develop as consequences of their disease or treatments.

What are the challenges in implementing a primary care delivered model?

Identifying patients who are stable post-treatment or on watchful waiting can be challenging. Secondary care clinicians are able to identify patients as they attend in clinic and then transfer them but this process can be quite slow as some patients are attending only annually. Primary care teams can identify suitable patients with appropriate guidance but this process can be time consuming (approximately 3-4hrs to run the searches and case find on a list size of 10,000) and needs to be resourced as an incentive to carry this out in the first instance. This could be in the form of practical assistance with case finding or a payment made to free up clinician time to carry out the process.

The standardised identification tool and template transfer letter to secondary care helps make this process easier to manage. The maintenance of a prostate cancer disease register will enable practices to identify possible new patients going forward. In addition as secondary care providers develop awareness of and confidence in the primary care pathway they are likely to transfer more patients routinely.

The timing of the launch of a local incentive scheme can affect its success. A launch at the beginning of the financial years is likely to be better received than a launch in quarter four.



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Involving local clinicians and practice managers in the development of tools to support the project ensures there is less resistance to their use. Using locally accepted language to describe the tools can also be an effective way of managing resistance. The use of online surveys and attendance at engagement events can assess the acceptability of processes and tools and the service itself.

We have learnt through the use of surveys that clinicians are not always confident in managing this patient group especially in regards to discussing holistic and supportive needs. Provision of free and easy to access e-learning modules ensures that clinicians have the skills and knowledge needed. We would recommend including the completion of at least one e-module as a mandatory criteria for incentive.

Clinicians are often confused about interpretation of PSA results after treatment. The lab comments on reference ranges for PSA refer to those without prostate cancer and can confuse clinicians. Good quality transfer letters from secondary care will mitigate against this. In addition, a clear mechanism to seek advice from secondary care clinicians is important. Reference ranges on lab results should indicate this does not apply to patients who have had treatment for their prostate cancer. The delivery of the Recovery Package which includes the provision of a Treatment Summary Record and holistic needs conducted at point of diagnosis will enhance the quality of information sent to primary care.

Engagements with all local trusts before the commencement of the incentive scheme means that all suitable patients can be transferred and that their transfer will be as smooth as possible.

What project support is required to implement a prostate cancer LIS?

The tools required to implement the LIS are available from TCST as a package (contact details below). Available resources range from a case finding tool to help practices to identify suitable patients, a welcome package for patients that contains advice on self-management and a directory to local services, clinical templates to conduct holistic follow-ups, multidisciplinary educational resources and a tool kit to equip primary care nurses in taking a leading role in offering the service.

We estimate that CCGs would need to provide project support for 6 months to engage with clinicians, and support the implementation of the package. In addition 2-3 clinical sessions per week of a GP/ Nurse would be required to help the engagement process, adapt model to local clinical governance structures and troubleshoot clinical issues.

Key recommendations:

- CCGs to offer to develop a LIS to support practices in offering an enhanced follow-up service
- Support mandatory use of a prostate cancer register in each practice to mitigate clinical risk
- Consult and engage with secondary care and agree clear mechanisms for advice or transfer back to secondary care



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- Mandatory training for at least one member of the practice clinical team to be included as part of the LIS
- Provide project support and clinical champion for implementation

How can I find out more?

The project team are available to answer any questions until December 2015. Please contact:

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From January 2016, please contact Sarita Yaganti (TCST Strategy Implementation lead) s.yaganti@nhs.net or Liz Price (TCST Senior Strategy Lead) liz.price4@nhs.net