Transforming Cancer Services Team for London

Business Case: Primary Care Led Stratified Follow-up for Prostate Cancer Patients

ALL AREAS HIGHLIGHTED IN YELLOW ARE ISSUES FOR LOCAL DECISION OR NEED TO BE COMPLETED USING LOCAL INFORMATION

Business Case: Primary Care Led Stratified Follow-up for Prostate Cancer Patients

Action requested:

This paper is provided for approval at the [ENTER NAME OF GROUP/BOARD]

Contents

1. Executive summary

In the UK, the numbers of men living with a diagnosis of prostate cancer will continue to increase as the population ages. The traditional follow up model follows a standard regime of hospital outpatient appointments and surveillance tests over several years. The National Institute of Clinical Excellence recommends that patients stable at 2 years after radical treatment and patients who are undergoing "watchful waiting" are offered follow-up outside of hospital in an appropriate setting[1].

Increasing incidence of cancer (currently 3% per year) alongside increased survival rates are putting huge pressure on outpatient resources and impacting on the quality and efficiency of services provided. The ten year survival for prostate cancer is 83.8%[2] and recurrence is usually detected through PSA monitoring which can be conducted in either a secondary or a primary care setting. The challenge of providing effective aftercare for this increasing number of men is a driver to redesign care pathways away from traditional consultant led models of follow up. Both patients and professionals have identified that many appointments are unnecessary, add no value and incur unnecessary costs for patients and the NHS. As 70% of cancer patients have at least one other long term condition[3] there are potential advantages in establishing a primary care led model of care which is fully integrated with the care of other long term conditions.

This paper outlines a proposal to introduce a primary care led stratified self-management pathway for stable low risk prostate cancer patients.

A number of options are considered within this proposal (see Figure 1)

Figure 1: Description of options

	Option	Description
1	Do nothing	Standard follow up regime continues with specialist team (tests and face to face outpatient appointments) for all patients irrespective of risk. Eventual unsupported discharge to primary care resulting in variation in service provision.

[1] *Prostate cancer: Diagnosis and management*. (CG175) NICE, 2014. https://www.nice.org.uk/guidance/cg175/resources/prostate-cancer-diagnosis-and-management-35109753913285

[2] Cancer Research UK Prostate Cancer Survival Statistics. 2011 http://www.cancerresearchuk.org/sites/default/files/cstream-node/surv_1_5_10yr_prostate.pdf

[3] *The burden of cancer and other long-term health conditions*. MacMillan, April 2015 http://www.macmillan.org.uk/documents/press/cancerandotherlong-termconditions.pdf

2	Specialist led follow up for all patients	Specialist led scheduling and monitoring of surveillance tests for all patients with or without the need for face to face review appointments depending on acute trust model. Eventual discharge to primary care when local criteria are met. Variable support after discharge dependent on local arrangements. Where clear criteria are present there should be reduced variation in service provision.
3	Primary care led supported self-management pathway for low risk patients	Patients who are under 'watchful waiting' and those who are stable 2 years after active treatment are transferred to primary care for scheduling and monitoring of surveillance tests and follow up. Patients are entered on a practice disease register and recalled at appropriate intervals for review. Fast-track referral back to specialist for abnormal results. High risk patients followed up in secondary care. Supported discharge to primary care and clear criteria for discharge leading to reduced variation in service provision.

An economic analysis of primary care and secondary care follow-up pathways shows that there could be at least 57% cost saving[4] if stable prostate cancer patients are transferred and followed-up in the community.

Option 3, primary care led supported self-management pathway for low risk patients, is the preferred option as:

- It offers high levels of patient satisfaction
- Care is delivered closer to home
- Reduced specialist input (virtual and face to face); no virtual management of test results
- There is a significant freeing up of out-patient capacity compared with option 1
- Cost per patient is significantly reduced
- There is a high level of patient safety
- Practice based care is integrated with holistic management of other long term conditions; improved uptake and access to rehabilitation
- There is reduced personal cost to patients associated with outpatient appointments
- Options 1 and 2 offer minimal advantage over primary care-led follow up
- Option 1 requires significant new capacity (consultant sessions and outpatient space) with rising demand

The benefits of a primary care led supported self-management pathway are summarised in Figure 2, below:

[4] *Economic analysis of care pathways for prostate cancer follow-up services*. ICF Consulting, February 2016. https://www.myhealth.london.nhs.uk/system/files/Economic%20analysis%20-%20Primary%20care%20led%20prostate%20cancer%20follow%20up%20service%20-%20Croydon%20-%202016.pdf

Figure 2: Benefits of option 3

Group	Benefits
For patients	Follow-up model based on patient choice Reduced personal costs (time, money) associated with outpatient attendances Rapid access to specialist if needed Integration of care with other long term conditions
For primary care	Improved service for patients Integration of care with other long term conditions Providing holistic, integrated care closer to home
For acute providers	Released outpatient capacity Improved access times for new referrals Increased time in clinic for those with complex needs Fewer overbooked clinics
For commissioners	More effective use of local outpatient capacity Improved quality of service for local population Improved communication between specialist and community teams Safer service - fewer patients 'lost to follow up' Monitoring surveillance tests remains under 'specialist watch'

The transfer of patients may be achieved in two ways:

1. Case finding 'bulk' transfer: suitable patients are identified from either hospital or GP records and are transferred 'en masse'. There would need to be an on-going process for identifying suitable new patients once this has been done. This would complete the majority of transfers more quickly but may result in some patients being concerned as they have not had an opportunity to discuss their follow up individually.
2. Gradual transfer: suitable patients are identified at routine outpatient review and the new follow up arrangements are discussed with the patient and a transfer is arranged by letter to the GP with the necessary follow up protocol. This may take longer to implement but may be a more effective method as each patient has the opportunity to discuss.

The method of transfer is a local decision and will depend on the support available for this project. Where bulk transfer is the preferred option a clinical nurse specialist may be able to identify suitable patients from hospital records, or where payment is being made to practices, the identification of suitable patients could be included in the payment.

Primary care led supported self-management pathway may be undertaken by each individual GP practice or in a GP federation it may be undertaken by a smaller number of practices on behalf of all.

The financial impact is as follows:

[INSERT SUMMARY based on CCG/SPG calculations

INSERT: Figure 3 should be the same as Figure 12 in Section 6]

Figure 3: Potential financial savings. Years 1 and 2 would be costs incurred as part of routine pathway prior to stratification / transfer to primary care

Sector	**Year 1 £**	**Year 2 £**	**Year 3 £**	**Year 4 £**	**Year 5 £**	**Total £**
Secondary care led follow up	*170	*96	*96	*96	*96	*288
Primary care led supported self-management pathway	n/a	n/a	*43	*43	*43	*129
Difference (savings)	n/a	n/a	*53	*53	*53	*159

*Costs above are outlines for illustrative purposes

Non-recurrent costs [ENTER SUMMARY AND TOTAL]

The outpatient impact is as follows:

[INSERT SUMMARY based on CCG/SPG calculations

INSERT: Figure 4 should be the same as Figure 13 in Section 6]

Figure 4: Potential number of outpatient appointments released

Sector	**Year 1**	**Year 2**	**Year 3**	**Year 4**	**Year 5**	**Total**
Secondary care led follow up	0	0	0	0	0	0
Primary care led supported self-management pathway [ENTER NUMBER OF APPOINTMENTS PER YEAR – i.e. NEW PATIENTS EACH YEAR PLUS PATIENTS ALREADY TRANSFERRED]	[new patients]	[New plus year 1 total]	[New plus year 2 total]	[New plus year 3 total]	[New plus year 4 total]	[Year 1 to 5 totals]

This proposal has the support of:

- [List the boards/groups that have approved this business case]

  For example: CCG Senior Management Team
  Acute Trust Cancer Board
  CCG Cancer Locality Group
  CCG Governing Board
  SPG Leadership Team
  Service user Group

2. Introduction

In the UK, the numbers of men living with a diagnosis of prostate cancer will continue to increase as the population ages. The challenge of providing effective aftercare for this increasing number of men is a driver to redesign care pathways away from traditional consultant led models of follow up.

The National Institute of Clinical Excellence recommends that patients stable at 2 years after radical treatment and patients who are undergoing "watchful waiting" are offered follow-up outside of hospital in an appropriate setting[5]. This paper outlines a proposal to support stratified pathways into primary care for stable prostate cancer patients. In 2012, the National Cancer Survivorship Initiative developed a stratification process to help identify which care pathway is most suitable for each patient based on the level of care needed for the disease, the treatment received and the patient's ability to self-manage, and therefore what level of professional involvement will be required

Increasing incidence of cancer (currently 3% per year) alongside increased survival rates are putting huge pressure on outpatient resources and impacting on the quality and efficiency of services provided. The ten year survival for prostate cancer is 83.8%[6] and recurrence is usually detected through PSA monitoring which can be conducted in either a secondary or a primary care setting. Both patients and professionals have identified that many appointments are unnecessary, add no value and incur unnecessary costs for patients and the NHS. As 70% of cancer patients have at least one other long term condition[7] there are potential advantages in establishing a primary care led model of care which is fully integrated with the care of other long term conditions.

Figure 5: Number of patients surviving with prostate cancer (data from 2009-2011)

	1yr (total patients)	5yr (total patients)	10yr (total patients)
North East London	549	2276	3465
North Central London	675	2821	4249
South East London	622	2335	3581
South West London	665	3020	4478
North West London	598	2735	4196
Essex (all Essex CCGs)	778	3042	4395

Data source: National Cancer Intelligence Network (NCIN) Cancer Prevalence e-Atlas

[5] *Prostate Cancer: Diagnosis and management* (CG175). NICE, 2014. https://www.nice.org.uk/guidance/cg175/resources/prostate-cancer-diagnosis-and-management-35109753913285

[6] Prostate Cancer Survival Statistics. Cancer Research UK, 2011 http://www.cancerresearchuk.org/sites/default/files/cstream-node/surv_1_5_10yr_prostate.pdf

[7] *The burden of cancer and other long-term health conditions.* MacMillan, April 2015 http://www.macmillan.org.uk/documents/press/cancerandotherlong-termconditions.pdf

As prostate cancer prevalence increases, the conventional and costly method of 'consultant-led' services becomes increasingly unsustainable. The paradigm has shifted to the development of guidelines and protocols to follow-up patients in primary care, bringing care closer to home. Studies within NHS Improvement test sites and elsewhere have found that with appropriate investment in quality initiatives such as needs assessments and care plans, information and education, up to 44% prostate of patients are suitable for a supported self- management pathway.[8,9]

An economic analysis of primary care and secondary care follow-up pathways shows that there could be a 57% cost saving[10] if stable prostate cancer patients are transferred and followed-up in the community. Furthermore, a review of existing primary care-delivered follow-up services showed that patients are in favour of care being delivered by their GP practice[11] providing that they receive relevant information regarding the change in their care, the potential side effects and consequence of treatment and information on accessing support services such as psychological, sexual and social support and incontinence services.

[8] *Stratified cancer pathways: redesigning services for those living with or beyond cancer*. NHS Improving Quality, 2013. http://www.nhsiq.nhs.uk/media/2431915/12_0020_proven_publication_stratified_cancer_pathways_1.6_final.pdf

[9] *Stratified pathways of care: from concept to innovation*. NHS Improvement, 2012. http://www.ncsi.org.uk/wp-content/uploads/Stratified_Pathways_of_Care.pdf

[10] *Economic analysis of care pathways for Prostate Cancer follow-up services*. ICF Consulting, February 2016. https://www.myhealth.london.nhs.uk/system/files/Economic%20analysis%20-%20Primary%20care%20led%20prostate%20cancer%20follow%20up%20service%20-%20Croydon%20-%202016.pdf

[11] *Enhanced primary care-led prostate cancer follow-up: Evaluating the quality, safety and financial validity of the Croydon model*. Transforming Cancer Services Team for London, February 2016 https://www.myhealth.london.nhs.uk/system/files/Evaluation%20-%20Primary%20care%20led%20prostate%20cancer%20follow%20up%20service%20-%20Croydon%20-%202016.pdf

3. Current pathway for low-risk or stable prostate cancer patients

Patients with prostate cancer who are stable after active treatment or those who are on a watchful waiting follow up pathway are currently followed up as described in Figure 6[12].

Figure 6: Description of current pathway

Year from diagnosis	Led by	Follow up
Year 1 to year 3	Specialist	Blood test and medical review at hospital outpatient clinic initially every 3 months rising to every 6 months
Year 4 and after	Specialist	Blood test +/- outpatient medical review every 6-12 months. Follow up may be undertaken remotely by the specialist so that the blood test is arranged at the hospital lab, if the result stable no outpatient appointment is arranged

The proposed new primary care led stratified follow up pathway is described in Figure 7[13] and is illustrated in Appendix 1.

Figure 7: Description of proposed new pathway

Year from diagnosis	Led by	Follow up
Year 1 to year 2	Specialist	Blood test and medical review at hospital outpatient clinic initially every 3 months rising to every 6 months
Year 3	GP	Blood test/medical review at GP practice every 6 months, recall through practice disease register Annual holistic review at GP practice linked to the annual long term conditions review Fast track referral back to specialist if problems
Year 4 and after	GP	Blood test/medical review at GP practice every 6-12 months Annual holistic review at GP practice linked to the annual long term conditions review Fast track referral back to specialist if problems

In both cases, patients should have a personalised care plan following holistic needs assessment that includes rehabilitation services and fast-track referral to the hospital based on raised PSA level or other clinical criteria. Patients should be aware of the factors that may trigger

[12] *Prostate cancer: Diagnosis and management*. (CG175) NICE, 2014. https://www.nice.org.uk/guidance/cg175/resources/prostate-cancer-diagnosis-and-management-35109753913285

[13] *Enhanced primary care-led prostate cancer follow-up: Evaluating the quality, safety and financial validity of the Croydon model*. Transforming Cancer Services Team for London, February 2016 https://www.myhealth.london.nhs.uk/system/files/Evaluation%20-%20Primary%20care%20led%20prostate%20cancer%20follow%20up%20service%20-%20Croydon%20-%202016.pdf

a referral back to the hospital. Issues relating to the patient's physical or mental health or social circumstances (whether linked to their cancer or not) should also be taken into consideration.

4. Options analysis

The options considered in this proposal are summarised in Figure 8.

Figure 8: Options analysis

Option	Description	Benefits	Limitations
1. Do nothing	Standard follow up regime continues (tests and face to face outpatient appointments) for all patients with specialist team irrespective of risk. Eventual unsupported discharge to primary care.	• In some areas, continuing specialist input to care • In some areas, good models of both primary and secondary care stratified pathways	• Significant variation in follow up models across different services. • Patients remain dependant on the specialist team. • Patients may eventually be discharged to primary care with no structured follow up guidance or arrangements in place. • Requires significant new capacity (consultant sessions and outpatient space) with rising demand from increasing incidence and prevalence rates. • Model is not personalised. It does not support rapid detection and management of a) recurrence or b) ongoing/late effects of treatment
2. Specialist-led follow up for all patients	Specialist led scheduling and monitoring of surveillance tests for all patients with or without the need for	• Continuing specialist input to care • Little impact on primary care	• Uncertain capacity for holistic needs assessment after treatment completion and referral to support

Option	Description	Benefits	Limitations
	face to face review appointments depending on trust model. Rapid access to specialist if results show a problem. Eventual discharge (local specialist decision) to primary care with variable support. [e.g. various Trusts across London including University College Hospitals, St Georges University Hospital, Guys and St Thomas NHS Foundation Trust] In some trusts there is an IT system driven virtual clinic for low risk men, which aims to provide remote support, assessment and information to empower men receiving long term prostate cancer follow-up and promote self-management. [e.g. St Georges NHS Trust (remote monitoring service); Hillingdon Hospital]	• Potential to develop clear pathways to hospital led cancer rehabilitation services.	services. • Increased pressure on access times for new and follow-up appointments and reduced time for those with complex needs. • Increasing volume of unnecessary appointments • Trusts may need to invest in robust IT systems to conduct remote surveillance safely • Potential for patients to be lost to follow up • Patient may see a number of different specialists • Lack of comprehensive clear guidance for primary care clinicians • Those patients eventually discharged may not have structured support in primary care • Uptake of this model has been low despite development of a number of resources to support implementation by the Integrated Cancer Systems

Option	Description	Benefits	Limitations
3. Primary care led supported self-management pathway	Low risk patients i.e. those who are under 'watchful waiting' and those who are stable 2 years after active treatment are transferred to primary care with clear guidance for follow up and individualised care plan. Patients are entered on a practice disease register and recalled at appropriate intervals for review. GP practice schedule and monitor surveillance tests and arrange fast-track referral back to specialist if problems are found. High risk patients followed up in secondary care [e.g. Croydon and Sutton CCGs]	• Follow-up is significantly cheaper than secondary care or shared care option • Care will be provided closer to home and be integrated into their primary health care. • Patient's cancer will be managed as a long term condition • Care will be integrated with other physical, mental health and social care needs. • Improved information at the point of transfer into primary care with an emphasis on meeting holistic needs through a range of available resources. • Holistic needs can be picked and patients either signposted or referred to support services • Freeing up of secondary care outpatient appointments so that those with an urgent clinical need can be seen in a timely manner. • Potential to 'up-skill' wider primary care teams such as practice and community nurses.	• Short term investment required for project management support to establish the model locally. • Lack of comprehensive, clear guidance for primary health care professionals. • Requires on-going investment in education for GPs and the primary care nursing workforce as treatment options change • May lack consensus between GPs, patients and specialist teams. • Capacity issues in primary care. • Potential for patients to be lost to follow up

Option	Description	Benefits	Limitations
		• Compliance with NICE guidance (2014) and robust evidence produced following Croydon project evaluation (evaluation supports financial, quality, clinical experience and patient experience case for change). • Tested resources available to support local commissioning and implementation of the Croydon model.	

Analysis of these options shows that **Option 3**, primary care led supported self-management pathway, is the preferred option as:

- It offers high levels of patient satisfaction
- Care is delivered closer to home
- Reduced specialist input (virtual and face to face); no virtual management of test results
- There is a significant freeing up of out-patient capacity compared with option 1
- Cost per patient is significantly reduced
- There is a high level of patient safety
- Practice based care is integrated with management of other long term conditions; improved uptake and access to rehabilitation
- There is reduced personal cost to patients associated with outpatient appointments (average £350 over 5 years[14])
- Options 1 and 2 offer minimal advantage over primary care-led follow up
- Option 1 requires significant new capacity (consultant sessions and outpatient space) with rising demand

The benefits of primary care led supported self-management pathway are shown in Figure 9

Figure 9: Benefits of primary care led supported self-management pathway

Group	Benefits
For patients	Follow-up model based on patient choice Reduced personal costs associated with outpatient attendances Rapid access to specialist if needed Integration of care with other long term conditions
For primary care	Improved service for patients Integration of care with other long term conditions Skills development: providing holistic, integrated care closer to home
For providers	Released outpatient capacity Improved access times for new referrals Increased time in clinic for those with complex needs Fewer overbooked clinics
For commissioners	More effective use of local outpatient capacity Improved quality of service for local population Improved communication between specialist and community teams

[14] *Prostate cancer stratified follow-up implementation resource pack*. London Cancer, March 2016 http://www.londoncancer.org/media/143816/Prostate-Implementation-Resource-Pack_March-2016_FINAL.pdf

	Safer service - fewer patients 'lost to follow up' Monitoring surveillance tests remains under 'specialist watch'

The transfer of patients may be achieved in two ways:

1. Case finding 'bulk' transfer: suitable patients are identified from either hospital or GP records and are transferred 'en masse'. There would need to be an on-going process for identifying suitable new patients once this has been done. This would complete the majority of transfers more quickly but may result in some patients being concerned as they have not had an opportunity to discuss their follow up individually.
2. Gradual transfer: suitable patients are identified at routine outpatient review and the revised follow up arrangements are discussed with the patient and a transfer is arranged by letter to the GP with the necessary follow up protocol. This may take longer to implement in full but may be a more effective method as each patient has the opportunity to discuss the transfer of follow up.

The method of transfer is a local decision and will depend on the support available for this project. Where bulk transfer is the preferred option a clinical nurse specialist may be able to identify suitable patients from hospital records or where payment is being made to practices the identification of suitable patients could be included in the payment.

Primary care led supported self-management pathway may be undertaken by each individual GP practice or in a GP federation it may be undertaken by a smaller number of practices on behalf of all.

Robust clinical guidelines are available to support primary care in managing those patients who are transferred. There will be clear referral routes back to secondary care for patients identified as requiring specialist management. Additional support services will be available in the community (rehabilitation services, physical activity programmes, and mental health services) so that patients will benefit from improved quality of care.

It is essential that this project has sufficient short term support for implementation. The local requirements for this are anticipated to be [The CCG may wish to explore alternative sources of funding for some of these costs]:

Project management: [DESCRIBE REQUIREMENTS – COSTS IN SECTION 6]

Project administration: [DESCRIBE REQUIREMENTS – COSTS IN SECTION 6]

Educational events: [DESCRIBE REQUIREMENTS – COSTS IN SECTION 6]

Other support: [DESCRIBE REQUIREMENTS – COSTS IN SECTION 6]

5. Risks and issues

The potential risks and issues of this approach are shown in Figure 8.

Figure 10: Risks and issues

	Risk	1 = low, 5 = high			Mitigation
		Probability	Impact	Risk score	
1	Low engagement from partner CCGs				CCGs to agree local commissioning arrangements with GP federations/networks
2	Low engagement from practices				Service to be offered at level of GP federation so some practices can offer the service on behalf of all Consider local incentive schemes for practices
3	Secondary care specialists not transferring patients				Implementation monitored through performance reporting and regular commissioner/provider discussions
4	Patient safety				Patient safety is significantly mitigated by effective safety netting systems in primary care which are being implemented. This risk is also present in secondary care led follow up
5	Under-skilled primary care workforce				Introduction of a primary care led supported self-management pathway should be accompanied by an education and training plan so that primary care staff are prepared for this role

Longer term workforce issues

The proportion of GPs who are female is now 51%. This has risen by more than 50% in the last 10 years and this is likely to increase further as more female than male doctors choose

to be trained as GPs and more male GPs approach retirement[15]. In some practices, it is common for female GPs to see predominantly women and children, and as a result they may become relatively inexperienced at managing male urological problems including interpretation of the digital rectal examination. This issue may be exacerbated by patient choice: male patients may prefer to see a male doctor for problems requiring an intimate examination or discussion of incontinence or sexual problems that may occur after treatment for prostate cancer. This can be partly addressed through continuing professional development for doctors and through improved patient involvement and patient information.

[15] *NHS Hospital and Community Health Service (HCHS) Workforce Statistics in England. Summary of staff in the NHS, 2003-2013.* HSCIC, March 2014. http://www.hscic.gov.uk/catalogue/PUB13724

6. Cost analysis

In determining the financial impact of this proposal a number of assumptions have been made. Figure 11 shows the financial assumptions.

Figure 11: Financial assumptions

Sector	Description	Cost*
Secondary care led follow up	Follow up appointment (tariff)	*£96
Primary care led supported self-management pathway	GP appointment or 'new patient' appointment	*£43
	Practice nurse appointment (annual follow up)	*£31.67
Blood tests	Blood test costs will be the same for both primary care and secondary care led arrangements.	

*Costs are shown for illustration purposes; these may vary depending on local arrangements.

£43 per appointment where it is clinically indicated that the patient will need to be more regularly reviewed but probably no more than twice per annum. This appointment may be with the nurse and or GP.

Both appointments would exclude Phlebotomy which should be claimed under an existing phlebotomy LCS or primary care contract.

The financial savings per patient per year are illustrated in Figure 12. Please note, in Figures 12 and 13, year 1 is the first year the patient is transferred to primary care (not the year from diagnosis). The number of patients suitable for primary care follow up is estimated to be [ENTER NUMBER e.g. 40% of the total number of existing prostate cancer patients]

Figure 12: Potential financial savings from Years 3-5 (Years 1 and 2 removed as secondary care follow-up is required for 1st 2 years before stratification / transfer to primary care)

Sector	Year 3 £	Year 4 £	Year 5 £	Total £
Secondary care led follow up	*96	*96	*96	*288
Primary care led supported self-management pathway	*43	*43	*43	*129
Difference (savings)	*53	*53	*53	*159

*costs are shown for illustration purposes; these may vary depending on local arrangements

For [xxxx ENTER NUMBER] patients the cost savings are estimated to be: £[xxxxx ENTER NUMBER e.g. £387 x estimated number of patients to be transferred]

Other estimated non-recurrent costs

The following non-recurrent implementation costs should also be considered:

Project management: [ENTER ESTIMATE]

Project administration: [ENTER ESTIMATE]

Educational events: [ENTER ESTIMATE]

e.g. Patient education/self-management events

Primary care workforce (GP/practice nurse) learning and development events

Other support: [ENTER ESTIMATE]

Recommendation

It is clear from the case outlined above that **option 3 - primary care led supported self-management pathway** is the preferred option.

The introduction of a primary care led supported self-management pathway will improve the efficiency and effectiveness of follow up care for prostate cancer patients. It will improve patient satisfaction and access to holistic integrated care closer to home. The recommendation is highly cost effective and will release significant outpatient capacity.

This proposal has the support of:

- [List the boards/groups that have approved this business case]

  For example:

  CCG Senior Management Team

  Acute Trust Cancer Board

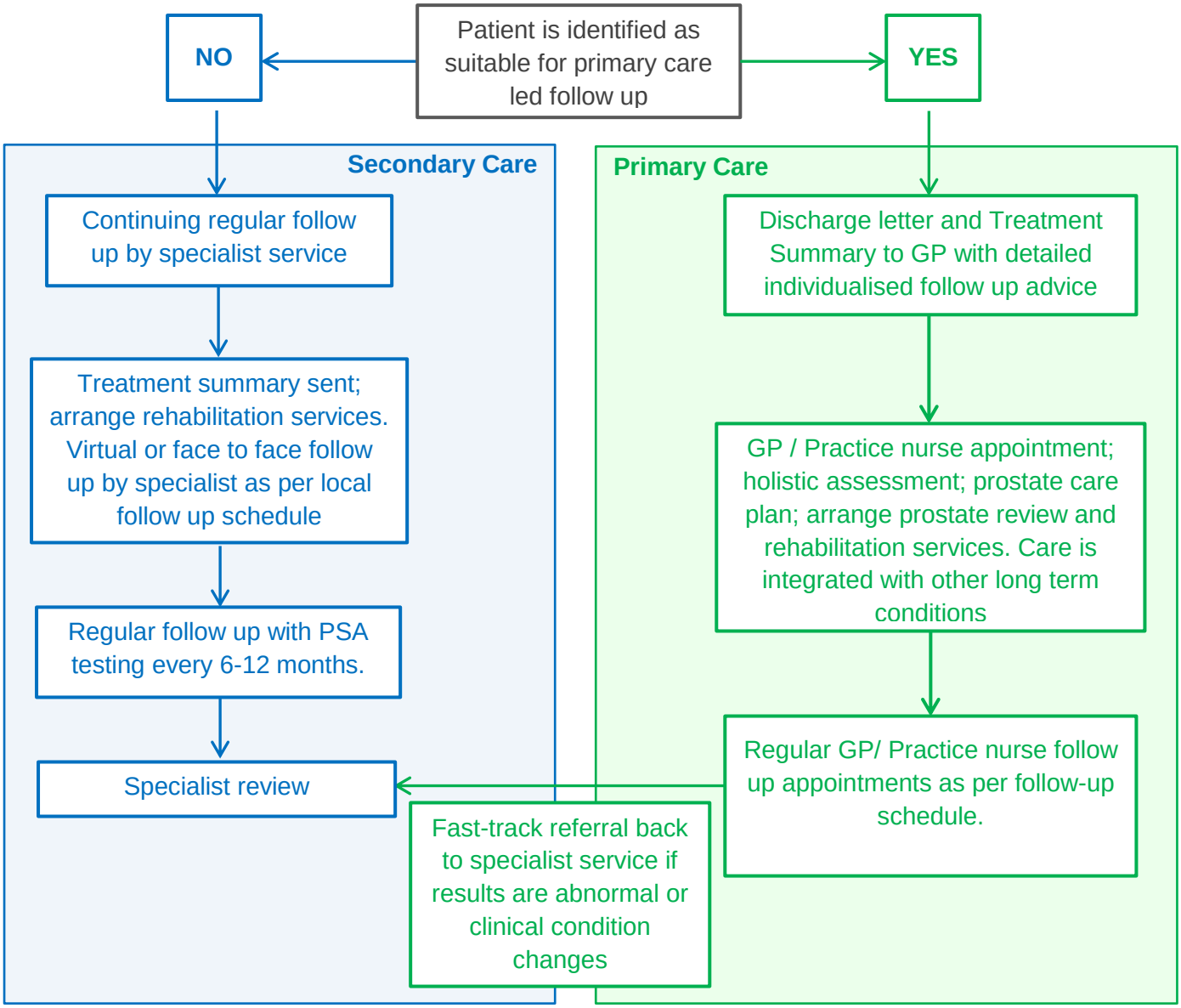
  CCG Cancer Locality Group

  CCG Governing Board

  SPG Leadership Team

  Service user Group

Appendix 1: Pathway diagram



Appendix 2: Implementation resources

Operational flow chart and other documentation/resources for Croydon project. Transforming Cancer Services Team for London, 2015. https://www.myhealth.london.nhs.uk/system/files/Operational%20Flowchart%20Prostate%20Cancer%20Sept%202015.pdf

Prostate cancer stratified follow-up implementation resource pack. London Cancer, March 2016. http://www.londoncancer.org/media/143816/Prostate-Implementation-Resource-Pack_March-2016_FINAL.pdf

Stratified pathways of care: from concept to innovation. NHS Improvement, 2012. http://www.ncsi.org.uk/wp-content/uploads/Stratified_Pathways_of_Care.pdf

Innovation to implementation: Stratified pathways of care for people living with or beyond cancer. A 'how to' guide. NHS Improvement, 2012. http://www.ncsi.org.uk/wp-content/uploads/howtoguide.pdf

Stratified pathways of care, National Cancer Survivorship Initiative, 2014. http://www.ncsi.org.uk/what-we-are-doing/risk-stratified-pathways-of-care/

Enhanced primary care-led prostate cancer follow-up: Evaluating the quality, safety and financial validity of the Croydon model. Transforming Cancer Services Team for London, February 2016 https://www.myhealth.london.nhs.uk/system/files/Evaluation%20-%20Primary%20care%20led%20prostate%20cancer%20follow%20up%20service%20-%20Croydon%20-%202016.pdf