SCHEDULE 2 – THE SERVICES

Service Specification No.	PSA03
Service	Arrangements for Follow Up of Patients with Prostate Disease in Primary Care
Commissioner Lead	NHS Vale of York CCG
Provider Lead	NHS Vale of York CCG GP practices
Period	2017/2018
Date of Review	12 months from being offered.

1. Population Needs

1.1 National/local context and evidence base

NHS Vale of York Clinical Commissioning Group is committed to improving patient care in a large variety of ways - particularly in providing the best possible care for patients as close to their homes as possible.

Historically, the majority of patients with prostate cancer have been managed within secondary care. NICE guidelines (CG175) (2014) recommends; men with prostate disease who have no significant treatment complications should be offered follow up outside hospital. Commissioners have therefore now developed a common specification for Prostate-Specific Antigen (PSA) monitoring to deliver safe and effective patient care in the community. This means that services will be commissioned in both primary and secondary care, enabling all Vale of York patients with diagnosed or suspected prostate cancer to be considered for discharge to primary care for PSA monitoring and follow up.

In order to fulfil the primary care element of the shared care arrangements, primary care practices are invited to provide the following standards of care through an NHS Standard Contract for services for 2016/17.

2. Outcomes

2.1 NHS Outcomes Framework Domains & Indicators

Domain 1	**Preventing people from dying prematurely**	✓
Domain 2	**Enhancing quality of life for people with long-term conditions**	✓
Domain 3	**Helping people to recover from period of ill-health or following injury**	✓

Domain 4	**Ensuring people have a positive experience of care**	✓
Domain 5	**Treating and caring for people in safe environment and protecting them from avoidable harm**	✓

2.2 Local defined outcomes

By signing up to the LES contract, primary care will be required to implement a robust call/recall system and review patients as per secondary care discharge follow-up care plans.

To offer more convenient access to safe, effective and patient-friendly follow up in a community based care setting for patients considered suitable for discharge from secondary care.

- Ensure patients have a positive experience of care
- To offer care closer to home
- To ensure patients receive treatment in the most appropriate place for that element of care
- To ensure patient safety through a co-ordinated approach to audit and review
- Fewer appointments taking place in the hospital, meaning fewer journeys for our patients
- Increase in the percentage of people who feel supported to manage their own condition
- Patient experience and quality of life is improved
- To assist patients to stabilising their condition to get patients back to living their lives
- To ensure that all practices are active in prevention and management of raised PSA and prostate cancer
- The service will also contribute to the transfer of appropriate care from hospital to GP surgery, allowing acute oncology providers to concentrate on more complex cases and improve access to hospital based services.

3. Scope

3.1 Aims and objectives of service

Aim

The primary care based element of the service will provide an efficient, safe and more patient-friendly service of PSA monitoring in primary care, delivered by practices providing list based primary medical care services. The service allows the acute urology providers to concentrate on more complex cases and improve access to hospital based services. The service will provide care closer to home and will be safety-netted by ensuring a robust call/recall process is implemented at practice level.

Objectives

- To establish a robust call and recall process for patients
- To provide follow up care in the community for patients that have been discharged from secondary care and require follow-up.
- Improve access to health services in the community
- To provide a service at an appropriate time, location and environment
- Patients are supported to self-manage their long term conditions within the community
- Provide services in line with NICE guidance and Care Quality Commission standards

3.2 Service description/care pathway

GP Principals have ultimate responsibility for the delivery of this service at practice level. Each practice may develop its own approach with regard to which health professionals have contact with the patient during the course of the surveillance programme and how contact is made. Individual clinicians may determine whether the follow up review takes place within a face to face or telephone consultation.

All GPs will adhere to patient management plans, as per secondary care discharge letter, and where indicated undertake face to face follow up appointments to ensure appropriate physical examination takes place.

Notification to Patients

Secondary care clinicians should ensure that patients are involved in decisions about their care and should provide appropriate information explaining their condition and that their on-going follow up care will be managed in primary care.

3.2.1 Clinical Governance Requirements

Clinical Governance requirements must be addressed and met as follows:

The Practice will be responsible for:

Practices must be satisfied that they are providing a robust call/recall system. By signing up to the contract they are confirming that they have the following arrangements in place:

1 Establish and maintain an electronic 'Prostate Cancer Register' of patients who have been identified by secondary care that meet the criteria for on-going management of their condition in primary care. Clearly mark patient's notes to flag up that they require prostate follow up – this needs to be easily identified should the patient move practice.

2. Establish a robust and an effective call and recall system of patients on the electronic Prostate Cancer Register. Patients should receive their follow-up appointment and any action needed is completed within:
    - 1 month of planned date, if follow-up is recommended quarterly
    - 2 months of planned date, if follow-up is recommended six-monthly
    - 3 months of planned date, if follow-up is recommended annually

3. In the event of a patient DNA, the practice is responsible for contacting the patient again to re-book their appointment, ensuring that any 'informed dissent' is recorded in the register. Practices should attempt to contact the patient at least 3 times to re-book their appointment, two of which should be via a hard copy letter posted to the patient's home address.

4. All results are recorded accurately (electronic transfer of results from acute pathology lab into electronic patient record). Action will be taken on receipt of results in accordance with secondary care discharge letter.

5. Practices should ensure they have a system for ensuring that results have been received for all blood samples sent as part of the PSA recall system, and that these results have been reviewed by an appropriate clinician and patient informed of appropriate action to be taken (e.g. date of next test or referral back to secondary care).

6. Submission of audit data which accounts for every relevant patient on the practice register. (Example template in Appendix A)

7. Practices should ensure that patients referred back to the hospital are removed from the call/recall system. Payment can be claimed for these patients for that year but not for subsequent years unless the patient is discharged back to primary care.

8. Nominate a Urology Liaison GP who will act as a conduit between their practice colleagues and the acute urology departments regarding PSA and prostate disease.

9. Should the contract be terminated, in line with the terms and conditions of the Standard NHS Contract, all patients will be referred back to secondary care.

GP Responsibilities

By signing up to the agreement, practices are confirming that GPs involved in the surveillance of patients with stable prostate disease will:

1. Provide PSA monitoring for patients being cared for on the Prostate Cancer Register, in accordance with secondary care discharge letter.

2. Review patients at appropriate intervals and where indicated refer back for hospital assessment as stated in secondary care discharge letter.

3. Undertake Digital Rectal Examination (DRE), where indicated in the management plan to determine on-going management of the patient (or following telephone/email advice from the consultant or urology specialist nurse).

4. The Urology Liaison GP will keep up to date on developments around the management of prostate cancer and will disseminate relevant information amongst practice colleagues regarding clinical updates and service changes required within the practice.

5. If uncertainty exists in the appropriate management of patients on the register, pro-active contact is to be made with acute urology provider colleagues for telephone/email advice and guidance.

Reporting

In order to qualify for payment, practices will need to submit an invoice and clinical audit results to the CCG using the Excel reporting template provided 'PSA Monitoring Claim Form' on a six monthly basis.

(The *national requirement for providers is monthly reporting (Schedule 6, Section C, National Requirements Reported Locally no. 2), the CCG requires only six monthly submission)*

Monitoring will take place to ensure practices adhere to the protocols set out under the details of this specification. Practices may be chosen at random for purposes of data validation. If practices fail to adequately demonstrate adherence to the protocols, payment will be re-claimed by the Vale of York Clinical Commissioning Group.

Payments

The service will be commissioned by the Vale of York Clinical Commissioning Group on the basis of patient outcomes in terms of active call/recall and confirmation all components of

service are provided as detailed in the specification.

Payment will be made in line with Schedule 3 of the contract.

A total payment of £40 can be claimed per patient on the Prostate Cancer Register who has had at least one PSA follow-up and any action needed is completed within:

- 1 month of planned date, if follow-up is recommended quarterly
- 2 months of planned date, if follow-up is recommended six-monthly
- 3 months of planned date, if follow-up is recommended annually

Or, in the event of a patient DNA, practices have attempted to contact the patient as per requirements outlined in the specification.

Practices should only claim one fee per patient per financial year regardless of the number of PSA tests given in that year.

Review of Service
The commissioning of this service will be subject to a review during 2016/17 to ensure the effectiveness of the service.

3.3 Population covered

All Vale of York male patients with stable prostate disease who have no significant treatment complications and have been diagnosed by a Consultant Urologist as suitable for follow up in primary care.

3.4 Any acceptance and exclusion criteria and thresholds

The Acute provider will identify patients deemed suitable for discharge from hospital based follow-up care and provide follow-up plans in secondary care discharge letters.

Discharges to primary care should only be made by a Consultant Urologist/Middle grade/Clinical Nurse Specialist, who will have diagnosed and staged the disease and recommended a management plan.

Primary care are able to decline to accept a patient where it is felt that there is good clinical reason as to why they are unsuitable and inform secondary care specialist colleagues of this.

If a discharge letter from the acute urology provider is received by the practice that does not provide the relevant clinical details required to enter the patient appropriately onto the practice PSA Prostate Cancer Register, the practice is advised to contact the Urology Consultant.

The secondary care discharge letter should include:

Patient Details *(incl. name, address, dob)*
Details of Diagnosis *(incl. PSA level on discharge, current treatment and treatment history)*
Recommendation / Follow up Plan *(incl. frequency of PSA monitoring, define indications for re-referral, length of time monitoring required)*

Practices may be chosen at random to have their PSA Follow-up list audited at which they would be required to produce an anonymised copy of the secondary care discharge letter.

Referral back to Secondary Care:

The GP will re-refer the patient to the relevant acute urology provider if:

- The criteria for re-referral as specified in the secondary care discharge letter are reached.
- PSA doubles from baseline discharge PSA
- New evidence of distant or local recurrence
- New bone pain
- Worsening / new LUTS
- Deterioration of renal function in presence of hydronephrosis
- Symptoms of spinal cord compression (refer urgently as per MSCC protocol)
- Newly abnormal rectal examination
- Haematuria (should be referred under 2 week rule)

The GP will refer the patient back to the acute urology provider as an urgent referral. Provision will need to be made by the consultant-led clinic to accommodate patients (i.e. within a maximum of 4 weeks of referral).
The exceptions to this are symptoms of spinal cord compression which must be referred urgently same day according to the MSCC protocol, and haematuria which should be referred under the 2 week rule.

3.5 Termination of Follow Up

The GP should consider removing patients from the practice Prostate Cancer Register for the following:

- If a patient develops an unrelated terminal illness or are felt to be unfit to continue follow up monitoring (e.g. advanced dementia, end-of-life) - this will be at the discretion of the patient's GP
- Monitoring should end at age 80 for most patients – there is no evidence that outcomes are improved by continuing to monitor after this age
- For patients with a recent diagnosis of prostate cancer, monitoring is reasonable to continue beyond 80 until 10 years post diagnosis when it can generally stop

4. Applicable Service Standards

4.1 Applicable national standards (eg NICE)

NICE Guidelines 2008 (Clinical guideline 58 Prostate cancer: diagnosis and treatment)

4.2 Applicable standards set out in Guidance and/or issued by a competent body (eg Royal Colleges)

4.3 Applicable local standards

The service will adhere to all local policies, procedures and guides.

5. Applicable quality requirements

5.1 Applicable quality requirements (See Schedule 4.)

This service will only be commissioned from appropriate providers who can demonstrate that they have achieved, or are working towards, Care Quality Commission (CQC) registration requirements and compliant with the essential standards relating to quality and safety.

The primary care provider must have achieved / or working to an agreed plan to achieve level 2 compliance against all requirements in the relevant NHS information governance toolkit.

Any Serious Incidents and concerns must be reported by the practice as per the CCG Serious Incident Policy. Any concerns regarding quality should be sent to VoY CCG: NYYCSU.SeriousIncidents@nhs.net

6. Location of Provider Premises

The Provider's Premises are located at: NHS Vale of York CCG GP practices.

7. Individual Service User Placement

NHS
Vale of York
Clinical Commissioning Group

Appendix A – Reporting Template

Please complete PSA Monitoring Claim Form in an Excel worksheet format provide and return to CCG Finance voyccg.finance@nhs.net

Example Reporting Template Only – Claims should not be submitted in Word format.

Name of practice:	Description
Period Covered (1st April to 30th September / 1st October to 31st March)	State which
Name of Urology Liaison GP	Description
Provide a description of how the urology liaison GP has kept up to date with developments for management of prostate cancer (e.g, new evidence, service changes) and how this information has been disseminated amongst practice colleagues.	Description
Provide description of how Prostate Cancer Register is established and maintained and how the call and recall service is provided. Describe how patients who DNA are managed.	Description (only needs to be provided annually)
I confirm no serious incidents or concerns related to this service have been reported by the practice to the CCG as per the CCG serious incident policy.	Tick box
I confirm serious incidents or concerns related to this service have been reported by the practice to the CCG as per the CCG serious incident policy. **State number of incidents reported:**	Tick box Number reported

Anonymised Patient number * Matching numbers should be generated for the same patient each time.	**Frequency of PSA monitoring requested by secondary care**	**Frequency of DRE monitoring requested by secondary care**	**Planned date of first patient follow-up from:** **1st April** **Or** **1st September**	**Date when patient informed of PSA result and any action needed is completed**	**Confirmation PSA follow-up has been actioned and patient informed of result within 1 month.** Payment can only be claimed for practices that meet the quality requirements in the specification. E.g. Date when patient informed of PSA result and any action needed is completed within: •1 month of planned date, if follow-up is recommended quarterly •2 months of planned date, if follow-up is recommended six-monthly •3 months of planned date, if follow-up is recommended annually Or, in the event of patient DNA the practice has contacted patient 3 times, as per the specification.	If No or DNA state reason and action taken
Number	**(3, 6, or 12 monthly)**	**(3, 6, or 12 monthly)**	**DD/MM/YYYY**	**DD/MM/YYYY**	**Yes/No/DNA**	**Description**

*Please note you can only claim once per patient per financial year regardless of PSA tests carried out.