National directives continue to encourage greater involvement of primary care in prostate cancer management. However, the complexity of this disease cannot accommodate absolute definitions of role responsibilities across primary and specialist care. This article examines an initiative to improve the management pathway for prostate cancer patients by increasing communication between commissioners and professionals within secondary, primary and intermediate care.

Turning points in prostate cancer management
Prostate cancer is the most common form of cancer in men, and accounts for 25% of all new male cancers in England and Wales. In 2006, 35,515 new cases of prostate cancer were diagnosed in the UK. The lifetime risk of being diagnosed with prostate cancer is 1 in 10 for men in the UK, with the peak incidence at 70–75 years.

Prostate cancer comprises a spectrum of disease from early localised cancer, which can be treated with curative intent with radical prostatectomy or radiotherapy; to advanced disease, which is managed with palliative hormonal manipulation. Prostate cancer remains a significant clinical problem, not only because of its high incidence and mortality, but also because of the morbidity associated with the advanced stages of this disease.

Over the past decade, public and professional interest in prostate disease (both benign and malignant) has escalated. To a large extent, this has been driven by significant advances in treatment options for benign and malignant prostate disease. Greater public interest increases the demand on services, which in turn leads to national guidelines for examining how patient care can be integrated across primary and secondary resources.

Multi-disciplinary teams, now commonplace in secondary care, often fall short of joining up primary care roles into the complete patient journey. Prostate cancer services need to be reviewed and redesigned according to local populations in the context of effective
commissioning of care across the wider multi-disciplinary team—secondary, primary and intermediate care.

The National Institute for Health and Clinical Excellence (NICE) clinical guideline, *Prostate cancer: diagnosis and treatment* (NICE, 2008), generated significant debate within the uro-oncology community. The complete guideline and specific recommendations within the guideline featured, unsurprisingly, at urology and oncology congresses throughout the year. The British Uro-oncology Group (BUG) selected four key topics for debate at its Annual Meeting in September 2008 (Table 1). One of the most pivotal conclusions emerging from this debate focused on the potential scope for primary care trusts (PCTs) and commissioners to become more familiar with some of the nuances of evidence within the NICE guidance. Overall, oncologists and urologists could become more involved in liaising directly with managers and PCTs on clinical issues. With a fuller understanding of both the clinical issues and local health economy needs among all parties, it is logical that the result should be an improved service to optimise management on a local basis.

### Paving a way forward

Teaming up with NHS Alliance, BUG implemented a series of three meetings to bring groups of secondary, primary and community care professionals together with commissioners and managers. The meetings primarily aimed to facilitate and encourage greater collaboration among all parties, to review their local service delivery for prostate cancer patients. Secondly, the project looked to increase awareness and understanding among secondary care professionals, in particular, of NHS reforms and commissioning processes in prostate cancer.

The meetings set a forum for all those participating to explore and debate local obstacles and challenges influencing optimum delivery of prostate cancer services on a local level, while agreeing outline strategies and approaches that can have a positive impact on improving local services in the future.

The meeting series, titled *Prostate Cancer—Improving Patient Journeys*, took place in London, Leeds and Bristol during the course of 2008 and 2009. A similar programme format was run for each meeting. Short plenary sessions presented views from the patient, secondary care, primary care and the commissioning sector, particularly focusing on differing models of service (how they had been improved or redesigned) in specific localities (Table 2).

The plenary sessions concluded with the
Overall, 90% of the respondents rated all the sessions four or five (where 5=excellent and 1=poor).

The road ahead

BUG and the NHS Alliance are committed to providing educational events, but our overriding concern is that we can facilitate the bringing together of colleagues to share experiences and think about how we can change our practice for the better in the future. We were encouraged by the response to this meeting series; almost 90% of the participants across the three meetings confirmed that as a direct result of the meeting, they may change their practice in the future.

In terms of the strategies discussed and aired for improving service delivery in the future, there was an enthusiasm on the part of clinicians and commissioners to further review the benefits in their localities of:

Table 3. What are the three key challenges in improving prostate cancer services in your locality?

- General development and agreement of primary/secondary care protocols and guidelines for all aspects of patient follow-up
- Lack of a well-developed, reliable and informed long-term management follow-up for prostate cancer patients in a primary care setting
- Identifying the most appropriate professional(s) for follow-up according to local demand
- Local agreement and standardisation of GP referral systems
  - Defining patient journeys for differing disease states such as hormone- or castration-refractory prostate cancer
  - Waiting time targets and the risk of breeching
- Identifying what is necessary clinically, to ensure early detection of recurrence, adequate support for patients and carers, and patient choice in terms of place and type of follow-up
- Effective primary/secondary care collaboration and communication
- Sometimes limited awareness of non-specialist carers and the public about prostate cancer and available management options
- Limited clinical resources, most critically, oncologists and nurse specialists
- Effective functioning of the multi-disciplinary team
- Ensuring patients receive greater information, particularly around surgery and prostate-specific antigen testing (PSA)
- Setting up and supporting local support groups to ensure that patients’ needs and views are truly understood and incorporated
- Managing the increasing demand for services
- Having the project management skills to successfully facilitate change

Overall, 90% of the respondents rated all the sessions four or five (where 5=excellent and 1=poor).
Further information

British Uro-oncology Group  
www.bug.uk.com
The British Uro-oncology Group (BUG) was formed in 2004 and is a registered charity. Its overriding aim is to meet the needs of clinical and medical oncologists specialising in the field of urology. As the only dedicated professional organisation for uro-oncologists, it provides an established networking and support forum for discussion and exchange of research and policy ideas.

NHS Alliance  
www.nhsalliance.org
NHS Alliance is an independent membership body for individuals, practices and PCTs. The organisation focuses on bringing together clinicians, managers and citizens in primary care. It has three core aims:
- Influencing government and relevant agents
- The development of policy and how different policies should be integrated
- The sharing of good practice.
Overall, its values centre on health improvement, equity and accountability.

- A nurse-led one-stop clinic
- Different strategies for primary care follow-up of patients
- Improvement in the provision of patient information and guidance on patient choice and decision-making
- Telephone follow-up of patients
- Closer links between GPs and secondary care specialist nurses
- Increased clinician involvement in service evaluation and design
- A greater focus on palliative care and end-of-life services for prostate cancer patients.

Sharing service models for prostate cancer services
Dr Tony Brzezicki, Professional Executive Committee Member at Croydon PCT, a GP, and Vice Chair of Croydon Practice-Based Commissioning Group, has headed a shared care service for prostate cancer follow-up. Following discussions with the local urologist, a protocol for follow-up was developed and agreed by all clinicians and by the PCT. Within the system, GPs are paid to carry out prostate cancer follow-up for suitable patients, resulting in savings of approximately £100 per patient.

There are approximately 3000 prostate cancer patients in Croydon and almost half of these are suitable for follow-up in primary care. A total of 70% of the practices have taken part in the scheme and, during the first 6 months, 671 outpatient appointments have been saved, as well as £51 000. The system is now being rolled out throughout the South West London Cancer Network.

Hilary Atkinson, Clinical Nurse Specialist in prostate cancer, Berkshire East Community Health Services, and Nikki Scarlioli, Macmillan Community Prostate Nurse, West Essex PCT, are the only two primary care employed nurses in the UK concerned with the management of prostate cancer. Their local service designs involve a physical face-to-face clinic approach, and the other a telephone-based clinic. Across both services, patients are followed-up and supported post-diagnosis and during most treatment pathways as appropriate. The services take responsibility for referral back into secondary care according to approved protocols.

These management pathways are now being requested and distributed throughout the UK and internationally as a model for best practice. Success has been recognised, with Hilary Atkinson being awarded the Queen’s Nursing Award, and Nikki Scarlioli being in the top 10 high-impact outcomes for East of England Strategic Health Authority.

Mr James Green, Consultant Urologist at Whipps Cross Hospital, London, presented his service redesign, which is part of the North East London Urology Cancer Network, taking referrals from five to six PCTs, in an area with a high rate of social housing.

Following his successful bid to provide a prostate cancer service within surgeries, the new design is proving highly effective; however, issues arising are being continuously evaluated and improved on. Some of the examples highlighted include:
IT: non-compatibility between primary and secondary care systems

Private companies are still pushing to commission work from surgeries, even though their bids have been unsuccessful

‘Creep’ whereby prostate nursing teams working within surgeries may be encouraged to see patients with other conditions.

In progressing services for prostate cancer in the future, Mr Green is keen for commissioners and clinicians to improve palliative care for prostate cancer patients. Currently, there is a huge emphasis on diagnosis and treatment of the disease. Prostate cancer patients spend longer undergoing palliative care than most other cancer patient groups, and therefore there should be a greater emphasis on treatment of disease progression and end-of-life care.

Despite challenges along the way, governance and standards have been maintained and remain within the secondary care team, while costs for all parties have been reduced.

Garrett Durkan, Consultant Urologist, Gateshead, and Lorraine Montgomery, Specialist Nurse Practitioner, Gateshead, shared the development of a locally-enhanced service (LES) for advanced prostate cancer follow-up. The LES encourages joint management of patients across primary and secondary care, led by the specialist nurse practitioner. The benefits of the service include:

- Care closer to the patient
- Less use of ambulance services
- Freeing-up of nurse-led appointments allocated to urgent cases
- Use of GP consultations for prostate cancer follow-up and other conditions
- Closer ties between primary and secondary care
- Overall higher standards of care for prostate cancer follow-up.

Comprehensive auditing of the LES is in progress, but the service is proving highly effective and is well received by the majority of local GP practices.

Conclusions

This project was successful in generating significant debate on clinical and commissioning issues in the field of prostate cancer, which benefited participants across a spectrum of professional roles and remits. Whereas a ‘one size fits all’ approach to service delivery for prostate cancer is certainly not appropriate because of the complexity of the disease, the sharing of different service models from around the UK enabled participants to learn about and consider different elements of service that may be beneficial in their locality. Face-to-face communication between professionals involved in delivering the care and those professionals responsible for designing and commissioning services was of significant value to all involved.

Conflict of interest: AstraZeneca provided sponsorship towards the Prostate Cancer—Improving Patient Journeys meetings. In addition, AstraZeneca provided a sponsorship grant towards this independently-developed article.