LONDON CANCER ALLIANCE
West and South

LCA Best Practice Prostate Pathway

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Delivering world class cancer care for London

Contents

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1 Purpose of the Document

This document outlines the LCA Best Practice Prostate Pathway as identified and mandated by the LCA Urology Pathway Group. The document is not intended to be a comprehensive set of clinical guidelines but details the necessary sequencing and timeliness of the various elements of the prostate cancer pathway to ensure it is delivered within the 62 day target.

2 Background

The key aim of the work programme of the LCA Urology Pathway Group, formed in June 2013, is to reduce variation in urological cancer care across the LCA provider organisations. As part of this work, the group reviewed referral-to-treatment times for all five of the urology cancers. The review identified wide variation between providers' performance against the national 62 day waiting times target, in particular for prostate cancer. The need for standardisation was therefore evident and, from this, the group mapped a best practice pathway to be implemented throughout the provider organisations.

3 Case for Change

In the reporting year 2012/13, 62 day first treatments for prostate cancer totalled 1,138, equivalent to 14% of the total 62 day treatments in the LCA. The LCA is failing to meet the 62 day standard for prostate cancer, reporting 78.6% compliance against the 85% national waiting times target. Just three of the 12 providers for prostate cancer were compliant, with seven trusts reporting lower than 80%. The variation amongst providers is extensive, with Imperial reporting 38% against the target compared with Mount Vernon reporting 96%. The below table outlines provider performance based on the hospital the patient had their first 2 week wait (2ww) appointment.

Site code	Site	Number of cases	Median Wait	Number of breaches 62 standard	% in target (62 day standard)
RYJ01	St Mary's Hospital - Imperial	29	**81**	18	37.9%
RYJ02	Charing Cross Hospital - Imperial	39	**75**	24	38.5%
RJ611	Croydon University Hospital	96	**58**	32	66.7%
RQM01	Chelsea and Westminster Hospital	13	**58**	5	61.5%
RFW01	West Middlesex University Hospital	55	**55**	14	74.5%
RV831	Central Middlesex Hospital – The North West London Hospitals NHS Trust	13	**50**	1	92.3%
RYQ50	Queen Elizabeth Woolwich - SLHT	129	**48**	27	79.1%
RJ7	St George's Healthcare NHS Trust	84	**46.5**	19	77.4%
RV820	Northwick Park Hospital – The North West London Hospitals NHS Trust	88	**45**	2	97.7%
RVR05	St Helier Hospital	55	**45**	14	74.5%
RAS01	Hillingdon Hospital	12	**44**	2	83.3%
RYQ30	Princess Royal University Hospital - SLHT	99	**43**	27	72.7%
RJ100	Guy's and St Thomas' NHS Foundation Trust	211	**42**	33	84.4%
RVR50	Epsom Hospital	71	**42**	13	81.7%
RAS02	Mount Vernon Cancer Centre – East and North Hertfordshire NHS Trust	50	**39.5**	2	96.0%
RJZ01	King's College Hospital	88	**39.5**	8	90.9%
	London Cancer Alliance Overall	**1138**	**48**	**243**	**78.6%**

4 The King's and Guy's and St Thomas' Prostate Pathway

4.1 Characteristics of the pathway

King's College Hospital NHS Foundation Trust (King's) and Guy's and St Thomas' NHS Foundation Trust (GSTT) were identified as two of the best performing trusts in the LCA. Both trusts have adopted a similar pathway. Therefore, the LCA Urology Pathway Group mapped the two trusts' prostate pathways (Appendix 1), from referral to treatment, to be put forward as the best practice pathway.

The efficiency of the proposed pathway hinged on the point at which patients are given an MRI in relation to their biopsy. Conventional prostate pathways indicate that a biopsy is performed prior to an MRI. However, as MRI can be compromised up to 8 weeks following a biopsy, this has a significant impact on the timeliness to treatment. Therefore, the King's and GSTT pathways reverse the order based on the risk classification of the patient (Appendix 2) following their first 2ww appointment.

Whilst the sequencing of diagnostics is the most pivotal factor in improving the efficiency of the pathway, other factors are also essential:

- Ensuring two week wait referrals are triaged daily by the urology team
- Establishing a prostate-focused clinic for patient's first 2ww appointment to be accommodated
- Regularly available slots for MRI and biopsy to ensure there is no delay in the diagnostic process
- MDT coordinator to be active in tracking the patients against the pathway. Notably they will need to receive the outcomes after the initial nurse-led clinic to ensure patients are booked into earliest available MRI slots.

4.2 Key factors to ensuring implementation

Both King's and GSTT have reviewed their experiences of implementing the pathways at their trusts and have compiled the following list of factors which enabled them to implement the pathway successfully:

- Clear responsibility for the problem – designated individual/s
- Focusing the patients in one/two clinics allows the cancer tracker and clinical team to focus on the problem
- Changing mind-set to book patients for pre-biopsy MRI
- MRI slots need to be available daily for the high risk patients to be booked into. Patients will then go on to have a TRUS biopsy which will require two days a week of available slots. This required significant engagement from radiology to make these available.
- Complex diagnostics and symptom management best delivered in an OSC so the 2ww problem is managed as well as the clinical problem.
- Personnel who understand the relevance of diagnosing significant cancer in the right population
- Recognising this is not a protocol – it is a multi-factorial problem solving situation
- The people who have a day-to-day feel for it are the people who are best placed to triage patients between diagnostics and watchful waiting/PSA surveillance with their primary care physician.

4.3 Impact of the pathway

Audits undertaken by both GSTT (Appendix 4) and King's (Appendix 5) have shown a positive impact since the introduction of the new pathway. The key points to note are that, not only are patients being seen for their 2ww appointment and being treated within the 62 day target, trust resources are also utilised effectively as the risk stratification reduces the need for inappropriate diagnostics. This reduces the burden and cost on the pathway and improves the patient experience.

5 Implementation and Monitoring Compliance

5.1 Dissemination

The LCA Urology Pathway Group presented the best practice prostate pathway at the inaugural LCA Urology Clinical Forum on 8 November 2013. The forum was attended by representatives from most urology MDTs from across the LCA provider organisations. The pathway has been reviewed and approved by the LCA Clinical Director, Dr Shelley Dolan, on behalf of the LCA Clinical Board.

5.2 Timeline for implementation

It is expected that trusts will begin to implement the pathway from 1 January 2014 with full implementation being anticipated from 1 July 2014. The key deliverables expected to be implemented by the 1 July 2014 are:

- Prostate focused clinic for initial 2 week wait referral consultation
- First 2ww appointment to be offered within 7 days
- MRI to be indicated pre-biopsy for all patients who would be candidates for radical curative treatment if a prostate cancer diagnosis is confirmed
- Patients to be given their Decision to Treat (DTT) by day 42
- Patients treated by day 62 of their pathway
- Robust data capture processes for recording the data items listed in section 5.4

5.3 Monitoring compliance

The pathway group will be monitoring compliance via regular reporting cycles which will form part of the quality metrics that underline the LCA Quality Assurance Framework. Provider trusts that do not comply with the timeline outlined above will be monitored via the pathway group's exception report and may be asked to provide an action plan ensuring implementation.

The LCA Urology Pathway Group can assist providers by supporting implementation where necessary and can escalate to the Clinical Board and Members' Board to gain traction if there are barriers which are prohibiting implementation.

5.4 Pathway metrics and focus for data collection

The LCA recognises the need to utilise existing data sources when monitoring compliance against best practice pathways. Therefore, the developed metrics are based solely on the Cancer Waiting Times (CWT) and Cancer Outcomes Services Dataset (COSD) data items. The pathway group encourages providers to capture the following data items to ensure completeness:

Cancer Waiting Times Data Items

- Cancer referral-to-treatment period start date
- Date first seen

- Cancer treatment period start date
- Treatment start date
- Cancer treatment modality
- Primary diagnosis (C61.0 patients only)

Cancer Outcomes Services Dataset

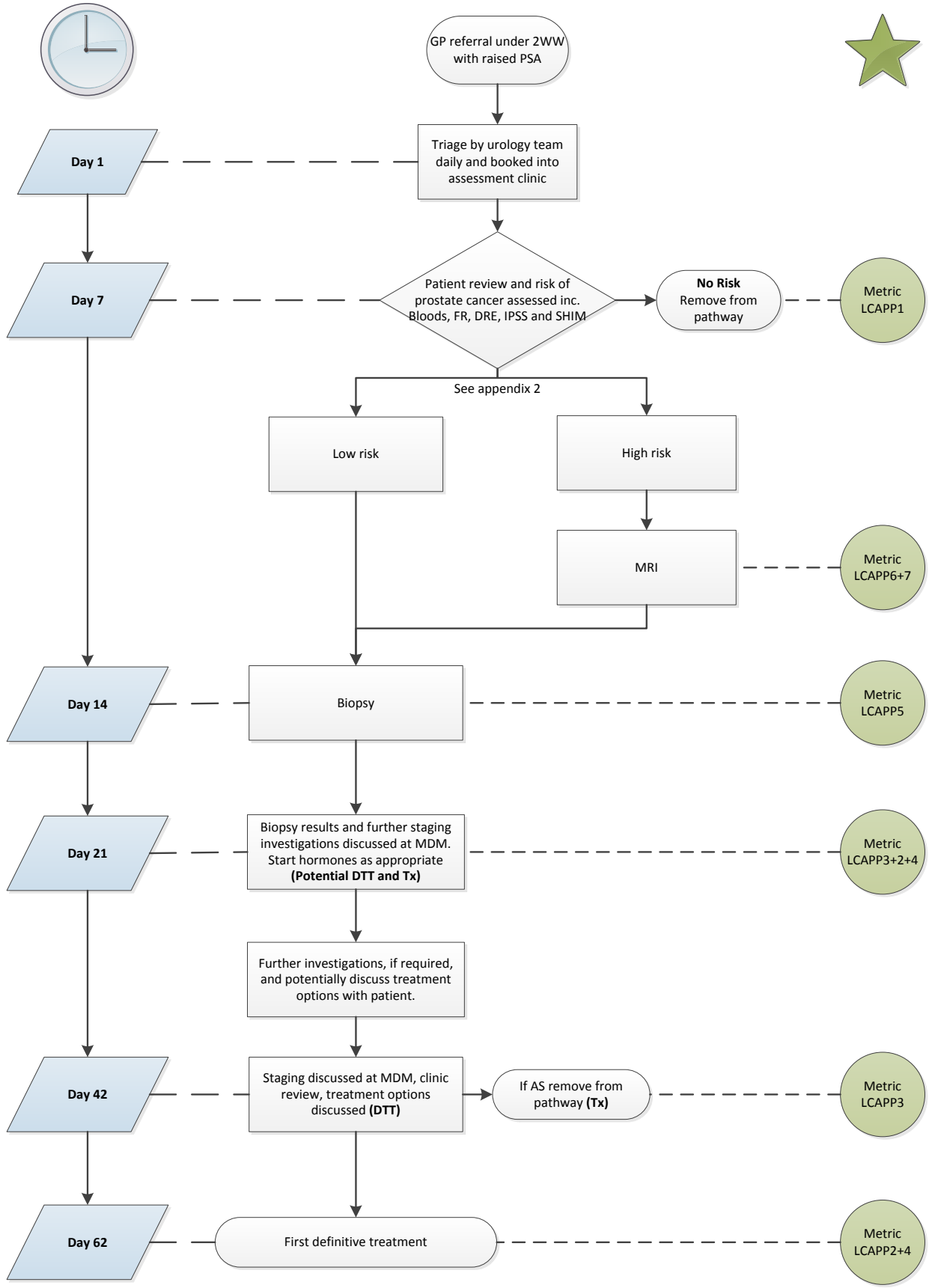
- (Data item no. CR0310) SITE CODE (OF IMAGING)
- (Data item no. CR0320) PROCEDURE DATE (CANCER IMAGING)
- (Data item no. CR0330) CANCER IMAGING MODALITY
- (Data item no. CR1010) SAMPLE COLLECTION DATE

Using the above data items, the metrics (Appendix 3) have been developed and the points of the pathway to which they relate have also been mapped (Appendix 1). The pathway group will analyse the metrics in more detail to determine targets – the details of these will be released in due course.

5.5 LCA support for implementation

The LCA recognises the challenges that trusts will face when implementing the pathway and can offer support via the pathway group and via the Clinical Board and Members' Board. Line of communication for escalating implementation issues will be through the LCA Urology Pathway Group project manager.

Appendix 1 – LCA Best Practice Prostate Pathway Flow Diagram and Anticipated Timescale



Key

DRE – Digital Rectal Examination IPSS – International Prostate Symptom Score FR – Flow Rate
SHIM – Sexual Health Inventory for Men DTT – Decision to Treat Tx - Treatment

Appendix 2 – Guidelines for Prostate MRI for Management of Localised Prostate Cancer

Pre-biopsy MRI of the prostate is indicated in all men referred with any of the following if they would be candidates for radical curative treatment:

1. Palpable abnormality on digital rectal exam
2. Two PSA measurements above the age-related normal range
3. If there is high clinical suspicion of prostate cancer and the patient is potentially fit for radical treatment if diagnosis proven

The use of an MRI is advised to prevent biopsy in the following patients:

1. Where prostate cancer is likely but biopsy confirmation is either risky or unnecessary
2. Where prostate cancer is likely but the MRI is normal begin PSA surveillance program to avoid a biopsy with a threshold for referral

If an MRI has not been performed before TRUS biopsy for whatever reason, 4 weeks should be left prior to imaging. In the vast majority of cases a clinical decision can be made without imaging and the imaging can be safely delayed to the point that is needed to guide the chosen treatment.

Those that shouldn't have an MRI include:

1. Patients with obvious metastatic disease unless mandated by trials
2. Patients who are not suitable for radical local treatment due to co-morbidities
3. Patients with a contra-indication to MRI scanning

Appendix 3 – Management of Metastatic Prostate Cancer: Guidance from the LCA Urology Pathway Group

Management of metastatic prostate cancer:

All patients should be seen at diagnosis jointly by a urologist and oncologist or by an oncologist to give them access to current and planned trials.

The patient should then be managed jointly by a urologist and oncologist or by an oncologist with input from a urologist with a special interest in metastatic disease and a prostate cancer clinical nurse specialist.

The referral pathway should not delay commencement of ADT.

Men already on ADT and not being followed up in the oncology clinic should be referred if they have any of the features below or at their first PSA rise from nadir on ADT.

Risk factors for early ADT failure:

Visceral metastases
Distant nodal metastases
Bone pain
Weight loss at presentation
Poor performance status due to disease progression
Younger age <60
Gleason score ≥ 8
High PSA at presentation (>500 at significant risk)
Poor PSA response (nadir ≥4)
Atypical variants/undifferentiated carcinoma

Remote follow-up is possible but needs careful risk stratification.

Palliative care should be arranged through the oncologist and led/supported by the CNS.

Appendix 4 – Prostate Pathway Metrics

Metric No.	Metric	What are we measuring?	Data item (s)	Source	Availability	Target
LCAPP1	First 2ww appointment for prostate cancer patients	Date from referral to first appointment is to be <8 days	2ww appointment date – 2ww referral date	Cancer Waiting Times	Now	93%
LCAPP2	62 day first treatment	Date from referral to first treatment <63 days	First treatment date – 2ww referral date	Cancer Waiting Times	Now	85%
LCAPP3	Decision to treat	Date from referral to decision to treat <31 days	Decision to treat date – 2ww referral date	Cancer Waiting Times	Now	Not yet set by the PG
LCAPP4	First 62 day treatment modality	% of patients receiving active monitoring as their first treatment	First treatment type	Cancer Waiting Times	Now	LCA comparison for outliers
LCAPP5	Biopsy	Date from referral to biopsy <20 days	Sample collection date – 2ww referral date	COSD Core Data Item	2014	Not yet set by the PG
LCAPP6	MRI	Date from referral to MRI <10 days	Procedure date (if imaging modality = MRI scan) – 2ww referral date	COSD Core Data Item	2014	Not yet set by the PG
LCAPP7	Pre biopsy MRI	Date of MRI to be before date of biopsy	Sample collection date – Procedure date (if imaging modality = MRI scan)	COSD Core Data Item	2014	Not yet set by the PG
LCAPP8	% complete for all COSD items	To assess the validity of the data received as the COSD dataset is likely to be incomplete	Sample collection date; Procedure date	COSD Core Data Item	2014	Not yet set by the PG

Appendix 5 – GSTT 2ww GP Referral Prostate Cancer Pathway Problems - Audit

All patients seen between 1/5/13 and 21/6/13 were seen by DC, RP or BC + NK within the capacity of the OSC. Patient numbers per clinic ranged between 10 and 3.

	Reference period	**Trial period**
n	70	65
TRUSBx	19	5
TPBx	5	4
TPBx and TURP	3	2
MRI	17	7
Breaches	14	2
Cancer Dx	13	10
% + biopsies	46%	73%
Inappropriate TRUS booked	11	0
Inappropriate TPBx booked	3	0

01/5/13 – 21/6/13 – Trial period

65 patients seen

Breach breakdown

2ww GP prostate refs – 2 patients breached (Both on first visit, patients requested later OPA date- unbelievable but truly breeched for this reason)

01/3/13 – 30/4/13 - Reference period

70 patients seen

Breach breakdown

2ww GP prostate referrals – 14 patients breached

1. Delay in diagnostics. TURP re-scheduled x3 (patient request and no capacity)
2. Delay to first OPA (15 days). Delay in diagnostics - patient on Abs due to UTI
3. Letter written incorrectly. Patient not put on AS post TRUS Bx
4. Delay in TURP (diagnostics). Patient choice then no capacity

5. Letter written incorrectly. Patient not put on AS post TRUS Bx
6. Administrative error with booking OPA with a prisoner
7. Delay in diagnostics. Capacity problem with TP Bx
8. Delay in diagnostics. Capacity problem with TP Bx
9. MRI booked not as 2ww. Delay for 6/52 before Bx
10. Patient not fit for TP biopsy, then delays in histology as incorrect information written on path form
11. Patient not fit for Bx as on clopidogrel
12. TRUS Bx changed to TURP + TP Bx. Capacity problem with TURP + TP
13. Patient away for 6/52. Left on pathway – not able to book first OPA
14. Delay in diagnostics. Capacity problem with TP Bx

Discussion

The 2ww management pilot has reduced burden on resources and delivered fewer breaches.

Achievements

We have successfully reduced on-the-day cancellations for inappropriate referrals for biopsy. This is critical for service improvement as well as cost efficiency.

Keys to implementation

- Clear responsibility for the problem - individuals
- Focusing the patients in one clinic allows the cancer tracker and clinical team to focus on the problem.
- Complex diagnostics and symptom management best delivered in the OSC so the 2ww problem is managed as well as the clinical problem.
- Same day TRUS is liked by the patients and has not pressured the OSC.
- Key to reduce pressure on the diagnostic pathway.

The key is in personnel who understand the relevance of diagnosing significant cancer in the right population. This cannot be put down in a protocol as it is a multi-factorial problem solving situation. The people who have a day-to-day feel for it are the people who are best placed to triage patients between diagnostics and watchful waiting/PSA surveillance with their primary care physician.

Conclusion

We will continue to concentrate the 2ww prostate cancer referrals in rotated OSC (Weds am and Thurs pm) supported by a specialist nurse capable of carrying out patient assessment and prostate biopsy (with appropriate training).

Appendix 6 – Nurse-led Approach for Direct GP Referrals for Suspected Prostate Cancer at King's College Hospital

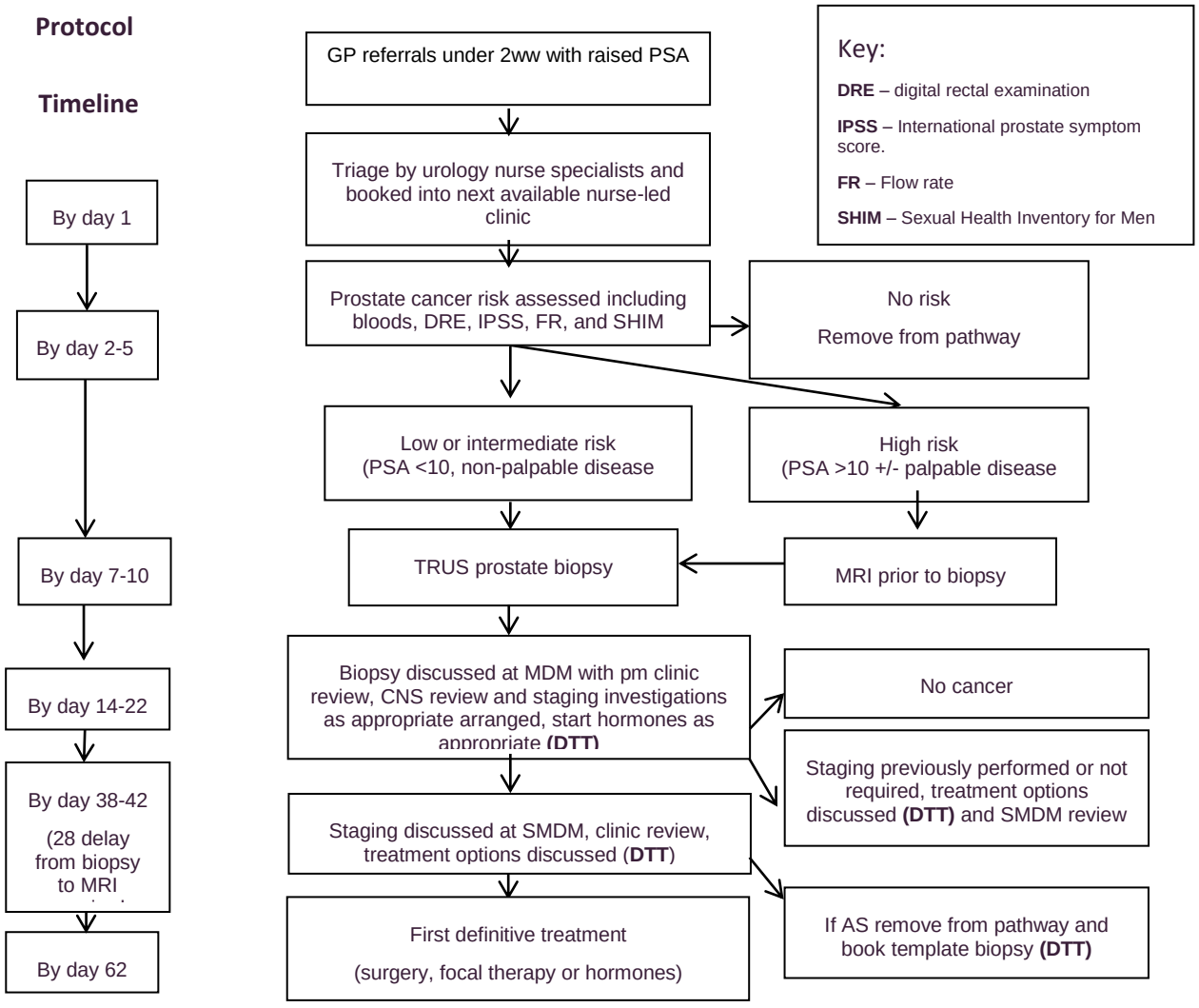
Lawrence Drudge-Coates and Vitra Khati, Urology Clinical Nurse Specialists

Introduction

In today's NHS practice, all urology departments are under considerable pressure to comply with the 2 week wait rule. Studies to date have focused on the appropriateness of the guidelines, compliance of referrals, and the poor yield of those urgent referrals, but very few have suggested specific benefits of a nurse-led approach. The objective of this audit was therefore to examine the initial outcomes of a urology nurse specialist developed approach to the assessment and management of suspected prostate cancer referrals.

Method

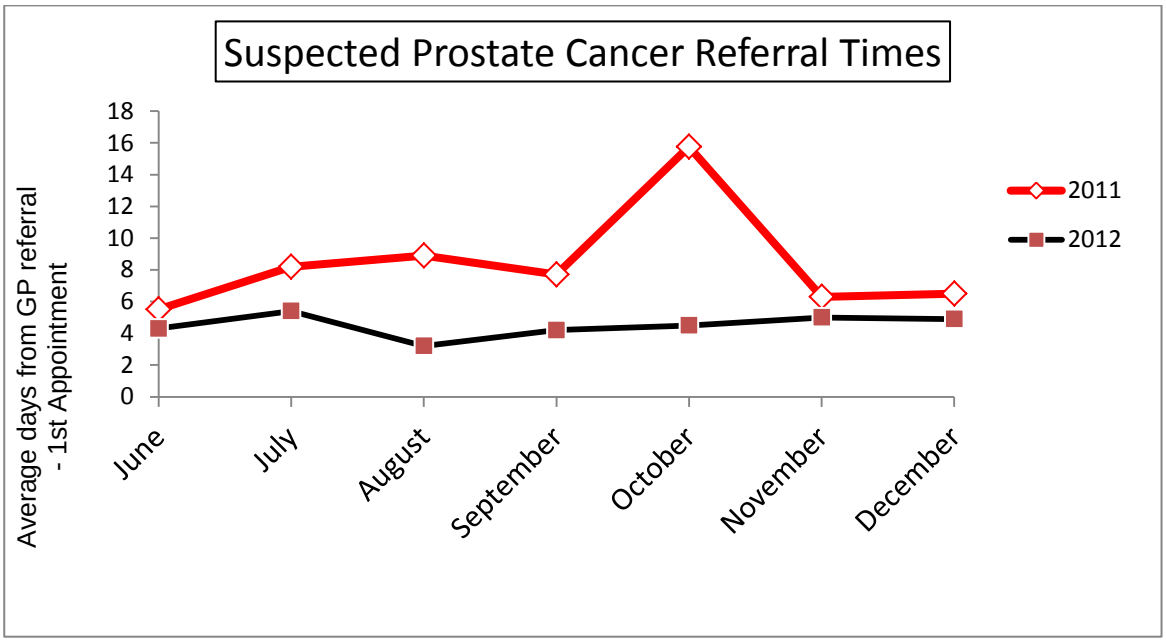
From May 2012 – December 2012 all GP 2 week wait referrals were vetted by the urology nurse specialist and allocated to specific nurse-led clinics. In all 123 suspected prostate cancer patients were seen. Using a protocol driven approach, a nurse-led assessment tool developed in conjunction with our consultant colleagues was agreed. All patients underwent initial lower urinary tract symptom and sexual health assessment, bloods and digital rectal examination, with subsequent diagnostic and staging investigations requested according to clinical findings and protocol. A patient questionnaire to evaluate the service was sent to the first 100 patients seen.



Initial results

In comparing the previous equivalent 6 months in 2011 (June – December) v 2012 (June –December) (Figure 1) : the waiting time to 1st appointment fell from 7.6 days to 4.5 days, resulting in a reduction of 59% due to the increased level of flexibility afforded by the nurse-led clinics. In respect of 14 day breaches, this fell from 7 in 2011to 1 in 2012 (patient admitted with pneumonia following GP referral).The patient questionnaire survey showed extremely positive results, with 86% of the patients very satisfied with the nurse-led service and 90% of patients happy with seeing a urology nurse specialist at their first appointment.

Figure 1: Average total days from GP referral – 1st appointment



Comments

Although initial findings, the data show a positive trend towards the benefits of a nurse-led approach in reducing waiting times from GP referral to 1st patient appointment for suspected prostate cancer patients. The flexibility afforded by the nurse-led clinics throughout the week plays a significant role in reducing this time, allowing patients to be allocated to any potential nurse clinic. In the context of patients removed from the suspected prostate cancer pathway but with outstanding lower urinary tract symptoms, treatments are either being initiated in this clinic time or GPs are being informed of the required treatment to be commenced, again another clinical benefit to this approach.

The vetting of all suspected urology cancer referrals is done on a daily basis by the urology nurse specialists, and appears to have provided a quicker appointment allocation. The validity of the referrals and clinical information are also scrutinised and where inappropriate referrals are made, this information is relayed and patients and are removed from the 2ww pathway. Initial work is now being carried out by the nurse in the clinic using prostate ultrasound to determine prostate size, and where relevant the requirement for template prostate biopsies so as not to refer for standard 12 cores biopsies. The potential for a one stop clinic in which prostate biopsies could be performed is also a potential.