

FAQs for PSA Surveillance and Monitoring

Q: If a patient has been discharged from secondary care with no confirmed prostate cancer but still requires follow up, will a payment be attached for the monitoring of these patients?

A: Yes, if monitoring is taking place under primary care following discharge from secondary care, a payment will still apply even if no cancer has been found but where regular monitoring of PSA is requested that is clinically appropriate.

Q: How do we identify patients and create a PSA register, what parameters should we be using?

A: Practices may choose to follow their own bespoke process to identify patients, but guidance will be issued prior to the introduction of the specification. It is expected each practice register will commence with a small number of patients, and numbers will grow over time as more are identified. Eligible patients must be recorded using a designated code provided by the ICB.

Q: If clinical advice is needed, how can this be obtained?

A: Practices can use advice and guidance for any clinical advice that is routine, however if there are clinical concerns that require urgent advice or referral, then the urgent cancer pathway may well be more appropriate.

Q: What is included in the review costings?

A: The cost of the review includes the time to call the patient in, review the blood test and review the patient as appropriate, either face to face, telephone call or other consultation and undertake any re-referrals to secondary care as needed. The cost of phlebotomy is within the phlebotomy specification.

Q: When will practices receive letters for monitoring? At present it tends to be every 6 months?

A: The urology teams as part of delivery planning will be asked to ensure they clearly request the timeframe for monitoring and the parameters on which a re-referral is required.

Q: We will require a route back into secondary care, current the form asks to repeat tests after 4 weeks if one test is elevated and refer if still remaining raised, we need clarity that this is not the case for these patients

A: If the PSA level is above that suggested by the discharging secondary team, then referral back on the urgent cancer pathway is the right route and a one-off test is acceptable in this situation to delay the need for further tests.

Q: How will you ensure that new referrals from secondary care for ongoing management are appropriate and not abused? Surgeries could end up with excessive numbers of people for PSA monitoring.

A: The referral criteria from secondary care will clearly highlight the needs of the patient. Only those patients that have been approved for management within primary care will have their care transfer as part of this LES.

Q: We need dedicated admin time to maintain and manage the register and to ensure there is a robust recall system. We will also need dedicated admin time on a 2-3 monthly basis to run searches to identify new patients, which will vary depending on the resulting numbers, so will need to review the allocation of time for this after running the searches. Has this been considered?

A: Practices will be expected to implement a process which suits their capacity. The ICB will not dictate the structure of the staffing. Administrative time has been allocated for the specification as part of the costings.

Q: Need to agree a PSA range as some urologists want PSA 2 or above
This is a normal range for us so difficult to know when to ref as result will be filed as normal

A: Patients referred from secondary care as part of this LES will have a bespoke plan. The identified PSA threshold will be particular to the patient being referred.

Q: How are you considering the border practices who may be liaising with urology services in Greater Manchester / further afar?

A: The team will try to ensure that comms are shared with other trusts that border the ICB.

Q: So if we got a letter through to code from urology, that had checked the PSA and they said the monitoring would be annual or 6 months - would we then do this PSA template and put it in there?

A: Yes that would be ideal. As long as the follow up was put on.

Q: For the PSA template does it need to be completed by a GP or can HCA do it?

A: Whoever is appropriate within the practice

Q: What about those on more frequent monitoring for PSA, i.e. 3 monthly if it only gives option for 6m and 12m?

A: You can use the page and include whatever time frame you wish

Q: Do we have to use the diary entry function?

A: No practices do not have to use the DQ diary entry searches.

Q: What does DV stand for? So if we go out on home visits we tick that if we take bloods?

A: Domiciliary Visit, yes