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Northern Cancer Alliance Gynaecology Oncology Stratified Follow Up Clinical Review and Surveillance Guidelines

Developed and endorsed by the Northern Cancer Alliance Gynaecology Clinical Leads

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INTRODUCTION

This document provides regional guidelines to complement existing National Institute for Health and Care Excellence (NICE) and NCA tumour specific guidance. This guideline does not override the individual responsibility of healthcare professionals in making decisions appropriate to the circumstances of the individual patient.

It is not anticipated that the guidelines will cover all clinical situations in all patients, but where unusual circumstances exist, it is expected that such treatments would be discussed in the appropriate MDT.

The guidelines will be reviewed on an annual basis. Where new treatments are introduced between revisions they will be added as an addendum to the current guideline.

Supported directed access offers a more effective approach to after-care than traditional medical models of follow-up which has the potential to reduce costs and improve patient satisfaction. Evidence for this model is based on the work undertaken by the National Cancer Survivorship Initiative in 2011. This aligns with the national strategy for implementation of patient-initiated follow-up (PIFU) pathways.

Patients with a gynaecological cancer of ovarian or endometrial origin will be considered for PIFU assuming they meet the inclusion criteria below.

STRATIFIED FOLLOW-UP

Stratified follow-up can lead to a reduction of routine appointments in a patient's pathway. Following treatment, aftercare is discussed with the patient and the appropriate pathway assigned. Patients may move between pathways as their needs change.

The pathways are as follows:

Supported self-management (PIFU): Patient led follow-up where the individual receives support and interventions to empower them to self-manage their health outside of a hospital setting. They receive surveillance tests but do not have routine clinic appointments.

In gynaecology, this pathway is suitable for patients who are clinically disease free and where any consequences of treatment are being managed to a level that allows the individual to live well. If individuals develop problems related to treatment once these are controlled the individual can re-enter a PIFU pathway. If individuals have suspicious symptoms and following investigation no disease is detected, then the individual can re-enter PIFU.

At the present time individuals should remain in PIFU for a period of 5 years.

Hospital led – face-to-face follow up: Clinician led follow up where the individual will receive surveillance tests as per the clinical guidelines. Clinic appointments are scheduled as required and can be face to face or telephone consultations, and with a Doctor or Nurse Specialist.

This arrangement should be reviewed regularly and when appropriate the individual can be transferred to PIFU. Local arrangements as to where follow-up takes place should be considered i.e. following adjuvant radiotherapy people are referred-back to their surgical team for follow-up which can continue following implementation of these guidelines. Individual choice should also be offered as to where this takes place i.e. local hospital or centre.

Supportive/end of life care services: Clinician led with palliative care input as required, when no further treatment options are available, attending hospital appointments is potentially difficult for people. Transfer of care to the G.P. and palliative care services should be discussed and the G.P. made aware of this discussion. Community palliative care teams should be involved with the consent of the individual.

The results will be reviewed by appropriately qualified or trained staff and the patient and GP informed of the results. This information may trigger a recall of the patient back to specialist services as required.

Patients suitable for stratified follow up should be offered a 1:1 appointment with a Cancer Nurse Specialist (CNS) at the end of their primary treatment to explain how stratified follow up works and to ensure the patient knows how to contact the service if there are any concerns or symptoms in between surveillance testing. This could be done at the same time as the end of treatment summary and review of the holistic needs assessment (HNA).

A system must be developed for rapid re-entry of patients to the specialist cancer service as required.

PATIENT SELECTION CRITERIA FOR STRATIFIED FOLLOW UP

Inclusion Criteria:

- Epithelial ovarian cancer stages 1a to 4
- Endometrial cancer

Exclusion criteria:

- Under 18 years at diagnosis
- Patients on clinical trials where the protocol requires clinical review
- Patients whose holistic needs assessment suggests that they are not yet ready to self-manage their aftercare
- Vulval cancer
- Cervical cancer
- Low grade serous ovarian cancer

The option of PIFU should be available for all individuals who are clinically disease free however, this pathway is not suitable for everybody and some may continue to need hospital-based aftercare.

Any individual participating in a clinical trial should be followed-up as per trial protocol.

Following the multidisciplinary meeting (MDT) individuals should be reviewed and made aware of their future management plan. Decisions regarding stratified follow-up can be discussed in the MDT but are only confirmed when a discussion has taken place with individuals. The chosen pathway is then documented in the medical notes and should be communicated to the G.P, preferably via the treatment summary. Regardless of follow-up pathway all individuals should be offered a treatment summary and holistic needs assessment with their CNS or community service if available.

MINIMUM FOLLOW-UP SCHEDULE

Following the end of treatment there will be:

- A review of the holistic needs assessment (HNA)
- A comprehensive information booklet be given to the patient which advises them of their planned follow up, access back into the service and support services available

- Completion of the end of treatment summary clearly stating the method of follow up and sent to the patient and their GP
- Information supplied regarding health and wellbeing
- Confirmation of booking of planned investigations and how results will be received

A minimum follow-up schedule should be agreed and communicated between the specialist team, primary care and the patient. The follow-up schedule may be conducted in the form of telephone clinics or virtual clinics in-place of conventional face-to-face clinics for patients.

Gynaecology Cancer – Epithelial Ovarian Origin

Investigation /Year	0 – 1	1 – 2	2 -3	3 – 4	4 – 5
Clinical review Ovarian stage 1a & 1b	PIFU	PIFU	PIFU	PIFU	PIFU
Clinical review Ovarian stage 1c & 2c	3-monthly nurse led	PIFU	PIFU	PIFU	PIFU
Clinical review Ovarian stage 3 & 4	3-monthly Oncologist / nurse-led follow up	3-monthly Oncologist / nurse-led follow up	Nurse-led follow up / PIFU	Nurse-led follow up / PIFU	Nurse-led follow up / PIFU
Investigation /Year	**0 – 2***		**2 -3**	**3 – 4**	**4 – 5**
Clinical review Ovarian stage 3 & 4 on PARPi*	On treatment protocol led by oncology team (Dr / nurse / pharmacy led). Minimum 3 month		Nurse-led follow up	Nurse-led follow up	PIFU

*NB If a patient completes their PARPi prior to the 4-year follow-up point they can be considered for PIFU in accordance with the non-PARPi stage 3 & 4 follow up

Patients who have Low Grade Serous Ovarian Pathology will be to be referred to the surgical team for follow-up after completion of chemotherapy. If no chemotherapy is given the patient will remain under the care of the surgical team.

See appendix 1 for further information including when the HNA and treatment summaries should be completed.

Gynaecology Cancer - Endometrial Origin

Investigation /Year	0 – 1	1 – 2	2 -3	3 – 4	4 - 5
Clinical review Stage 1A Grade 1 & 2	PIFU	PIFU	PIFU	PIFU	PIFU
Clinical review Endometrial Surgery followed by brachytherapy	PIFU	PIFU	PIFU	PIFU	PIFU
Clinical review Surgery followed by external beam radiotherapy ± brachytherapy ± chemotherapy	PIFU	PIFU	PIFU	PIFU	PIFU
Clinical review Primary radiotherapy / chemo radiotherapy	PIFU	PIFU	PIFU	PIFU	PIFU

For patients whose treatment is palliative, consideration should be given to discharging them back to the care of their GP.

See appendix 2 for further information including when the HNA and treatment summaries should be completed

SURVEILLANCE

All patients following initial treatment for gynaecology cancer will be given information about self-care and surveillance. A list of symptoms that could be a cause for concern and a contact number for the Gynaecology CNS will be given as part of the information pack developed by Trusts and included in a patient's treatment summary.

Patients who contact any member of the specialist team with worrying symptoms will be seen by the appropriate team within two weeks (in line with 2 week wait) and if necessary, the case will be discussed at the MDT meeting.

A treatment summary should be sent to the GP and patient within 6 weeks following primary treatment - surgery, chemotherapy or radiotherapy. Follow up after surgery should focus on post-operative issues, promoting and sustaining recovery (including early detection and management of late effects) and future planning.

DISCHARGE FROM SERVICE

All patients on this pathway will be discharged back to the GPs care at **5 years** (unless they are palliative and may be discharged sooner) and will have to re-access the service via their

GP. Written information will be given to the patient/GP on the patient's treatment summary to advise them regarding this date.

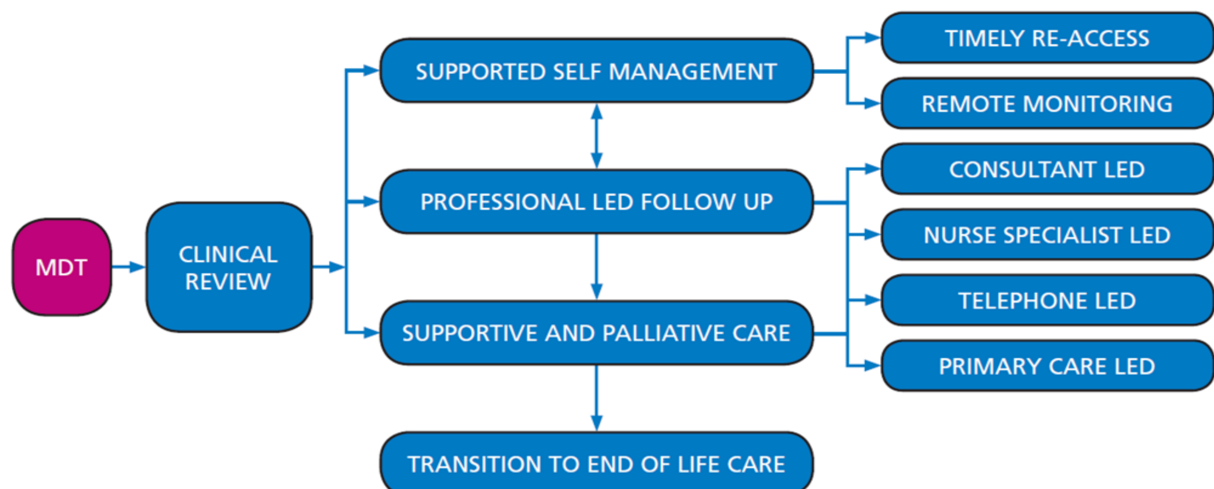
APPENDIX

1.1 CLINICAL RESPONSIBILITIES AND ROLES

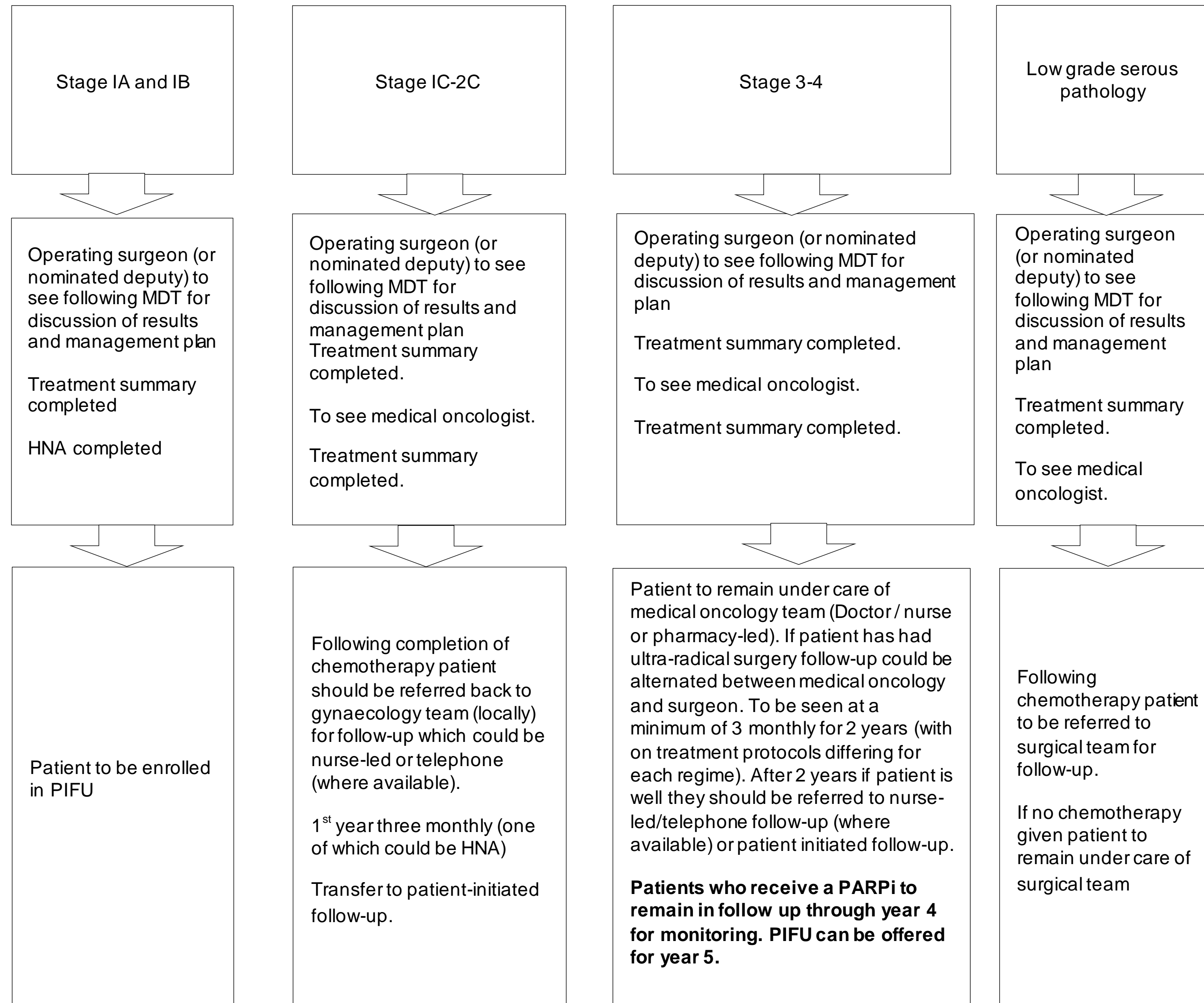
Stratification
The clinical team / consultant is responsible for identifying patients suitable for supported self-management. The decision should be made based on holistic needs assessment, clinical judgement and discussion with the patient, then recorded appropriately within the Trust clinical systems.

Stratified Follow up Consultation
The CNS will manage the stratified follow up consultation. They will ensure that the patient is provided with written information, a treatment summary has been completed and a copy has been sent/given to the patient and sent to the GP. A holistic needs assessment will also be carried out and action taken as necessary. All surveillance and scans should be in place and patients are aware of how results will be received.

Re- access to Services
Patients will receive verbal and written information about how to re access the service if they have a problem or concern at the consultation appointment with the CNS. Patients should contact their clinical team via telephone who will give them verbal advice or arrange a clinic appointment. Patients can also re-access the service via their GP.



1.1 Summary of follow up guidelines – Epithelial Ovarian Cancer



All patients should be offered a holistic needs assessment approximately four weeks after completion of chemotherapy

If patient has surgery alone the assessment should be offered six-weeks post-surgery.

1.2 Summary of follow up guidelines – Endometrial Cancer