1 Foreword

This High Value Pathway for prostate cancer has been developed and produced by clinicians, patients, managers and commissioners from across Yorkshire and the Humber.

Appreciation is expressed to a number of individuals and organisations who contributed significantly to the Steering Group, Clinical Expert Group and the wider stakeholder engagement process, listed in chapter 8.

A special thank you to the patients and carers, who attended the focus groups to share their experiences to help improve the pathway for future patients.

Thank you also to Prostate Cancer UK who have collaborated with us and shared the results of a national cancer awareness survey to inform our recommendations.

Miss Clare Rogers Consultant Breast Surgeon, Doncaster Royal Infirmary and Clinical Network Cancer Lead Clinician South Yorkshire. Also Chair of the Prostate Cancer High Value Pathway Steering Group and the Clinical Expert Group.
The overall aim of this work is to improve cancer outcomes for patients with prostate cancer in Yorkshire and the Humber, by optimising care through a seamlessly delivered High Value Pathway, available to all no matter where they live.

The pathway aims to maximise value that patients derive from their own care and treatment, ultimately improving outcome and experience whilst considering the current and future context, to meet the needs of men and their carers who are diagnosed with and living with prostate cancer.

This pathway provides guidance for those responsible for forward planning cancer services, including CCGs and Trusts, Local Authorities, patients, Sustainability and Transformation Plan Leads and Cancer Alliances. It seeks to describe guiding principles and recommendations not a detailed description of how the pathway is to be delivered.

2.1 Principles and recommendations of the High Value Pathway

- Provide a best-practice pathway for patients with prostate cancer from the point of referral to follow up and then living with and beyond cancer
- Reduce variation in outcomes and access to treatments by ensuring that all patients have access to, and are offered timely referral, diagnosis and optimal treatment and care in line with national clinical guidelines
- Reduce delays in patient care which cross organisational boundaries, by defining clear pathway and decision making points between secondary and tertiary care providers
- Improve patient choice and experience of their cancer care
- Improve quality and efficiency
- Consider how the needs of patients are considered as a whole; integrating cancer care into wider aspects of health and social care

2.2 Scope

This High Value Pathway covers the patient pathway from symptom awareness, referral for investigation to follow up and survivorship interventions and includes services provided at local units and specialist cancer centres. The High Value Pathway does not include end of life care and covers adult patients only.
The recommendations in the pathway are where possible evidence based. Where there is limited or no evidence then clinical consensus has been sought to endorse the best practice that is included. Evidence includes:

- National Institute for Health and Care Excellence (NICE) Prostate Cancer: Diagnosis and Treatment Guidance CG175 (January 2014)
- NHS Five Year Forward View (October 2014)
- NICE: Suspected Cancer: Recognition and Referral Guideline NG12 (Published June 2015)
- NICE Quality Standards QS91 (June 2015)
- Recommendations from the National Prostate Cancer Audit (2014)
- Implementing the Cancer Taskforce Recommendations: Commissioning Person Centred Care for People Affected by Cancer (April 2016)

This pathway document does not seek to replace or override any existing service requirements or clinical guidance, but to enhance cancer care in Yorkshire and the Humber.

The NHS Standard Contract Service Specification for Specialised Kidney, Bladder and Prostate Cancer B14/S/a should be referred to for patients requiring:

- Radical prostatectomy
- Cryoablation/radiofrequency ablation as appropriate.

Plus radical external beam radiotherapy and radical brachytherapy.

The NHS Clinical Commissioning Policy: Robotic-Assisted Surgical Procedures for Prostate Cancer B14/P/a will be referred to for patients requiring this type of surgery.

Patients and carers experience has played an important part in the pathway development and recommendations. This includes literature reviews, assessment of Patient Reported Outcome Measures (PROMS), information from national cancer charities, a Living With and Beyond Cancer workshop organised by Yorkshire Cancer Patient Forum and two local patient focus groups held in 2015. Further detail is included throughout the document and in the supporting information.

The PROMS Quality of Life of Colorectal Cancer Survivors in England report (2015) highlighted a number of elements of care that affect quality of life of people with cancer. (See Figure 2 an adapted tentative model of factors determining the quality of patient experience – in the Supporting Information Pack). Access to aspects of care associated with positive outcomes include timely diagnosis and referral, co-ordinated care, emotional support, patient preparation, sign posting and perceived good aftercare and follow up. Failure to provide these aspects of care have a negative impact on quality of life and can delay the transition to living well beyond cancer. The structural aspects of service delivery include coordinated care across primary and secondary sectors and hospital departments, good communication links, and the provision of effective aftercare. Alongside structural aspects, supportive services to prepare patients for their cancer journey with practical and emotional support are imperative to achieve positive quality of life outcomes for people with cancer.
According to the Office of National Statistics, the UK population is projected to increase by 9.7 million over the next 25 years from an estimated 64.6 million in mid-2014 to 74.3 million in mid-2039. By mid-2039 more than one in twelve of the population is projected to be aged 80 or over. (See Supporting Information Pack –Reference 1)

Nationally, there were 47,300 new cases of prostate cancer in the UK in 2013 and prostate cancer accounts for 13% of all new cases in the UK. (Source: CRUK Prostate Cancer Statistics): (See Supporting Information Pack - Reference 3)

Prostate cancer is the most common cancer diagnosed in men in the UK and is projected to increase

Fig 1 (Cancer Research UK Prostate Cancer Statistics – July 2016)

<table>
<thead>
<tr>
<th>Number of cases</th>
<th>Proportion of all cases</th>
<th>Age at diagnosis</th>
<th>Trend since the 1970s</th>
</tr>
</thead>
<tbody>
<tr>
<td>47,300</td>
<td>13%</td>
<td>70+ years</td>
<td>+ 155%</td>
</tr>
</tbody>
</table>

New cases of prostate cancer, 2013, UK

<table>
<thead>
<tr>
<th>Percentage prostate cancer is of total cancer cases, 2013, UK</th>
<th>Age that more than half of prostate cancer cases are diagnosed, 2011-2013, UK</th>
<th>Prostate cancer incidence rates have increased since the late 1970's, GB</th>
</tr>
</thead>
</table>

The lifetime risk of being diagnosed with prostate cancer is approximately 1 in 8 for white men, 1 in 4 for black men, and 1 in 13 for Asian men. Prostate cancer mainly affects men over the age of 50 and the risk increases with age. However, black men have been shown to be diagnosed with prostate cancer on average five years younger than white men.

Estimated projected figures for the UK by 2030

The numbers of newly diagnosed prostate cancer for the UK is projected to increase to 61,089 by 2030


Prostate Cancer is Projected to Increase in the UK

In Yorkshire and the Humber, there were 3,231 newly diagnosed cases of prostate cancer in 2007 and 4,235 in 2013. Assuming that Yorkshire and the Humber would see a similar increase in prostate cancers as estimated for the UK, we may expect as many as 5,470 prostate cancers by the year 2030.

Fig 3: Prostate Cancer is projected to Increase in Yorkshire and the Humber

Estimated projected figures for Yorkshire and the Humber by 2030

In Yorkshire and the Humber although one and five year survival is higher than the England average and is improving, there are significant differences in survival from prostate cancer.

Nationally, one and five year survival is improving

More than 8 in 10 (84%) men diagnosed with prostate cancer in England and Wales survive their disease for ten years or more (2010-11).

It is expected there will be a corresponding increase in demand for investigations, treatment and drugs and therapies

In Yorkshire and the Humber

Prostate Cancer is Projected to Increase in Yorkshire & Humber

Fig 1 (Cancer Research UK Prostate Cancer Statistics – July 2016)


Fig 3: Prostate Cancer is projected to Increase in Yorkshire and the Humber

Prostate Cancer is Projected to Increase in Yorkshire & Humber

Nationally, one and five year survival is improving

More than 8 in 10 (84%) men diagnosed with prostate cancer in England and Wales survive their disease for ten years or more (2010-11).

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In Yorkshire and the Humber although one and five year survival is higher than the England average and is improving, there are significant differences in survival from prostate cancer.
5 Context

Fig 4 below shows that there were significant differences in survival from prostate cancer across Yorkshire and the Humber (2006-2008 followed up to 2013).

The reasons for this variation are not clear, but it may be that there are differences in the proportion of patients who are diagnosed early, including variation in access and uptake of PSA testing. Differences in the local organisation of urological services and their processes and procedures may also have an impact on survival, but this requires further exploration.

6 High Value Prostate Cancer Patient Pathway

6.1 Prostate Cancer Future High Value Pathway

This diagram overleaf depicts the high level steps, high value recommendations and timelines of a future prostate cancer pathway.

Fig 4: There are significant differences in survival from prostate cancer across Yorkshire and the Humber (NCIN – Public Health England Nov 2015)

There are significant differences in survival for prostate cancer patients across Yorkshire and the Humber (NCIN – Public Health England Nov 2015)

Age Standardised Net Survival for patients diagnosed 2006-2008 (followed up to 2013)
1. Commissioners should consider their current service configuration and capacity plan for the introduction of MRI and (where possible) of mpMRI prior to biopsy.

2. Patients referred for testing by a GP, because of symptoms or clinical judgement, should either be definitively diagnosed with cancer or cancer excluded and this result should be communicated to the patient within four weeks.

3. GPs should consider/facilitate a significant event audit on those patients who are referred from another specialty and any incidental findings or patients undergoing in secondary care.

4. Patients should undergo in secondary care investigations that they are likely to need prior to undergoing a TRUS/Biopsy. The request for stool sample (indicating to the laboratory that it is sepsis) prior to undergoing a TRUS/Biopsy.

5. GPs should consider working with charities, radio, press, TV.

6. Should consider using appropriate communication methods, including rare and unique communities raising awareness of prostate cancer. This includes black men, older men, men with a higher than average risk of prostate cancer. This is in accordance with NICE guidelines. This should be proactive in understanding the needs of men in such communities and identifying the health needs of such communities through active community engagement.

7. GP decision to refer on symptoms and populations which may present with prostate cancer. As agreed by the Yorkshire and the Humber Urology MDTs to adhere to national NHS England Commissioning Guidance for people affected by cancer (as shown in Figure 7).

8. TRUS biopsy clinic or attends for an urgent slot/opd clinic or attends one stop clinic or a one stop appointment via the biopsies clinic.

9. Referral received within 24 hours (Day 1). TRUS biopsy clinic or urgent slot/opd clinic or attends one stop appointment via the biopsies clinic.

10. Investigative results including biopsy results shortly before or at the time of the 2ww referral. This would need local services to be available to review these results.

11. Biopsy. The request for stool sample (indicating to the laboratory that it is sepsis) prior to undergoing a TRUS/Biopsy.

12. Local MDT discussion (may occur with other specialties). The patient will be informed by a Consultant Urologist that they will progress to the appropriate follow up pathway (as described in Figure 6). The patient will be informed by a Consultant Urologist that they will progress to the appropriate follow up pathway (as described in Figure 6).

13. Further investigations &/or specialist MDT.

14. Similarily, where a suspicion of a prostate cancer results from a referral or diagnosis of prostate cancer.

15. Further investigations &/or specialist MDT.

16. commissioners and providers should implement the recovery pack (as listed below): Individuals at low risk of recurrence should be encouraged towards supported self-management. The patient will be informed by a Consultant Urologist that they will progress to the appropriate follow up pathway (as described in Figure 6).

17. Further investigations &/or specialist MDT.

18. commissioners and providers should implement the recovery pack (as listed below): Individuals at low risk of recurrence should be encouraged towards supported self-management.

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6 High Value Prostate Cancer Patient Pathway

6.2 Awareness, signs and symptoms and populations who have an increased risk

In the UK, about 1 in 8 men are likely to get prostate cancer at some point in their lives. Older men, men with a family history of prostate cancer and Black men (1 in 4) are more at risk.

Recommendations:
1. Commissioners and providers should be proactive in understanding and identifying the health needs of their local population, including awareness of prostate cancer signs and symptoms
2. They should commission and provide services to raise awareness of prostate cancer in men who are at (higher than average risk) of prostate cancer (this includes black men, older men and men with family history of prostate cancer)
3. Commissioners should consider raising awareness of prostate cancer in the seldom heard communities (Black and ethnic communities, people with learning disabilities, older people, people with mental health problems) through active community engagement.
4. Commissioners and providers should consider using appropriate communication methods, including social media and mainstream media (radio, press, TV)
5. Commissioners and providers should consider working with charities and third sector organisations to promote and empower men at risk of prostate cancer
6. Consider further research to understand the needs of men in Yorkshire and the Humber

Good practice:
In areas of England where prostate cancer is a priority and there are higher populations of Black and Ethnic Minorities a range of approaches have been commissioned and are described in the All Parliamentary Stakeholder Group Report (2012) which include:
- Building capacity within communities through training and support to community health champions
- Raising awareness of signs and symptoms and provide advice and support
- Setting up a prostate clinic in a community setting (Newham Community Prostate Clinic)

Leeds City Council Public health team commissioned Black Health Alliance to deliver prostate cancer awareness sessions. Through groups and one to one sessions, participants reflected and reported greater understanding of the signs and symptoms of cancer. Feedback from group sessions also highlighted that fear surrounding a cancer diagnosis and embarrassment were key barriers to seeking further support.

Evidence:

We would like health organisations to be more creative in raising awareness of prostate cancer with communities; for example, information and events in football grounds and to use different formats e.g. DVDs, social media

(Focus group member)

6.3 Referral

Referral from Primary Care

Recommendations:
7. Before primary care referral, the referring GP should assess and record performance status of the patient to aid with triage and assessment in secondary care
8. A patient who presents with symptoms suggestive of prostate cancer should be referred to a secondary care team specialising in the management of the disease in accordance with NICE referral guidelines for suspected cancer
9. GPs should consider/facilitate a request for a Prostate Specific Antigen (PSA) test for all men over 50, especially if they have a family history, including all black men aged over 45
10. Local services should be available to provide all GPs with access to TRUS biopsy/outpatient appointment via the two week wait referral process
11. GPs should consider asking the patient to provide a stool sample, (indicating to the laboratory that is prostrate biopsy) in order to establish if they have fluoroquinolone resistant flora. (which could lead to sepsis) prior to undergoing a TRUS/Biopsy (the request for stool sample should be done at the same time as the 2ww referral and should not delay the 2ww referral). This would need local agreement.
12. Patients on a 2 week wait urgent suspected prostate cancer referral should be offered a leaflet explaining the 2 week wait process and the investigations that they are likely to undergo in secondary care

Prostate Cancer Risk Management Programme (Public Health England 2015)

The NHS Prostate Cancer Risk Management Programme (PCRMP) provides GPs and primary care professionals with information to counsel asymptomatic men aged 50 and over who ask about prostate specific antigen (PSA) testing for prostate cancer.
- A summary sheet is available that helps GPs give clear and balanced information to asymptomatic men who ask about prostate specific antigen (PSA) testing.
- The PSA test is available free to any well man aged 50 and over who requests it.
- GPs should not proactively raise the issue of PSA testing with asymptomatic men.
- GPs should use their clinical judgement to manage symptomatic men and those aged under 50 who are considered to have higher risk for prostate cancer.

Evidence:
NICE Prostate Cancer: Diagnosis and treatment guidance CG175 (January 2014)
An urgent referral for prostate cancer should be made for the following –

NICE: Suspected Cancer: Recognition and Referral Guideline NG12 Published June 2015

Refer men using a suspected cancer pathway referral (for an appointment within 2 weeks) for prostate cancer if their prostate feels malignant on digital rectal examination (new 2015)
Consider a prostate-specific antigen (PSA) test and digital rectal examination to assess for prostate cancer in men with:
- Any lower urinary tract symptoms, such as nocturia, urinary frequency, hesitancy, urgency or retention or
- Erectile dysfunction or
- Visible haematuria (new 2015)

Refer men using a suspected cancer pathway referral for an appointment within 2 weeks for prostate cancer if their PSA levels are above the age-specific reference range (new 2015)
Consider alternative contributing factors that may influence an individual's PSA range

(Focus group member)
Below please find further details of the prostate cancer risk management programme from the following link: https://www.gov.uk/guidance/prostate-cancer-risk-management-programme-overview

**Good practice:**

**Suspected Urological Cancer 2ww Fast Track Top Tips - (Y&H CN GP Cancer Lead Forum)**

All referral forms should include prompts for the referring GP to cover the following points with the patient prior to the referral, ideally in the form of tick boxes which require confirmation of discussion with the patient before the referral can be processed:

- Has it been explained to the patient that this referral is for investigations that could lead to a cancer diagnosis?
- Have you checked that the patient will be available in the next 14 days to attend an appointment?
- Have you provided the patient with further information about the appointment (a leaflet is recommended)
- Check patient’s contact details are up to date

**6.4 Emergency presentations and incidental findings**

Emergency presentations include: an emergency route via A&E, emergency GP referral, emergency transfer, emergency consultant outpatient referral or emergency admission or attendance

**Recommendations:**

13. Patients should be referred from emergency departments to the relevant multi-disciplinary Urology team which may be a tertiary centre dependant on the local configuration of services. If patients present at a later stage requiring emergency surgery, patients should be referred to the specialist MDT team at the appropriate point of the agreed best practice pathway.

14. Similarly, where a suspicion of a prostate cancer results from a referral or review for other reasons e.g. outpatients or incidental findings - the patient should be referred to the relevant multi-disciplinary Urology team for onward management, in line with agreed best practice.

15. GPs should carry out Significant Event Audits on those patients who are diagnosed with cancer as an emergency admission

**Evidence:**

10% of prostate cancer patients in the Yorkshire and the Humber Clinical Network presented through an emergency route on their way to be diagnosed with cancer care during 2006-2013 (NCIN Routes to Diagnosis). This is 1% higher than the England average of 9%.

**We would like clear written and verbal information on the choice of treatments available and the likely side effects**

(Focus group member)

**6.5 Diagnosis and staging**

**Recommendations:**

16. Urology Services across Yorkshire and the Humber should use the age specific reference range for PSA values when testing for prostate cancer (as shown in Table 1). As agreed by the Yorkshire and the Humber CN Prostate Cancer Steering Group in 2016

17. Urology MDT teams, whilst complying with current NICE guidelines regarding MRI for suspected prostate cancer, should be encouraged to move towards multi-parametric MRI (mpMRI) prior to biopsy in the next few years. When the results of the Prostate MR Imaging Study (PROMIS) clinical trial are published there will be further evaluation of the role of mpMRI prior to biopsy.

18. Commissioners and providers should assess their current pathway and capacity plan for the introduction of MRI before biopsy

19. Urology MDTs should work jointly with their Microbiologists to minimise infection rates and consider regular use of rectal swabs/stool culture prior to TRUS biopsy

20. Providers should carry out an annual audit on infection after biopsy.

21. Patients referred for testing by a GP, because of symptoms or clinical judgement, should either be definitively diagnosed with cancer or cancer excluded and this result should be communicated to the patient within four weeks.

22. Urology MDT’s to consider the patient’s physiological age rather than their chronological age

23. Men with prostate cancer have a discussion about treatment options and adverse effects with a named nurse specialist.

24. Men with prostate cancer to have access to decision tools to support choice of the best treatment option

25. Men with prostate cancer to be given detailed written information about treatment options and adverse effects

26. Urology MDTs to ensure complete and accurate data is submitted to the Cancer Outcomes and Services Dataset (COSD) and the National Prostate Cancer Audit (NPCA) as required

The following PSA ranges have been agreed by the Yorkshire and the Humber Clinical Network Prostate Cancer Steering Group, and represent clinical consensus across the region.

Table 1: Age specific reference ranges for PSA values agreed by the Yorkshire and the Humber Clinical Network Prostate Cancer Steering Group (2016)

<table>
<thead>
<tr>
<th>Age specific reference ranges for PSA values</th>
<th>&lt;</th>
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</thead>
<tbody>
<tr>
<td>40-49 years</td>
<td>2.5 ng/ml</td>
</tr>
<tr>
<td>50-59 years</td>
<td>3.0 ng/ml</td>
</tr>
<tr>
<td>60-69 years</td>
<td>4.0 ng/ml</td>
</tr>
<tr>
<td>70-79 years</td>
<td>5.0 ng/ml</td>
</tr>
</tbody>
</table>

**Evidence:**

NICE Prostate Cancer: Diagnosis and Management Guideline (CG 175) published January 2014
### 6.6 Treatment

**Recommendations:**

27. Patients should have access to a Clinical Nurse Specialist (CNS) with uro-oncology background.

28. Patient access to a surgeon, CNS & oncologist to support treatment decision making should be offered.

**Evidence:**

NICE Prostate Cancer: Diagnosis and Management Guideline (CG 175) published January 2014

### 6.7 Managing adverse effects of radical treatment

**Recommendations:**

29. Men with prostate cancer to have early and ongoing access to a specialist continence service, erectile dysfunction services, lymphoedema service and psycho-sexual counselling.

**Evidence:**

Managing adverse effects from radical treatment in the NICE Prostate Cancer: Diagnosis and Management Guideline (CG 175) published January 2014

**We would like further support from health professionals and others to look at our health needs after treatment** *(Focus group member)*

### 6.8 Follow-up and living with and beyond cancer

**Recommendations:**

30. Yorkshire and the Humber Urology Teams to adhere to national NHS England Commissioning Guidance for people affected by cancer, as shown below.

31. At diagnosis, men with prostate cancer should, if clinically appropriate, be assigned the relevant risk stratified follow up pathway (as described in Figure 6). The patient will be informed by a Consultant Urologist that they will progress to the appropriate follow up pathway after a certain period of time has elapsed, or on completion of treatment.

32. Commissioners and providers should review existing resource commitment and adopt and implement risk stratified follow up for stable prostate cancer (as described in Figure 7).

**Evidence:**

Managing adverse effects from radical treatment in the NICE Prostate Cancer: Diagnosis and Management Guideline (CG 175) published January 2014

**Active Surveillance patients would only be placed on a risk stratified follow up pathway if they have moved from Active Surveillance to Watchful Waiting.**

33. Individuals at low risk of recurrence should be encouraged towards supported self-management.

34. Commissioners and providers should implement the recovery pack by 2020 (as listed below):

- Holistic Needs Assessment and care planning at key points of the care pathway
- A treatment summary completed at the end of each acute treatment phase, sent to patient and GP
- A Cancer Care Review completed by GP or practice nurses to discuss the person’s needs
- A patient education and support event, such as a Health and Wellbeing Clinic to prepare the person for the transition to supported self-management which should include advice on healthy lifestyle, financial and benefits advice, plus physical activity.
NHS providers should ensure the availability of personal support services including cancer information and advice centres, sexual function and continence advice and psychological counselling should be improved.

Access to a local prostate support group should be offered, which can provide a supportive forum to share information and experiences with other men and their carers.

Information and support services available for carers should also be clearly explained.

Commissioners and providers to work towards implementation of the positive factors determining the quality of patient experience diagram, (as described in figure 2 in the Supporting Information Pack).

**Evidence:**
Follow up guidance from the NICE Prostate Cancer: Diagnosis and Management Guideline (CG 175) published January 2014 (see supporting information pack).

Commissioning Person Centred Care for People Affected by Cancer (NHS England April 2016)


**Good practice:**
- Prostate Cancer Follow Up Service Specification: Wakefield CCG – included in the Supporting Information Pack
- Shared Care pathways: Wakefield CCG – included in the Supporting Information Pack
- Community pathways: HEY Trust – included in the Supporting Information Pack
- Follow Up Prostate Cancer Pathway: Leeds Teaching Hospitals NHS Trust – The Urology Team at Leeds have developed a number of evidence based risk stratified pathways of follow up care for prostate cancer patients, which are currently under review. When the pathways have been reviewed and updated they will be available for information on the Yorkshire and the Humber Clinical Network website.

**Cancer Care Review Template**
The Macmillan primary care community has worked with the main GP IT system providers, INPS, SystmOne and EMIS, to develop CCR templates - similar to those for other chronic disease to ensure the consistency and quality of the review.

**Cancer Care Review – Insight, Opportunities and Top Tips**
The Clinical Network alongside the GP Leads Forum and the Yorkshire Cancer Patient forum have developed an insight, opportunities and top tips document focusing on the Cancer Care Review.

The aim of the document is to illustrate the evidence and benefits of conducting a Cancer Care Review, plus it offers practical guidance on carrying out the Cancer Care Review.

The document is located on the Yorkshire and the Humber Clinical Network website [here](#).
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Dr Jennie Lawrence
GP Advisor for Macmillan Cancer Support, NHS Scarborough and Ryedale CCG

Miss Kate Linton
Consultant Urologist, Chesterfield Royal Hospital NHS Foundation Trust

Ms Lisa Marriott
Cancer Network Manager, Yorkshire and the Humber Clinical Network

Dr Louise Merriman
GP Cancer Lead, NHS North Derbyshire CCG

Mrs Angela Millett
Quality Improvement Lead (Cancer), Yorkshire and the Humber Clinical Network

Dr Susan Morgan
Consultant Histopathologist, Sheffield Teaching Hospitals NHS Foundation Trust

Dr Abdul Mustafa
GP Cancer Lead, NHS Wakefield CCG

Miss Clare Rogers (Chair)
Consultant Breast Surgeon, Doncaster & Bassetlaw Hospitals NHS Foundation Trust

Mr Matthew Simms
Consultant Urologist, Hull & East Yorkshire Hospitals NHS Trust

Ms Fiona Stephenson
Quality Improvement Manager (Cancer), Yorkshire and the Humber Clinical Network

Mr SK Sundaram
Consultant Urologist, The Mid Yorkshire Hospitals NHS Trust

Mrs Lisa White
Urology Oncology Clinical Nurse Specialist, Leeds Teaching Hospitals NHS Trust

Mrs Sandra Wilby
Administration and Support Officer, Yorkshire and the Humber Clinical Network

8.3 Stakeholders

Airedale NHS Foundation Trust
Barnsley Hospitals NHS Foundation Trust
Bradford Teaching Hospitals NHS Trust
Calderdale and Huddersfield NHS Foundation Trust
Chesterfield Royal Hospital NHS Foundation Trust
Doncaster and Bassetlaw Hospitals NHS Foundation Trust
Harrogate and District NHS Foundation Trust
Hull and East Yorkshire NHS Foundation Trust
Leeds Teaching Hospitals NHS Foundation Trust
Mid Yorkshire Hospitals NHS Trust
Northern Lincolnshire and Goole Hospitals NHS Foundation Trust
Rotherham NHS Foundation Trust
Sheffield Teaching Hospitals NHS Foundation Trust
York Teaching Hospitals NHS Trust

NHS Airedale, Wharfedale and Craven CCG
NHS Barnsley CCG
NHS Bassetlaw CCG
NHS Bradford City CCG
NHS Bradford Districts CCG
NHS Calderdale CCG
NHS Doncaster CCG
NHS East Riding of Yorkshire CCG
NHS Greater Huddersfield CCG
NHS Hambleton, Richmondshire and Whitby CCG
NHS Harrogate and Rural District CCG
NHS Hardwick CCG
NHS Hull CCG
NHS Leeds North CCG
NHS Leeds South and East CCG
NHS Leeds West CCG
NHS North East Lincolnshire CCG
NHS North Kirklees CCG
NHS North Lincolnshire CCG
NHS Scarborough and Ryedale CCG
NHS Sheffield CCG
NHS Rotherham CCG
NHS Vale of York CCG
NHS Wakefield CCG

Doncaster Metropolitan Borough Council

Prostate Cancer UK
Macmillan Cancer Support
Public Health England
Yorkshire Cancer Patient Forum
Yorkshire and the Humber Clinical Network