VICTORIAN TUMOUR SUMMITS PROJECT

Quality of life in prostate cancer: understanding models of care

Project report

Victorian Integrated Cancer Services

Cancer Council Victoria

VICTORIA State Government

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Table of Contents

Table of Figures

Executive summary

The Victorian Prostate Cancer Summit held in Melbourne in May 2016 was an opportunity for clinicians from various disciplines to prioritise actions that could reduce unwarranted variations in practice and improve cancer outcomes for men with prostate cancer in Victoria. Addressing quality of life (QoL) issues was highlighted as an important variation in practice and a challenge for clinicians and health services. The summit proposed that a more coordinated approach between service providers was needed to address the unmet needs of men with prostate cancer. This report aims to build a common understanding of enablers and barriers to addressing this challenge to inform collective action.

Prostate cancer patients can experience debilitating side effects from their treatment that can have ongoing physical, emotional, psychological, practical and financial impacts. In Victoria different integrated models of care typically evolved through opportunities to secure start-up funding for specialist nursing roles such as the Prostate Foundation of Australia nurses or nurse practitioners. This project has uncovered several examples of integrated models of care that feature nursing roles that are specifically tasked with identifying and addressing patients' QoL needs, which are described in detail in this report. However, due to a limited scope of this investigation it was not possible to include all examples of models of care that may exist in Victoria or to recommend a solution to the challenge of service coordination. Systematic mapping of service levels and referral pathways for QoL in prostate cancer across Victoria is needed to inform subsequent action.

The greatest enabler to developing and sustaining integrated models of care in prostate cancer are passionate health professionals committed to providing the best care to their patients. Another significant advantage is the investment of the not-for-profit sector in funding nursing roles and programs that continue championing QoL needs. Organisations such as the Movember Foundation and Prostate Foundation of Australia play a critical role in developing and sustaining integrated models of care. The Prostate Cancer Outcomes Registry, as its coverage continues expanding, is also well positioned to inform local health services and teams about the levels of their patients' reported needs.

The optimal care pathways provide a framework for collective action and create an opportunity for focused statewide effort in this area. Through a coordinated statewide program Integrated Cancer Services are in a position to support local teams and hospitals to map existing services and referral pathways both within hospitals and in the community. This data is needed to evaluate service use and to inform subsequent optimisation of care. Support for men with prostate cancer through a systematic, coordinated approach will ultimately ensure a more equitable access to information, education and interventions for all Victorians touched by prostate cancer.

Introduction

The Victorian Prostate Cancer Summit held in Melbourne on 25 May 2016 gathered 71 participants from across Victoria to identify actions aimed at reducing variations in practice and improving outcomes for men with prostate cancer. Multidisciplinary clinicians and representatives from government and the not-for-profit sector highlighted six potential opportunities for statewide action. Addressing the quality of life (QoL) needs of men with prostate cancer through a coordinated approach that uses existing and new integrated models of care was prioritised for post-summit action.

The purpose of this report is to build a common understanding of the issue of unmet QoL needs drawing on existing evidence and views from key clinical groups and organisations. The report offers an overview of the prevalence of QoL needs in prostate cancer, the level of care to be expected and information on existing models of care in Victoria. Exemplar models are presented as well as clinical and non-clinical perspectives on barriers and enablers to achieving integrated models of care. In this report a 'model of care' is broadly defined as the way healthcare services are delivered and organised and an 'integrated model of care' is defined as a service that is organised to address both a patient's medical and QoL needs.[1]

The report is based on a mixed-methods inquiry conducted between August 2016 and March 2017. The inquiry captured mainly information about first-service touch points around the time of diagnosis, describing models of care based predominantly in the acute setting. The summit participants were invited to contribute their views via a survey, individual interviews and focus groups on a broad topic of barriers and enablers to addressing QoL needs for men with prostate cancer. A list of participants is provided in Appendix 1. We acknowledge that many services including allied health, community or primary care-based services were not described in detail.

Prevalence of QoL needs

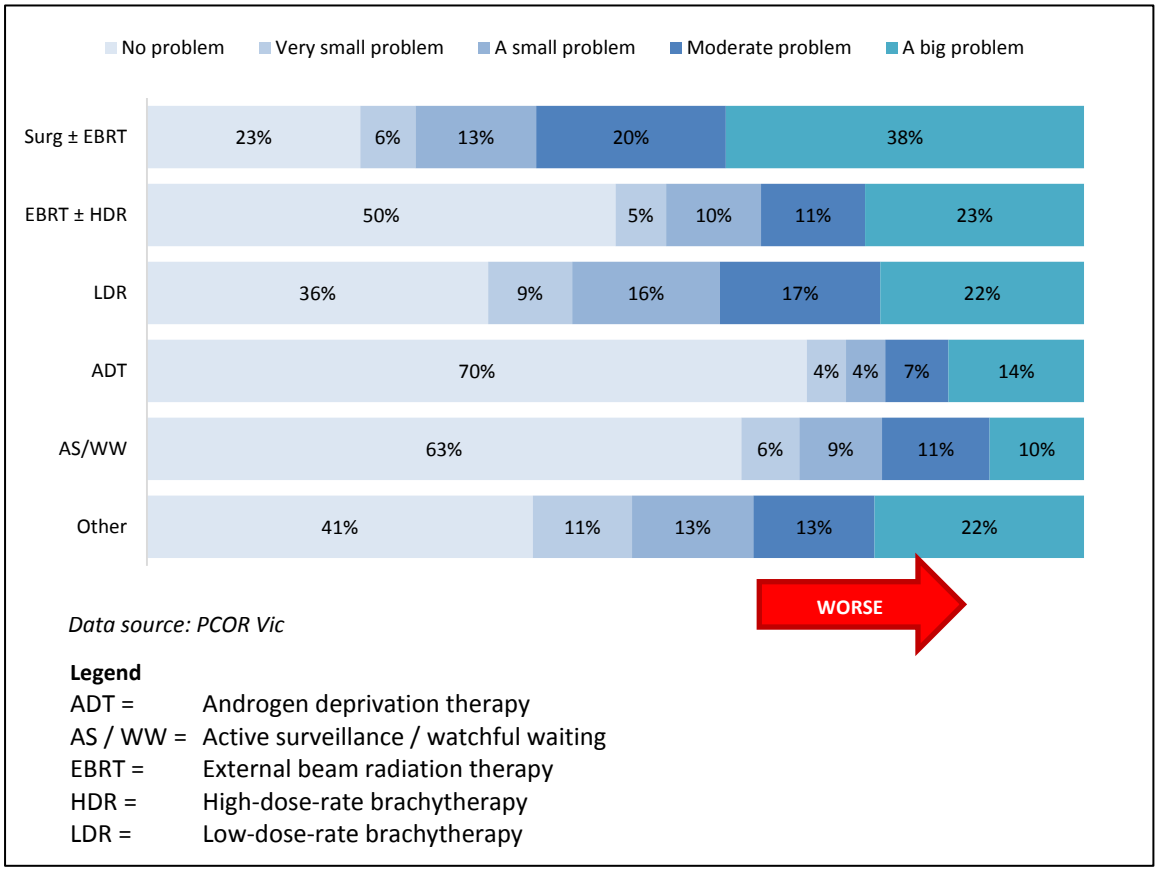
Understanding the prevalence of QoL needs in prostate cancer is a complex equation. In spite of declining incidence, prostate cancer remains the most commonly diagnosed cancer in Victoria with 4,355 cases confirmed in 2015.[2] At the same time the increasing survival rate is increasing the prevalence of prostate cancer (relative survival in Australia has increased from 58 per cent to 92 per cent since 1982[3]). Depending on a stage of disease at diagnosis, men with prostate cancer report unmet needs ranging from fear of recurrence, fatigue, distress, anxiety, depression, erectile dysfunction and urinary incontinence after treatment and psychological concerns associated with a potentially life-threatening condition.[4]

Patterns of prostate cancer treatment impact on the prevalence of QoL needs. It is well documented that psychological distress, sexual dysfunction and incontinence are the most common long-term effects of prostate cancer treatment.[5] Patterns of treatment are changing due to the increasing uptake of treatment surveillance protocols for localised disease. For the period of 2008–2011, and in a cohort of 2,724 men with prostate cancer, around 64 per cent received radical treatment (44 per cent prostatectomy and 20 per cent external beam radiation therapy).[6] A more recent analysis of the linked Victorian Cancer Registry, Victorian Admitted Episode Data and Victorian Radiotherapy Data Sets for 2011–2013 (n = 12,662) shows a lower utilisation of radical treatments to around 50 per

cent.[7] While less radical treatment may eventually result in lower prevalence of QoL needs, this will only occur for a group of men diagnosed with localised disease.

Several other factors contribute to men experiencing variable long-term physical and psychosexual effects of cancer treatment. These include socioeconomic disparities between regional and metropolitan areas, disease presentation and access to care.[5] Men in regional areas of Victoria are more likely to present with symptoms and have more advanced disease,[7,8,9] an important finding to consider when seeking a system-wide solution to address unmet QoL needs. The Prostate Cancer Outcomes Registry (PCOR) ANZ collects outcomes data for around 78 per cent of men diagnosed with prostate cancer in Victoria.[10] The registry uses the prostate-specific QoL questionnaire called EPIC-26 to obtain patient-reported levels of general health and specific levels of urinary, bowel and sexual bother. This data is collected over the phone at 12 months post active treatment. Sexual health is the leading QoL issue reported by men with prostate cancer. The 2015 PCOR Vic report indicates that sexual bother is more frequently reported as a moderate or big problem (see Figure 1) when compared with urinary- and bowel-related issues two years post prostatectomy or radiotherapy treatment.[11] High prevalence of sexual health-related issues has been reported in other research, with around 47 per cent of men with prostate cancer identifying sexual health issues as an unmet need.[12]

Figure 1: Sexual bother (EPIC-26), 2009–2014 (*n* = 7,558)



Data source: PCOR Vic

Legend

ADT =	Androgen deprivation therapy
AS / WW =	Active surveillance / watchful waiting
EBRT =	External beam radiation therapy
HDR =	High-dose-rate brachytherapy
LDR =	Low-dose-rate brachytherapy

Optimal care pathways

Optimal care pathways (OCPs) describe what care patients should expect to receive from diagnosis through to survivorship or end-of-life care. Developed through extensive clinical consultations, these documents aim to assist clinicians and health services in providing quality care across the whole cancer care journey.[13]

The OCPs state that all members of the multidisciplinary team have a role in providing supportive care. In terms of the QoL needs, the OCPs highlight the importance of assessing supportive care needs at every step of the cancer journey, setting an expectation that referrals will be made to appropriate health professionals or organisations for interventions to address the needs. The OCP for prostate cancer highlights that routine and systematic supportive care needs screening of the patient and family, using a validated screening tool, is important. The OCP provides a list of common indicators in patients that may require referral for support (see Box 1). Based on identified needs a list of health professionals and organisations that should be considered for referrals is provided in Box 2.

Box 1: Common indicators in patients with prostate cancer that may require referral for support

- Changes in continence
- Altered sexual health or performance
- Poor performance status
- Breathlessness
- Pain
- Difficulty managing fatigue
- Difficulty sleeping
- Malnutrition (as identified using a validated malnutrition screening tool or presenting with weight loss)
- Distress, depression or fear
- Living alone or being socially isolated
- Having caring responsibilities for others
- Cumulative stressful life events
- Existing mental health issues
- Aboriginal or Torres Strait Islander status
- Being from a culturally or linguistically diverse background

Box 2: List of health professionals and organisations to be considered for referring to

- Community-based support services (such as those provided by state and territory Cancer Councils)
- Dietitian
- Exercise physiologist
- Genetic counsellor
- Nurse practitioner and/or specialist nurse
- Occupational therapist
- Peer support groups (contact the Prostate Foundation of Australia on 1800 22 00 99 or Cancer Council on 13 11 20 for more information)
- Physiotherapist
- Psychologist or psychiatrist
- Social worker
- Specialist palliative care
- Speech therapist

Models of care

Once men are diagnosed with prostate cancer there is an expectation that they will have access to an integrated team approach.[13] This approach entails medical, nursing and allied health professionals considering all relevant treatment options and collaboratively developing an individual treatment and care plan for each patient.[13] The core disciplines comprising prostate cancer multidisciplinary teams are, in alphabetical order: medical oncologist, nurse (with appropriate expertise), pathologist, radiation oncologist, radiologist/imaging specialist and urologists. Additional expertise may be required from a number of other health professionals to ensure all clinical and psychosocial aspects of care are provided.[13]

The core disciplines meet regularly to plan treatment and individualised care plans. In Victoria there are 19 uro-oncology multidisciplinary meetings (MDMs) based mainly in public health services (see Appendix 2). More MDMs may be located in the private sector given that around 60 per cent of surgical care for prostate cancer is provided in the private sector.[7] While all team members play a role in supporting men with prostate cancer in their QoL needs, the presence of specialist nursing roles such as prostate cancer specialist nurse (PCSN) and nurse practitioners was noted. Twenty such roles exist currently in Victoria and they are further described below.

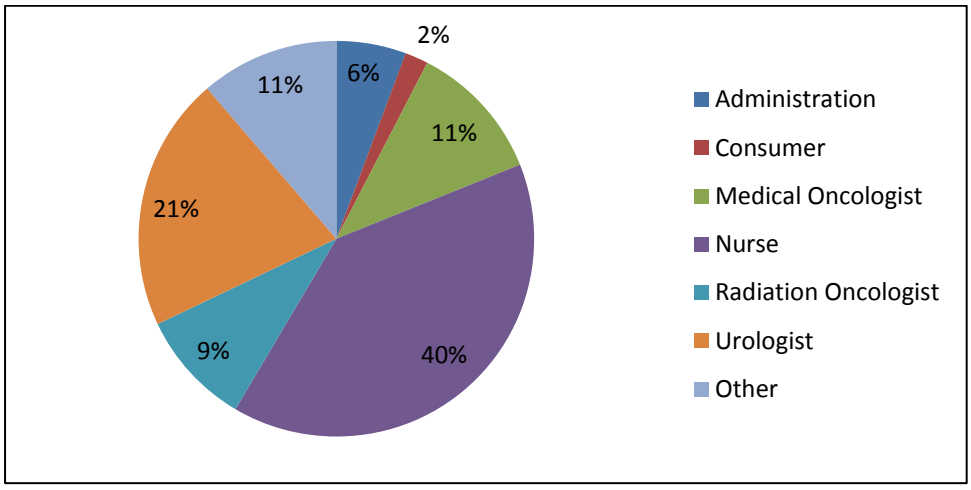
The Prostate Cancer Specialist Nursing Program, through the Prostate Foundation of Australia (PCFA), funds the placement of PCSNs in a variety of Australian healthcare settings in partnership with health service providers. Many Victorian healthcare services were successful in obtaining this funding through a submission process. These roles provide patients with information, education, coordination of services and psychosocial support.[14] Implementation of these roles began in 2012, and there are now PCSN roles located at 10 sites across Victoria. The PCSNs follow a specific framework of competencies set out by the PCFA.

Nurse practitioner roles specialising in urology, incontinence and prostate cancer exist within some healthcare services in Victoria. Nurse practitioners provide similar education and psychosocial support to the PCSNs. In addition, nurse practitioners' scope of practice includes prescribing medications, ordering diagnostic tests, following up test results, complex clinical assessment, referring to other medical services, arranging admissions and clinical procedures. The Department of Health and Human Services' Nursing and Midwifery Workforce Unit offers scholarships to support Victorian nurses to undertake a master's program that will lead to endorsement as a nurse practitioner. The department also offers funding (up to $30,000) to develop nurse practitioner-based models of care that will improve outcomes for patients and access to timely care.

Perspectives on integrated models of care

The following sections summarise qualitative data collected via stakeholder consultations. Systematic data collection to obtain a representative sample of clinicians was outside the scope of the inquiry. Therefore, all findings are offered as general insights into a perceived level of integrated models of care in Victoria. An online survey was distributed to summit attendees and clinicians involved in uro-oncology MDMs via eight Integrated Cancer Services (ICS) and the Cancer Council of Victoria Urology Clinical Networks. Fifty-three responses were obtained. The majority of survey respondents were either specialist medical practitioners (41 per cent) or nurses (40 per cent). Figure 2 offers a breakdown of respondents by role. Eighty three per cent (44) respondents indicated they worked in both regional/rural and metro settings and 42 per cent (22) worked exclusively in metro settings.

Figure 2: Survey respondents by role



The survey results are summarised in Box 3.

Box 3: Survey results

- 22 per cent (12) of survey respondents thought their healthcare service offered an integrated model of care that effectively supported the QoL issues of men with prostate cancer and did not need any improvement.
- An additional 51 per cent (27) reported their model of care is integrated but improvement was needed.
- Over 50 per cent (29) of clinicians identified having access to a social worker to support men with prostate cancer.
- Over 60 per cent (33) had access to either a PCFA nurse or a nurse specialist.
- 18 per cent (10) had access to a nurse practitioner role that supported men with prostate cancer.
- Only 10 per cent of respondents (5) reported having no access to services to support men with prostate cancer.
- 90 per cent of survey respondents (48) agreed that the development of an effective integrated model of care to address the QoL issues of men with prostate cancer should be a priority for their health service.

Medical perspectives

In relation to integrated models of care doctors viewed their role as the first point of contact for all medical and QoL issues, especially at the initial diagnosis and assessment phase. Doctors considered nurse specialists play an important enabling role in providing information, psychological support and symptom management.

A prostate cancer nurse specialist provides a point of contact for patients and doubles as basic counsellor. (Urologist)

In my private rooms I have a nurse specialist who has time to properly integrate and address quality-of-life issues and bring any problems to my attention. (Urologist)

Delegation to a nurse to identify QoL issues may only occur if a nurse specialist or practitioner role is available.

If used wisely, a well-trained nurse practitioner acts as a prostate cancer nurse, a social worker, a psychologist, a registrar. The nurse practitioner has time to take calls, discuss issues and side effects of treatment. This frees up time to see other patients. (Oncologist)

The support services that individual doctors choose to refer to can be shaped by ease of access. Referral pathways for QoL interventions seem to be influenced by a doctor's professional networks and the availability of in-house services (e.g. an erectile dysfunction outpatient clinic). Medical practitioners suggested that one type of integrated model of care may not work for the whole state,

and local needs must be considered when implementing a model of care to address the QoL needs of men with prostate cancer.

Nursing perspectives

Identifying and addressing patients' QoL needs were highlighted as core aspects of all specialist nursing roles. All interviewed nurses reported providing education, information about diagnosis and side effects, psychological support and referrals to services. The majority of these roles were located in acute care settings. There was only one PCFA nurse based in a community health care centre. All nurses agreed their involvement with the patient was the most frequent at diagnosis and the beginning of the treatment stage. Patients were often followed up until six months post diagnosis and encouraged to contact the nurse specialist up to two years after the treatment. However, the frequency of contact with patients decreases considerably one year after the treatment. Patients were often referred to their general practitioner or community for follow-up.

The uro-oncology team's understanding of the nursing roles was reported as critical to the efficiency and effectiveness of nursing service. All existing nurse specialist roles evolved according to the demands of the organisation funding it and were mostly developed from existing nurse consultant roles. The interviewed nurses attributed some of the issues around unclear role delineation to the expectation already set in place before a nurse specialist (PCFA role or nurse practitioner role) was implemented. PCFA nurses who had not previously had a nurse consultant role reported fewer issues with enacting their PCFA role.

> *My role was encouraged by medical staff to focus on the sexual health issues of patients to increase the medical staff's capacity to see more complex patients.* (Nurse)

Creating a strong business case, securing sustainable funding and ongoing organisational support were all reported as important enablers to developing both PCFA nursing and nurse practitioner roles. Having clear policies, guidelines and role expectations provides a successful framework for integrating these roles into existing multidisciplinary teams. Securing support from teams, especially those that include a urologist, was seen as crucial to creating an integrated model of care. Enablers specifically for nurse practitioner candidates were access to scholarships and appropriate remuneration once accredited.

> *One of the best things we did was map services in our region to build a business case. This provided us with a clear direction and enabled us to develop a concise role description and gain management support.* (Nurse)

On the flipside of enablers, key barriers to these nursing roles included skill and commitment to preparing a business case, access to ongoing funding and access to referral services to address identified QoL needs. For nurse practitioners, remuneration for study including backfill and lack of ongoing sustainable funding affected job security. Most nurses highlighted access to services in the community to support sexual health issues of men to be limited, leaving gaps in the quality of care they provide.

Referral pathways between acute services and primary care are still very ad hoc. To be able to provide men with an effective model of care we must do this better to ensure that men's survivorship issues are adequately followed up. (Nurse)

I think the most rewarding part is that our roles allow us to really identify men's issues, but sometimes when it comes to sexual health issues I just don't have anyone to refer to. The lack of resources is really frustrating. (Nurse)

Integrated Cancer Services' perspectives

Five ICS managers were interviewed to obtain a broader perspective on a whole-system approach to barriers and enablers to addressing QoL needs for men with prostate cancer. The ICS bring together clinicians, consumers and service providers who have the ability to influence the development and implementation of evidence-based care. The role of the ICS is to promote system integration across organisational boundaries and to encourage collaborative approaches to evidence-based service development.[15] Effective communication processes between acute, primary and community care to support coordinated care and formalised referral processes were highlighted as enabling integrated models of care. Unclear funding agreements, confused governance and lack of sustainable funding for nursing roles have been suggested as barriers to achieving effective models of care. Territorial issues between clinicians and services could lead to fragmented referrals and services. Sustainable funding was considered important to support the ongoing development of PCFA and nurse practitioner roles. However, lack of research evidence to support the financially sustainable implementation of PCFA and nurse practitioner roles was also revealed as an obstacle when facilitating a submission for funding. It was suggested that consumers' level of health literacy could also be a barrier to accessing support services. It has been documented elsewhere that men with prostate cancer can be reluctant to access psychological or psychosexual support.[16] Engaging with local health services to advocate for creating effective models of care and supporting the development of business cases were also viewed as a key enabling role for the ICS.

Exemplar models of care

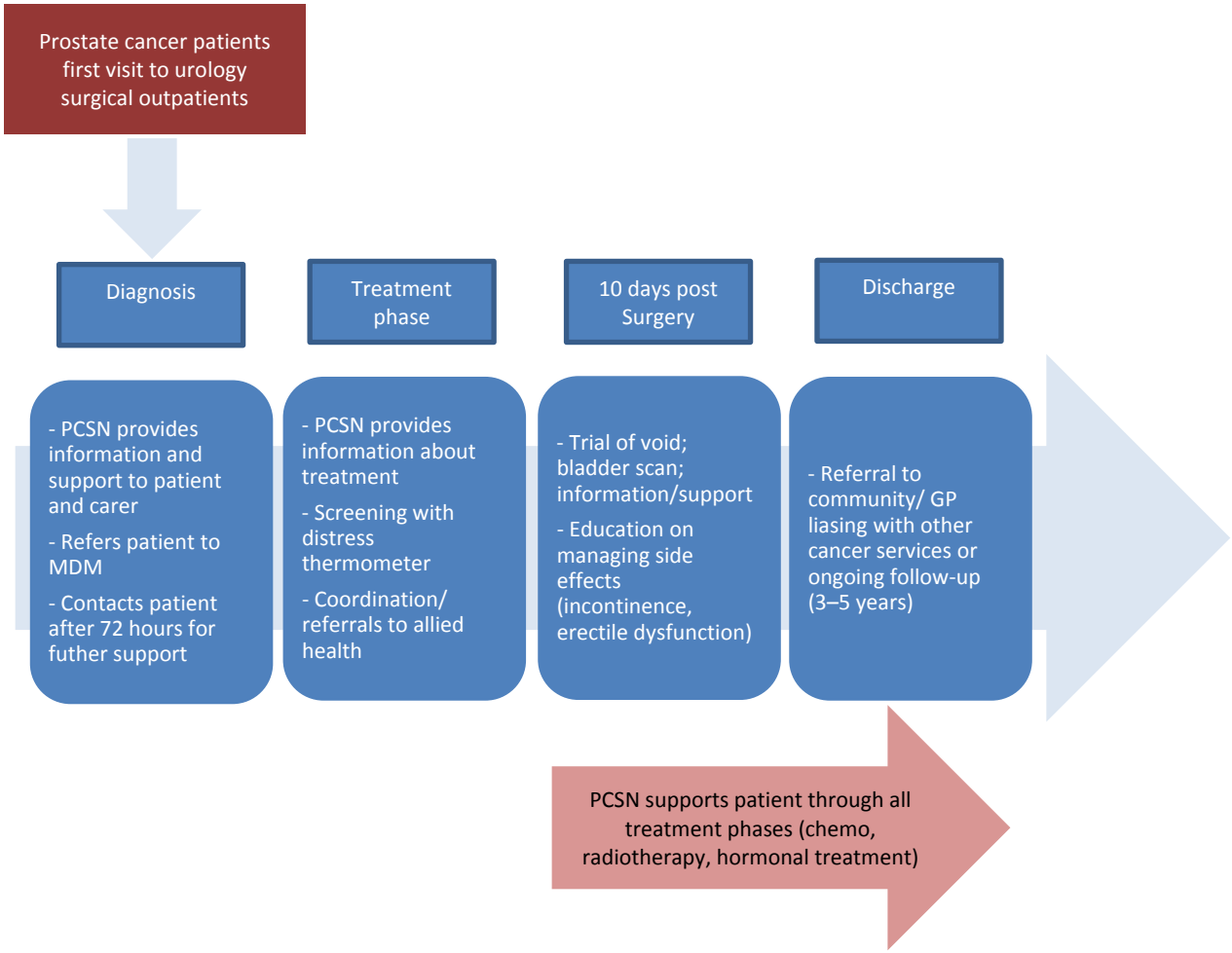
The way each service is organised into a model of care seems to have evolved organically from the needs of local clinical teams (i.e. volume of service) combined with opportunities to secure start-up funding (i.e. PCFA funding rounds). The most common feature of these models of care is the inclusion of a specialist nursing role. Most services are located in the acute hospital setting; however, there are several examples based in the community including a shared care model between acute and primary care services. By definition, in a shared care model the clinicians share equal responsibility in caring for individual patients; they also share information including results from tests and knowledge to monitor and treat the patient. The survivorship project for prostate cancer patients using a shared care model is being piloted at Western Health and North Western Melbourne Primary Network. Twenty survey respondents offered examples of effective integrated models of care within their health services. Three examples were chosen to describe in this report on the basis of their comprehensive service coverage, patient capture and innovation. Further interviews were conducted with three services to gather more detailed information provided below.

Barwon Health – the prostate cancer specialist nurse role

The PCSN role within Barwon Health works flexibly to respond to the service's and patients' needs. This role offers a comprehensive review across all treatment modalities and the opportunity to see the majority of prostate cancer patients who attend the service for treatment. Referrals come from all service areas; however, the majority of patients are linked into the model of care at diagnosis through surgical services. The PCSN nurse provides information on strategies to manage side effects of treatment (incontinence, erectile dysfunction), support and referrals to services across all stages of treatment. Patients who have completed their treatment are linked with their general practitioner and community services and may be followed up three to five years post treatment by the PCSN. When discharged from the service patients are still encouraged to contact the PCSN if issues arise.

The Barwon Health model is depicted graphically in Figure 3.

Figure 3: Tasks and responsibilities of the Barwon PCFA role



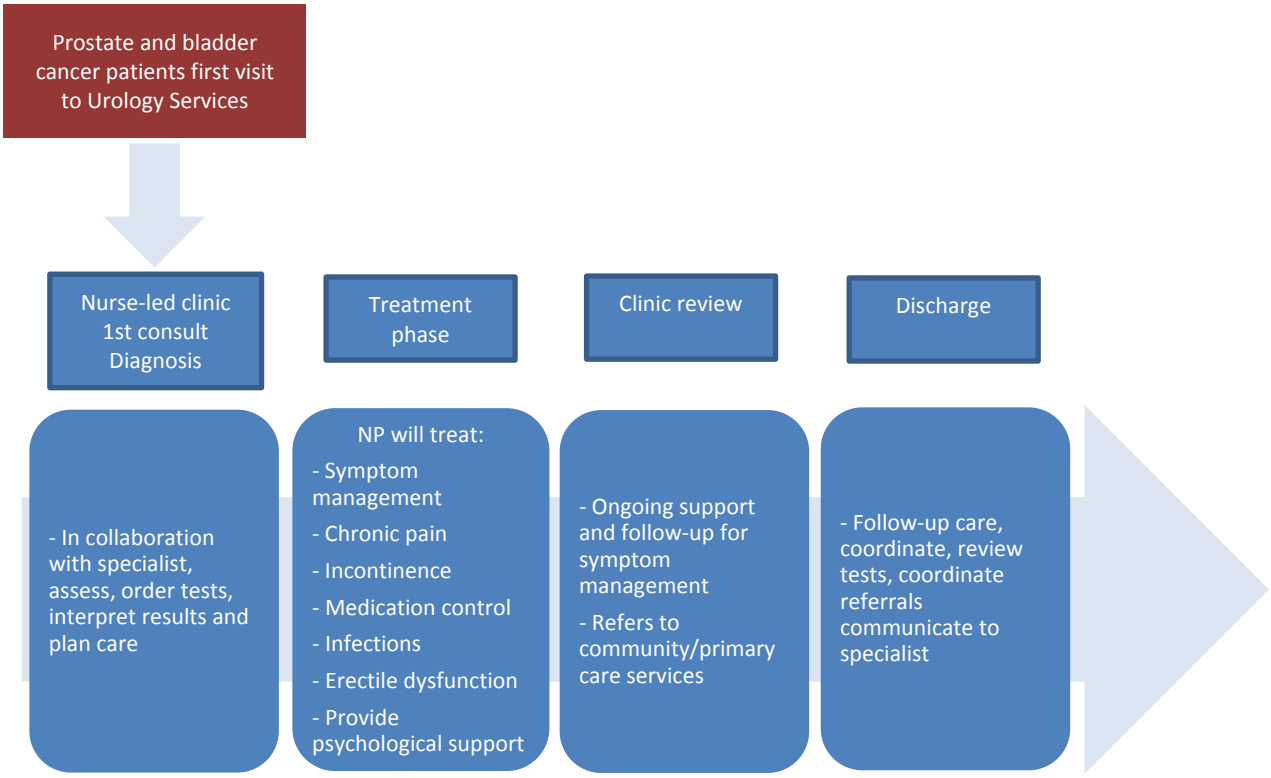
Bendigo Health – urology/oncology nurse practitioner

Key components of the Bendigo Health nurse practitioner role include coordination and initiation of diagnostics for the identified patient group, monitoring ongoing clinical issues associated with the patient's diagnosis and prescribing from a formulary. The role works closely with urologists in the

region and covers both public and private settings. The nurse practitioner and urologists have reported a high level of satisfaction with how the role is functioning across settings and within the uro-oncology team.

The Bendigo Health model is depicted graphically in Figure 4.

Figure 4: Tasks and responsibilities of the Bendigo Health nurse practitioner role



National demonstration project: TrueNTH

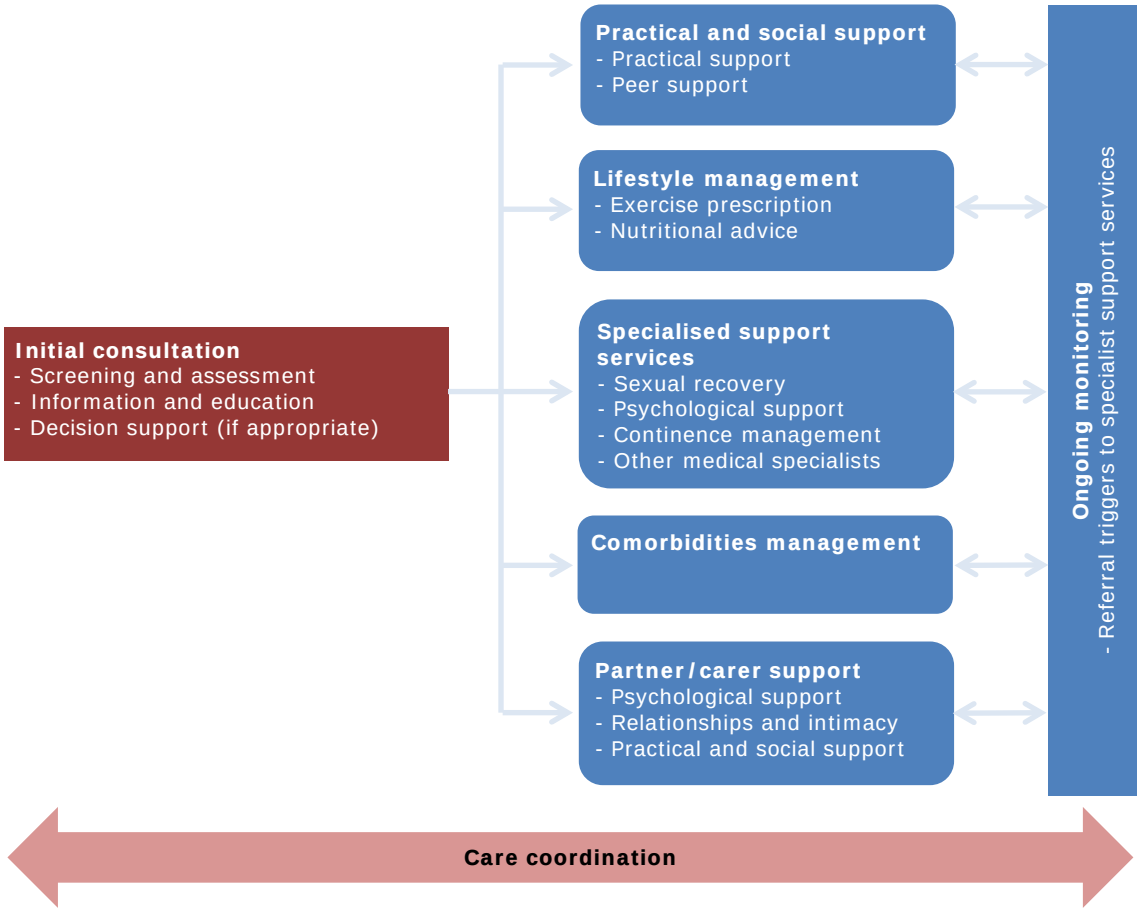
The Movember Foundation, in collaboration with key stakeholders, developed an integrated model of care that incorporates interventions based on the type of a need men with prostate cancer are likely to experience at different points in their pathway and severity of their disease. The model includes the following interventions:

- decision support to guide men in deciding which treatment option to take using an evidence-based decision-making tool
- lifestyle management such as:
  - exercise prescription to improve general fitness delivered by an exercise physiologist
  - nutritional advice from a dietitian
  - pelvic floor muscle training prescribed by a suitably qualified physiotherapist
- specialised clinical support for sexual recovery, psychosocial support and continence management.

The model was used to develop a program called TrueNTH. After a successful pilot, TrueNTH was extended in 2016 into a national demonstration project. Demonstration sites for Victoria are Austin

Health and Barwon Health. The model involves a nurse coordinator linking men into various services via web-based technologies and remotely using telehealth consultations. The program aims to address the key QoL needs men experience after prostate cancer treatment such as anxiety, depression, fatigue, sexual dysfunction and incontinence.[4] The pathway of care is presented in Figure 5.

Figure 5: TrueNTH pathway



Summary

The significant level of unmet QoL needs for men with prostate cancer is well documented in the literature and supported by clinician reports in this inquiry. According to Victorian data collected via the PCOR (ANZ), sexual health issues are the most reported QoL need at 12 months after treatment. Interestingly, this inquiry indicates a potential gap in access to interventions addressing sexual health needs.

The publication of the OCP for men with prostate cancer sets an expectation about the level of care patients should be receiving not only in relation to their medical but also their supportive QoL needs. The OCP places an emphasis on a systematic identification of supportive care needs and equitable access to intervention-type services via referrals. In terms of different integrated models of care, most have evolved from local health service conditions and opportunities to secure start-up funding. Several exemplar models of care were identified and described in the report.

A team approach is critical to delivering an integrated model of care that is effective. From a medical perspective, easy access to specialist nursing roles and allied health professionals is important to ensure appropriate use of medical time and skill. There is still a small proportion of health professionals who report lack of access to QoL services for their patients. All integrated models of care identified through this inquiry featured a specialist nurse role and were mostly located within the acute sector. Clear role guidelines and expectations provide a successful framework for developing prostate cancer specialist nursing roles. Securing support from teams, especially those with urologists, was seen as crucial for integrating nursing roles into existing multidisciplinary teams. Sustainable funding for these roles has been most strongly identified as a barrier to effective models of care.

Many clinicians agreed that developing an integrated model of care should be a priority for their health services. Identifying service gaps and solutions at the local level was considered as the most efficient approach in building an integrated model of care. There are opportunities for better coordination between acute and community settings in relation to accessing QoL types of interventions. Referral pathways already exist between acute and community care; however, these are not always formalised. A global solution to support the QoL issues of men with prostate cancer may not address each region's specific needs. ICS are in position to support health services and local teams to map existing QoL services and referral pathways they commonly use. This information is essential to forming solutions that could result in a more coordinated approach to addressing unmet QoL needs across Victoria.

Next steps

Is the current approach to addressing the QoL needs of Victorian men with prostate cancer coordinated? A more comprehensive investigation is required to truly answer this question. However, this inquiry has indicated that the level of reported unmet need is significant for health services and teams to ask themselves if more could be done. There is an appetite for focusing collective effort to create equitable access to QoL services irrespective of where patients live or receive their care. A clinical dialogue about variations in care started at the summit and will continue with a renewed focus on the OCP. The Department of Health and Human Services prioritised the OCP for men with prostate cancer as one of the two priority pathways for implementation in 2017–2018 for Victoria. This means that all eight ICS and six Primary Health Networks will be supporting a focused effort to address unwarranted variations in care identified at the summit. Commencement of this activity is planned for October 2017. This creates a unique opportunity for cross-sector collaboration.

Appendix 1: List of participants

Participants		
Focus group		
Name	**Role**	**Organisation**
Ann Marie Alexander	Director of Nursing	Prostate Cancer Foundation Australia
Carla D'Amico	PCFA/Prostate Specialist Nurse	Austin Health
Christopher McNamara	PCFA/Prostate Specialist Nurse	
Judy Cornick	PCFA/Prostate Specialist Nurse	Bairnsdale Regional Health Service
Jude Mays	PCFA/Prostate Specialist Nurse	
Judy Jeffery	PCFA/Prostate Specialist Nurse	
Diane Pead	PCFA/Prostate Specialist Nurse	
Trish Husband	PCFA/Prostate Specialist Nurse	
Kenneth Burston	PCFA/Prostate Specialist Nurse	
Jo Hiscock	PCFA/Prostate Specialist Nurse	
Cindy Ogluszko	PCFA/Prostate Specialist Nurse	Footscray Hospital
Chris Redpath	PCFA/Prostate Specialist Nurse	Barwon Health
Chris Britton	PCFA/Prostate Specialist Nurse	Riverina Cancer Care Centre (NSW)
Individual interviews		
Name	**Role**	**Organisation**
Sue Riches	ICS Program Manager	BSWRICS
Kathy Simons	ICS Program Manager	NEMICS
Kathy Quade	ICS (Acting) Program Manager	WCMICS
Illana Solo	ICS Strategic Manager	LMICS
Chris Packer	ICS Strategic Manager	HumeRICS
Lucy Cuddihy	Executive Director	Barwon Health
Dan Schiftan	Senior Policy Advisor	Nursing & Midwifery Workforce, DHHS
Kathryn Schubach	Uro-oncology Nurse Practitioner	VCCC/Peter Mac
Stuart Willder	Men's Health Nurse Practitioner	Western District Health Service
Chris Redpath	PCFA/Prostate Specialist Nurse	Barwon Health
Carla D'Amico	PCFA/Prostate Specialist Nurse	Austin Hospital
Luke Derriman	Urology/Continence Nurse Consultant, Nurse Practitioner Candidate	The Alfred
Dave Gray	Urology Nurse Practitioner	Prostate Cancer Centre
David Heath	Uro-oncology Nurse Practitioner	Bendigo Health
Kelly Koschade	Prostate Cancer Nurse Specialist (palliative)	Latrobe Regional Hospital
Chris Britton	PCFA/Prostate Cancer Care Coordinator	Wagga Wagga Community Health Service
Judith Mayes	PCFA/Prostate Specialist Nurse	Bairnsdale Regional Health Service
Cyril Dixon	Project Lead	TrueNTH
Prostate summit clinical working party contributors		
Name	**Role**	**Organisation**
Prof. Jeremy Millar	Director of Radiation Oncology	Alfred Health/Monash University
Prof. Damien Bolton	Director of Urology Surgery	Austin Health/University of Melbourne
Prof. Ian Davis	Medical Oncologist	Eastern Health/Monash University
A/Prof. Declan Murphy	Consultant Urological Surgeon	Epworth/VCCC
Dr Keen-Hun Tai	Radiation Oncologist	VCCC
A/Prof. Justin Tse	Director of Medical Student Education	St Vincent's Clinical School
Prof. Mark Frydenberg	Urological Surgeon	Monash Medical Centre

Appendix 2: List of nurse roles and MDMs by ICS and health service

Integrated Cancer Service	Role	Health service	MDM
Barwon South Western Regional ICS	PCFA Nurse	Barwon Health	Yes
	Urology Nurse Practitioner	Western District Health	Yes
Gippsland Regional ICS	PCFA Nurse	Bairnsdale Regional Health Service	Yes
	PCFA Nurse	Latrobe Regional Hospital (Palliative Care)	No
Grampians Regional ICS	PCFA Nurse	Ballarat Health Services	Yes
Hume Regional ICS	PCFA Nurse	Goulburn Valley Health, Shepparton	Yes
		Albury/Wodonga North East Health	Yes
Loddon Mallee ICS	PCFA/Urology Nurse Practitioner	Bendigo Health	Yes
	PCFA Nurse	Mildura Base Hospital	No
North Eastern Melbourne ICS	PCFA Nurse	Austin Health	Yes
		Epworth Hospital	Yes
	Urology Nurse Specialist	North Eastern Urology, Heidelberg	Yes
	Urology Nurse Specialist	North Eastern Urology, Heidelberg	
		Northern Health	Yes
Southern Melbourne ICS	PCFA Nurse	The Bays Hospital Mornington	Yes
	Urology Nurse Specialist	Casey/Moorabbin Hospital	Yes
	Urology Candidate Practitioner	Casey Hospital	Yes
	Urology Nurse Practitioner Candidate	The Alfred	Yes
Western & Central ICS	PCFA Nurse	Footscray Hospital	Yes
	Urology Nurse Practitioner	VCCC/Peter Mac	Yes
	Urology Nurse Practitioner	Prostate Cancer Centre/RMH	Yes
		St Vincent's Hospital	Yes

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