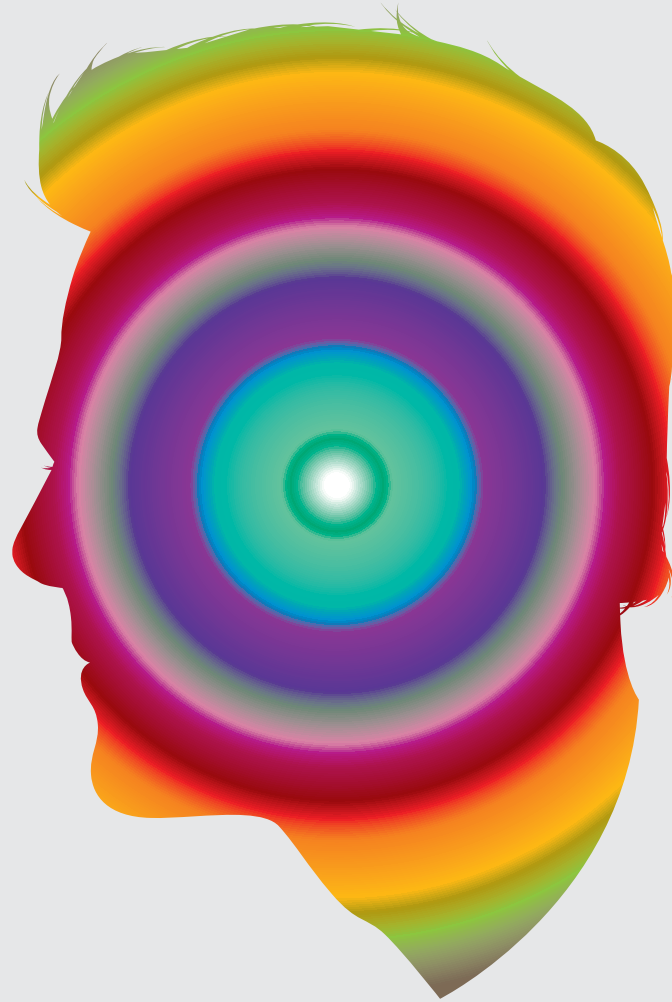


Delivering Healthy Ambitions Better for Less



Overview.

There is increasing demand for follow up care following cancer diagnosis and treatment.

Current models of follow up care do not always comply with clinical guidance and good practice, are costly and do not meet patient expectations.

A new model has been implemented for breast cancer follow ups that offers good clinical care, high levels of patient satisfaction and significant financial savings. This model may have other applications where the potential exists to improve quality and reduce cost.

Why cancer follow ups?

There are 2 million people in the UK living with or beyond a cancer diagnosis.

This figure is likely to increase by around 3% each year due to the aging population and improving care.

As the number of survivors increase, so do the numbers of patients needing follow up. There is increasing evidence that current follow up strategies do not address the needs of patients or their physicians.

What is the challenge?

The 2002 Improving Outcomes Guidance for Breast Cancer suggested a total of 3 years of clinical follow up. This was rejected by most clinicians on the grounds that endocrine therapy was usually given for five years and therefore treatment had not finished until year five. The 2009 NICE Guidance on Early Breast Cancer removed the recommendation on the length of follow up.

Evidence compiled by NICE suggests that appropriately placed GPs and breast care nurses can offer the same reassurance in a non-acute setting if clear guidelines for follow-up can be given, and if assurances are given that patients will be seen urgently by the specialist on an open access basis.

Currently the cancer networks have agreed follow up protocols, for example North Trent's state that 'As a minimum, follow-up should be offered to early stage breast cancer patients in moderate and poor prognostic groups on a 6 monthly basis for 2 years with extended coverage for younger patients, then annually up to 5 years, and in excellent and good prognostic groups on an annual basis for up to 5 years with extended coverage for younger patients'.

All clinical follow up takes place in secondary care and is performed by 'an appropriately trained individual' that varies between the different hospitals in the region. Patients also have a yearly mammogram for a minimum of 5 years. Mammography appointments do not necessarily coincide with clinical visits.

How could we deliver better for less care?

The breast teams were asked to review current follow up practices to develop a new model that ensures:

- a) Patients obtain appropriate follow-up, investigations and holistic support in a convenient setting
- b) Compliance with NICE Guidance for breast cancer follow up and established best practice where available.
- c) Reduction in cost to the NHS of breast follow up.

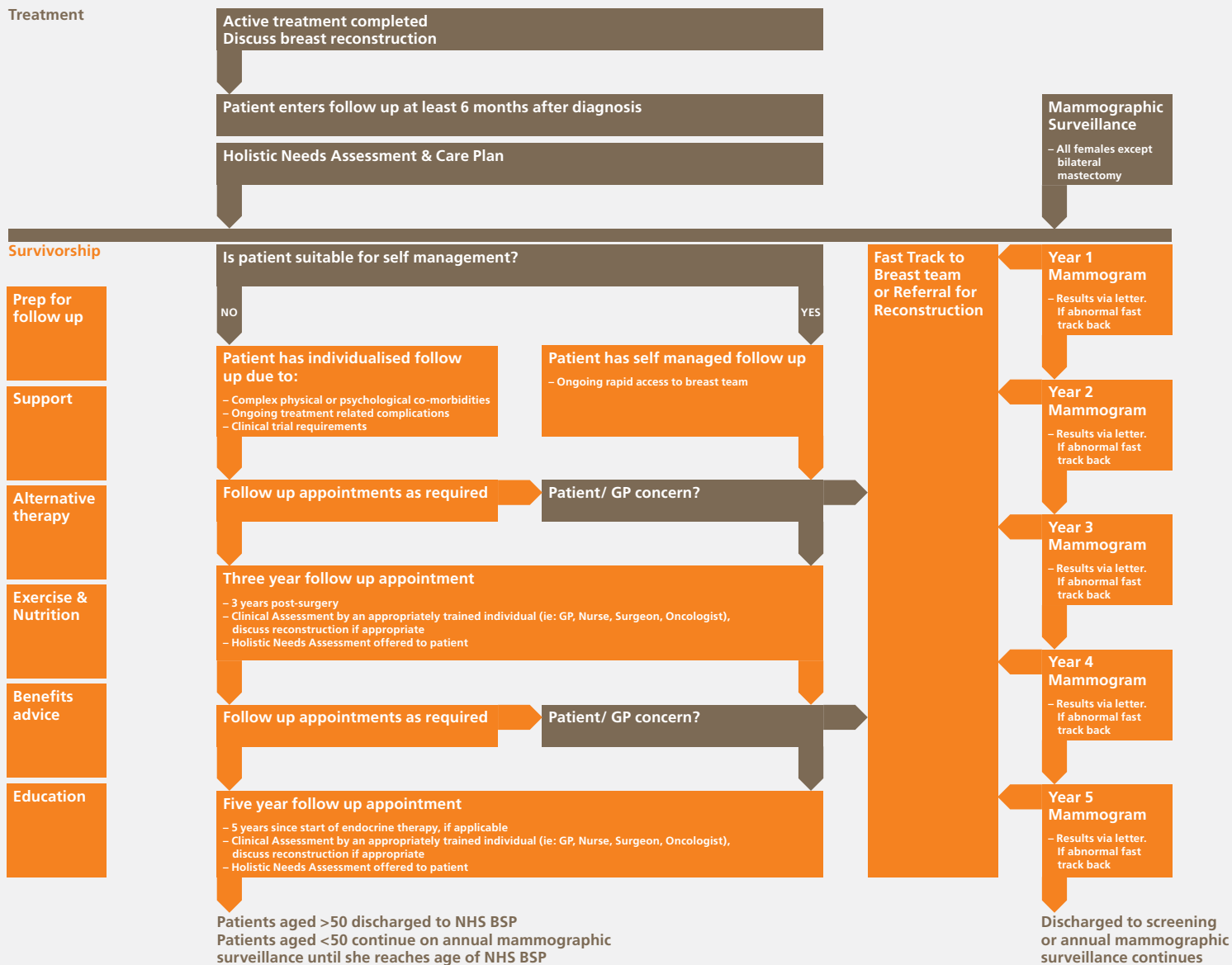
Once the breast teams had developed a new follow up model, the pathway was further developed with input from clinicians, patients and commissioners, to focus on:

- educating and empowering patients in their disease management
- providing adequate and timely support
- preventing unnecessary hospital attendances.

A new model

The result was the development of a patient-led, self-managed follow up programme where scheduled follow up visits were reduced from anywhere between 5 and 12 appointments to just 3. Efficiency has been increased by streamlining the appointments to coincide with mammographic screening and with the 3 and 5 year endocrine treatment decision-making appointments.

Figure 1. Breast Cancer Follow Up Pathway (North Trent Cancer Network)



Implementation

- Empowering patients through self-management

The majority of recurrences of breast cancer are detected by the patient outside of their scheduled follow up appointments, and so it follows that patients should be equipped with the skills to detect changes and be empowered to act upon them accordingly. Patients with ongoing treatment related complications, or with physical or psychological co-morbidities may be less able to self manage and so an individualised follow up pathway runs alongside the self-managed follow up pathway to provide additional clinical support to this patient group

- Educational Preparation

Clinical intentions of follow up do not match patient expectations. An initial follow up interview with the patient at least 6 months post diagnosis will provide the opportunity for patients to discuss their expectations, develop self management skills, and allow a holistic needs assessment to be completed

- Holistic Needs Assessment

A holistic needs assessment will be conducted prior to the patient entering follow up. This tool will help clinicians to assess the patient's suitability to self-manage. It will also help to identify patient needs and facilitate the development of an action plan to address them appropriately

- Supportive Events

A range of projects that support the survivorship agenda will be the 'backbone' of the new follow-up pathway. The projects will provide a range of supportive, holistic and complementary services that provide individualised support for patients along their cancer journey. The projects are brought together in regular events in each locality, where patients receive the latest information and access relevant services at a time when they require them. The events cover the following as a minimum:

- Finances/Benefits
- Nutrition/Exercise
- Fatigue
- Pain
- Lymphodemia

The content of the events will develop over time according to local needs and preferences, and as a result of the holistic needs assessment process that will identify what supportive services patients require.

Patient benefits

In areas where care is coordinated and patients are supported to self-manage, unplanned and emergency admissions have been reduced. Further, where people are well supported the number who can return to work is increased, leading to a positive impact on self-esteem, finances and contribution to society. Benefits for patients include:

- Empowerment
- Reduction in stress associated with follow up attendances
- Reduce costs to patient (travel and time).

Financial benefits

The average savings to PCTs in Yorkshire & the Humber over a 5 year time period are estimated to be around £175,000 per PCT. This figure only accounts for savings as a result of reducing outpatient appointments through the use of the self-managed follow up programme.

Whilst additional financial benefits such as reductions in unplanned and emergency admissions have been identified at sites implementing the approach, we are currently unable to estimate the magnitude of these savings. There were approximately 25,000 emergency admissions relating to breast cancer in England in 2008/09 at an average emergency admission cost of £1,400. The average annual cost of these admissions to the NHS in Yorkshire & the Humber is £3.5m, a total of over £18.2m over 5 years.

The National Cancer Survivorship Initiative (NCSI) are further exploring evidence of the reduction of emergency and unplanned admissions as a result of self-management .

Figure 2. Savings per PCT

PCT	Savings per PCT					Total
	Year 1	Year 2	Year 3	Year 4	Year 5	
Barnsley PCT	2,063	21,908	22,347	33,136	33,799	113,253
Bradford & Airedale Teaching PCT	3,761	39,939	40,738	60,407	61,615	206,459
Calderdale PCT	1,510	16,041	16,362	24,262	24,747	82,922
Doncaster PCT	2,502	26,567	27,099	40,182	40,986	137,336
East Riding of Yorkshire	3,192	33,895	34,573	51,266	52,291	175,217
Hull Teaching PCT	2,025	21,506	21,936	32,527	33,177	111,170
Kirklees PCT	3,230	34,298	34,984	51,875	52,913	177,300
Leeds PCT	5,990	63,610	64,882	96,209	98,133	328,824
N.E. Lincolnshire Care Trust Plus	1,371	14,555	14,846	22,015	22,455	75,242
N. Lincolnshire PCT	1,427	15,160	15,463	22,929	23,387	78,366
N. Yorks & York PCT	7,555	80,230	81,835	121,347	123,774	414,741
Rotherham PCT	2,229	23,671	24,145	35,802	36,518	122,365
Sheffield PCT	4,399	46,713	47,647	70,652	72,065	241,476
Wakefield District PCT	2,642	28,053	28,614	42,430	43,278	145,016
NHS Yorkshire & The Humber	43,893	466,147	475,470	705,038	719,139	2,409,687
PCT average						172,120

Assumptions used to estimate PCT savings:

- Pre-intervention all high risk patients (80%) had 2 visits in their first 2 years in follow-up then 1 visit annually up to year 5, low risk patients are assumed to have 1 annual visit for 5 years. (In some organisations trusts were found to have up to 4 visits per year for high risk patients in their early years in follow up, this analysis may therefore underestimate such savings)
- After implementation of new models of care, self care patients (85% of cases) are assumed to have 1 visit every other year and complex cases continue to have 2 visits in first 2 years and 1 thereafter
- Each outpatient appointment is assumed to cost £76
- The annual death rate of patients on the follow-up programme is assumed to be 4% per year; the number of new patients entering follow up grows at 2% per year.

Key contacts

Clinical

Clare Rogers
Consultant Surgeon and Breast NSSG Chair
clare.rogers@dbh.nhs.uk

Sheryl Warttig
Cancer Service Improvement Manager
North Trent Cancer Network
sherylwarttig@nhs.net

Strategy

Tim Barton
Strategy Lead, NHS Yorkshire and the Humber
tim.barton@yorksandhumber.nhs.uk

Economic Modelling

Helen Mercer, Economist
NHS Yorkshire and the Humber
helen.mercer@yorksandhumber.nhs.uk

Better for Less briefings

All NHS Yorkshire and the Humber Better
for Less briefings are available from:

www.healthyambitions.co.uk/betterforless