Business planning and commissioning

Hazel Brodie, University of Southampton

Liz Price, Transforming Cancer Services Team, London

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Objective

In this session participants will learn about the key steps involved in implementing stratified follow up – including working with Executives and Commissioners to secure investment. Participants of this session will identify key common barriers to securing investment and will discuss ways to overcome these (including the development of a benefits realisation plan).

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Group Discussion (10 – 15mins)

What feels impossible?

5 minutes discussion on tables

Feedback two points from each table

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Benefits realisation in acute led stratified follow up

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Benefits

- Supported self-management
- Remote monitoring
- Primary care
- Evidence

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The opportunity cost of inaction

If we understand the predicted benefits, we can articulate the benefits that are not realised as a result of delayed implementation or inaction.

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Benefits of Supported Self-Management

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Remote monitoring refers to the monitoring of a health condition outside of conventional clinic appointments. In the case of cancer follow-up, patients will continue to have surveillance tests (e.g. blood tests, Xrays, scans) and may be asked to fill out patient reported outcome measure questionnaires (PROMs) or health needs assessment questionnaires to monitor symptoms and wider needs.

Supported Self-Management involves the systematic provision of supportive interventions and education to increase patient's knowledge, skills and confidence to manage their health problems. Key skills include self-appraisal of progress and issues, goal setting and problem solving. In cancer follow-up it is important that supported self-management interventions empower patients to recognise and report signs and symptoms of potential cancer reccurrence and late effects of treatment. Patients should also be supported to take steps to improve their overall health and wellbeing (e.g. managing fatigue, fear of recurrence).

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Research published by the Health Foundation showed that supporting patients to manage their health conditions can reduce avoidable use of health services. An analysis of Patient Activation Measure™ (PAM) responses collected from over 9,000 patients in Islington CCG found that, compared to those who felt least able (PAM level 1), those who felt most confident and able to manage their health condition (PAM level 4) had:

- 38% fewer emergency admissions;
- 32% fewer A&E attendances;
- 18% fewer general practice appointments;
- and were 32% less likely to attend A&E with a minor condition that could be better treated elsewhere.

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Benefits of remote monitoring

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Benefits of remote monitoring

- Calculate the potential capacity release
- Define the resource required – is it cost effective?
- How will the released capacity be used?

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What is a migration plan?

Developed at early stage in project planning

Sets out:

Numbers of patients to be "migrated" on to pathway per year / quarter
Clinics and patient groups to be targeted first

Supports business case and service delivery
Typically covers 5 year period

ESSENTIAL FOR EFFECTIVE IMPLEMENTATION OF STRATIFIED FOLLOW UP PATHWAY

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NHS Trust A
Prostate pathway migration plan

Start date: 01/04/2019
Aim: Increase caseload by 250 patients per year, reaching maximum caseload of 2900 patients by 2029

	Y1	Y2	Y3	Y4	Y5
Patients on remote monitoring year end (n)	250	500	750	1000	1250
Patients on remote monitoring mid year (n)	125	375	625	875	1125
OPAs saved per year	188	563	938	1313	1688
OPAs saved (cumulative)	188	750	1688	3000	4688
Staffing	1.0FTE B4 CSW 0.2 FTE B7 CNS	1.0FTE B4 CSW 0.2 FTE B7 CNS	1.0FTE B4 CSW 0.4 FTE B7 CNS	1.0FTE B4 CSW 0.4 FTE B7 CNS	1.0FTE B4 CSW 0.6 FTE B7 CNS
Clinics / patient groups	Q1: Telephone clinics (all) Q2: Nurse led clinics Q3: Watchful waiting Q4: Radical prostatectomy	Q1: EBRT / Brachy Q3: ADT	Q1: Active surveillance Q3: IHT / focal therapy		

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Why create a migration plan?

- Understand the population under follow up
- Prioritise patient groups to be moved onto supported-self management first.
- Agree rate of patient migration to supported self-management (e.g. 200 patients per year)
- Describe resource requirements to deliver supported self-management pathway.
- Quantify expected benefits for organisation (e.g. OPAs) to support business case

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Step 1:

- How many patients are on cancer follow up under the care of your organisation? Take into account:
  - incidence,
  - mortality
  - discharge to other hospitals,
  - discharge to general practice
  - follow up period

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Step 2:

- What proportion of patients on follow up are suitable for a supported self-management pathway? At what point do they become eligible? Consider:
  - Published guidelines
  - Published research
  - Shared learning from other organisations

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Step 3:

- How many patients can you move onto the supported self-management pathway each year? Considerations:
  - Is there a support worker / care coordinator role dedicated to support the work involved in enrolling patients to the pathway?
  - A support worker can enroll 150 (0.6FTE) to 350 (1.0 FTE) patients per year.

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Step 4:

- Which groups of patients will you move onto the supported self-management pathway first? Considerations:
  - Patient benefit
  - Busy clinics
  - Member of staff leaving
  - Need more time in theatre
  - Nurse led clinics to free up CNS time to deliver supported self-management pathway

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Step 5:

- What is the average number of OPAs saved per patient per year on the pathway? Considerations:
  - Number and frequency of OPAs in routine clinical follow up (pathway protocols)
  - Time since treatment. Most follow up regimens have more frequent consultations in the early stages of follow up.

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Step 6:

- Project costs and benefits:
  - Costs include: CNS/Support worker time. IT systems. Patient information resources. Room hire for educational sessions.
  - Main quantifiable benefit is OPA savings, but others may include improved patient and staff experience, and improved management of complex cases due to increase clinic capacity

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Benefits of an integrated pathway with primary care

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Benefits

- Prostate cancer follow up is integrated with primary care management of other biopsychosocial factors for the rest of the person's life.
- Structured pathway to transfer care from acute team to primary care
- Care is provided close to home.
- Primary care clinicians receive education and development in managing prostate cancer as a long term condition.
- Primary care teams take more active role in supporting patients after prostate cancer diagnosis, with wider impact on raising awareness of other cancers.

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Case for change

- In the UK, **cancer remains** the leading cause of mortality (NHSE).
- **1 in 2 people** born after 1960 **will get cancer sometime** in their lifetime (CRUK)
- **50% of people diagnosed with cancer** in England and Wales **survive their disease for ten years or more** (CRUK).
- In 2017, **1,954,000 people in England** were living with or beyond cancer (diagnosed any time since 1995, PHE).
- In England, it's expected around **2,979,000 people living with and beyond cancer by 2030** (2017 prevalence, PHE).
- **70% of people who have cancer, have at least one other long term condition** (Macmillan).
- **15 months after diagnosis,** cancer **patients have 60% more A&E attendances, 97% more emergency admissions and 50% more contact with their GPs** than a comparable group (Nuffield Trust)
- **25%** of individuals **had unmet physical and psychological needs** at end of treatment (Macmillan)
- **47%** of cancer survivors **express a fear of their cancer returning** (Macmillan).
- The 2016 National Cancer Experience Survey showed that **London CCGs fall considerably short of the best in England on questions relating to the support patients received from their GP** (NCPES).

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Top tips re primary care development

- Involve Local Medical Committees and primary care commissioners from the start
- Consider commissioning service at Primary Care Network level (it's an ideal model for PCN's to try).
- Service specification and business case will be required – TCST has sample ones that you can use.
- Primary care nurses are ideally placed to run this service because of their expertise in long term condition management, but need the support of their GPs colleagues and adequate education.
- Remote monitoring/safety netting processes – practices will need to maintain an accurate prostate cancer register. And then run a search query once a month to manage call/recall processes for PSA testing.
- Practices will want standardised patient letters and protocols – TCST has lots of resources that you can use.
- Model fits with the NHS Comprehensive Model of Personalised Care and long term management of all cancer patients.
- Consider a wider primary care development programme – managing cancer as a long term condition (eg late effects of any cancer, signs and symptoms of recurrence, biopsychosocial needs), early diagnosis, prevention, safety netting.

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Learning needs of primary care teams

- Training Needs Assessments – TCST has surveys that can be used.
- Education for the workforce – ensure any training that is commissioned or delivered locally includes:
  - Personalised care & support planning
  - Stratified follow up criteria
  - Consequences of treatment
  - Biopsychosocial factors
- Consider access to education for primary care nurses – most education is directed towards GPs and nurses are often not released to attend training.
- Practice Nurse Forums, Training Hubs, Macmillan GPs
- TCST online education toolkit for primary care – will be published in October.

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Commissioning timetables

- Commissioners will want to de-commission acute activity and transfer funds to primary care to support enhanced schemes.
- Trusts require six months notice of changes to their contracts.
- Primary care contract negotiation timetables are not as clear. Make sure you are in touch with your primary care commissioners.
- Primary care billing periods are often six month/annually. So there is enough time to move the money around (if acute and primary care commissioners are joined up!).
- Timing the release of primary care patients depends on the Urologists willingness to transfer care - it also takes a long time! By which time, primary care teams might have been ready to go and waiting for months (or years…).

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Project management challenges to consider

- Buy in from secondary care – despite urology boards signing off the pathway, individual clinicians (urologists, oncologists) aren't always confident in primary care's ability to manage these stable patients.
- Buy in from primary care – at practice level, some GPs do not want to take on the long term management of cancer. Clinical leaders and Primary Care Networks are keen.
- Safety netting – primary care has clinical systems for safety netting (ie remote monitoring mechanisms) but use them to varying levels of effectiveness.
- Commissioners still think this pathway will save them money – it is cost neutral but does release outpatient appointments.
- Scale of implementation – at one Trust or CCG level means that clinicians will need to consider different discharge and re-referral criteria depending on where the patient lives. Patients will also have a different pathway depending on their postcode.

- Local relationship building eg speed dating events between primary and acute care
- Single points of contact for primary care to access acute care expertise
- Education & training in primary care, including PSA levels, late effects, safety netting etc.
- Acute care understanding of primary care safety netting systems
- Increase visibility of SFU as part of CCG/STP outpatient transformation programmes
- Implement pathway at ICS level to minimise variation.

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Summary

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Benefits

- Supported self-management
- Remote monitoring
- Primary care
- Evidence

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H.Brodie@soton.ac.uk
www.Southampton.ac.uk/truenth-ssm

Liz.Price4@nhs.net
https://www.healthylondon.org/our-work/cancer/

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