Protocol for Supported Self-Management in the follow up of Breast, Colorectal and Prostate cancer
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Executive Summary

The number of people living with and beyond a cancer diagnosis in England is set to rise from 2 million in 2010, to almost 4 million in 2030\(^1\). There is increasing evidence that the current arrangements for follow up do not meet all of the needs of those living with the consequences of their cancer, and its treatment\(^2\).

Traditional out-patient consultations do not provide the best environment to allow holistic and personalised care planning. Furthermore, the culture of education and rehabilitation seen in other long term conditions such as cardiac, diabetes, and respiratory medicine have not yet been fully embraced in cancer services.

This protocol has been developed to support the redesign of aftercare services for patients who have undergone treatment for breast cancer, colorectal cancer, and prostate cancer. These services utilise a model of supported self-management, in which the educated patient manages their follow-up, continuing to receive all regular evidence based surveillance investigations, but only attending for face to face clinical review if triggered by a patient’s concern or abnormal test result.

The basic principles that underpin supported self-management for follow-up are:

➢ Patients and professionals work collaboratively to form personalised care plans
➢ There is a programme of appropriate patient education, supported by written information and access to online portal for those who are IT enabled
➢ There is consistent implementation of self-management support interventions
➢ All clinical evidence-based surveillance investigations continue unchanged
➢ Robust systems are in place to ensure tracking and monitoring of investigation requests and results
➢ There is fast track re-entry for clinical review if required

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1 Introduction

1.1 Overview of the importance and role of the protocol

The main purpose of follow-up after cancer treatment is to monitor for disease recurrence, manage any side effects related to treatment and provide information, support and reassurance for patients. Many clinicians believe that following up patients who are essentially well is neither clinically beneficial, nor cost effective.\(^3\)

There is little evidence that intensive follow up improves overall mortality\(^4\). The majority of recurrences are detected either by patients themselves or by investigations which can be planned and undertaken without a patient having to attend an outpatient clinic.

Limited clinical resources mean the provision of routine follow-up may lengthen waiting times for new referrals, compromising the efficiency of diagnostic services and reduce the time available to deal with patients who have complex clinical needs.

Supported Self-Management Follow Up (SSM FU)

This is a model whereby patients manage their own follow-up, with back up from the clinical team as needed, in order to limit risk and ensure a satisfactory patient experience.

This includes the following elements:

- Assessment of individual patients to identify suitability for SSM FU.
- The patient is prepared and supported to enable recovery to a healthy lifestyle, and preparation for all the potential consequences of their disease and treatment.
- Exit interview/workshop to ensure patient appropriately prepared with information and education.
- Detailed written information is provided, also available online.
- Clear protocol for re-entry into service if required.

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\(^4\) Tjandra J, Chan MK. Follow up after curative resection of colorectal cancer: a meta-analysis. *Dis. Colon Rectum* 50 (11) 1783-1799
➢ Treatment summary sent to GP outlining patient’s discharge from treatment into SSM FU.
➢ Routine follow up investigations continue as before with robust tracking mechanism managed by support worker and reviewed by appropriate clinician
➢ Standard clinical follow up for those not suitable for SSM FU or participating in clinical trials.

1.2 Scope of Protocol
➢ All patients with breast cancer, colorectal cancer, and prostate cancer who have been assessed as appropriate for SSM FU.
➢ Experience suggests that this should be 65% of all patients treated for breast cancer, 50% of prostate patients & 50% of colorectal patients.
➢ All medical, nursing, AHP, management and support staff involved in the care of patients with breast cancer, colorectal cancer and prostate cancer.

1.3 Purpose of the Protocol

The purpose of this protocol is to:
➢ Define duties and responsibilities of staff in regard to SSM FU.
➢ Specify the tumour specific pathways for SSM FU
➢ Outline a system for monitoring compliance and improvement.
➢ Aim to achieve a shift in aftercare for breast, colorectal, and prostate patients undergoing treatment from the current model of routine outpatient clinic follow up to informed and prepared patients self initiating contact with health services when necessary.
➢ Aim to achieve a reduction in clinic based follow-up appointments
➢ Promote personalisation of care based on effective assessment and care planning
➢ To achieve greater flexibility and responsiveness for the clinical teams providing breast, colorectal, and prostate cancer services while increasing the new to follow-up patient ratio.

1.4 Definitions

Definitions of words and terms used within this protocol are outlined below:
➢ Self-Management
  o Awareness & active participation by the person in their recovery, recuperation & rehabilitation to minimize the consequences of treatment & promote survival, health & wellbeing (Co-Creating Health –The Health Foundation)
➢ Supported Self-Management
  o What health services do in order to aid and encourage people living with a long term condition to make daily decisions that improve health related behaviours & clinical, & other outcomes. (Co-Creating Health –The Health Foundation)

2 Related Policies/Guidelines

The Protocol for Supported Self-Management for Breast, Colorectal and Prostate Cancer Follow-up is linked with, and must be read in conjunction with, the following policies/guidelines:
3 Roles and Responsibilities

- Chief Executive

The Chief Executive has ultimate responsibility for governance arrangements and therefore for ensuring that there are robust processes in place for follow-up of patients after potentially curative cancer treatments. The Chief Executive delegates this responsibility through the Medical and Nursing Directorates.

- Clinical Leads

Clinical leads in all tumour sites will retain overall responsibility for the patient's well-being, taking NICE guidance into account and reviewing their practice against recommendations/best practice. In addition, Clinical Leads will approve any local amendments to the example follow-up pathways.

- Clinical teams

Clinical teams will ensure that the patients are suitably prepared and equipped to manage their follow-up and understand the process for rapid return if necessary. More detailed responsibilities are shown below in Table 1.

- Cancer Services Team

Cancer Services teams will support the implementation and audit of processes associated with the SSM FU pathway, ensuring targets for recruitment, satisfactory patient experience and adherence to protocols.

<table>
<thead>
<tr>
<th>Role</th>
<th>Responsible person</th>
</tr>
</thead>
<tbody>
<tr>
<td>Identifying patients suitable for SSM FU and referring to Support Worker for registration (must be documented in notes and end of treatment summary)</td>
<td>Clinician reviewing patient at end of treatment</td>
</tr>
<tr>
<td>This must include type and frequency of</td>
<td></td>
</tr>
</tbody>
</table>

Table 1: Roles and Responsibilities of Clinical Team
investigations, and (in the case of prostate) the target range for PSA

<table>
<thead>
<tr>
<th>Task</th>
<th>Responsible Parties</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ensuring patient is adequately prepared for SSM FU and attends exit interview/workshop</td>
<td>Support worker and Clinical Nurse Specialist</td>
</tr>
<tr>
<td>Ensuring surveillance investigations are scheduled and carried out in a timely fashion</td>
<td>Support worker</td>
</tr>
<tr>
<td>Sending reminders to patients who have missed surveillance investigations or are overdue</td>
<td>Support worker</td>
</tr>
<tr>
<td>Reviewing surveillance investigation results and taking appropriate action</td>
<td>Clinical Nurse Specialist via “virtual clinic”</td>
</tr>
<tr>
<td>Reviewing incoming messages and health MOTs from patients</td>
<td>Support worker and Clinical Nurse Specialist</td>
</tr>
<tr>
<td>Ensuring patient and GP are informed of results of investigations</td>
<td>Support worker</td>
</tr>
<tr>
<td>Monitoring compliance with protocols and reviewing deviations from the pathway</td>
<td>Lead Clinician</td>
</tr>
</tbody>
</table>

### 4 Process for Monitoring Compliance/Effectiveness

The treating Trust will monitor any incident, complaint or claim arising out of SSM FU ensuring that these are followed up and processes reviewed if necessary. Any such incidents will be shared (anonymised) with the appropriate network groups so that lessons learned can be utilised across all participating sites.

In addition, key aspects of the pathway will be audited as shown in Table 2.

**Table 2: Monitoring SSM FU Protocol**
<table>
<thead>
<tr>
<th>Element of Protocol to be monitored</th>
<th>Tool/Method</th>
<th>Frequency</th>
<th>Who will undertake</th>
<th>Where results will be reported</th>
</tr>
</thead>
<tbody>
<tr>
<td>All patients in SSM FU are recorded and appropriate surveillance tests organised</td>
<td>Cross check of Tracker tool against Somerset, back up database and clinical records</td>
<td>Monthly</td>
<td>Support Worker</td>
<td></td>
</tr>
<tr>
<td>All patients in SSM FU are receiving investigations in a timely manner and these are being acted upon appropriately</td>
<td>Audit of 10% of cases in SSM FU</td>
<td>Quarterly</td>
<td>Clinical Nurse Specialist</td>
<td></td>
</tr>
<tr>
<td>Results being communicated to patient and GP in a timely manner</td>
<td>Audit of 10% of cases in SSM FU</td>
<td>Annually</td>
<td>Support worker</td>
<td></td>
</tr>
<tr>
<td>Patient satisfaction (to include response time to patient concerns/messages)</td>
<td>Survey of patients in SSM FU</td>
<td>Annually</td>
<td>Clinical Nurse Specialist</td>
<td></td>
</tr>
<tr>
<td>Completion rate of Health MOT</td>
<td>Audit of records on Tracker</td>
<td>Quarterly</td>
<td>Support Worker</td>
<td></td>
</tr>
</tbody>
</table>

## 5 Recommendations for recording activity

National Tariff Payment System guidance for 2017/18 and 2018/19 states that new models for non-face to face follow up should be incentivised to increase the adoption of technology. Although reference costs are available, it is suggested that providers and commissioners should agree local prices for such activity.

A consistent approach to recording activity associated with the pathways across Cheshire and Merseyside is recommended. Tariffs will need to be negotiated through the normal contracting routes however key elements of the pathway lend themselves to existing coding structures.

There are two national codes for 'virtual' i.e. non-face to face follow ups which are:
National Codes:
National Code Description

NF2FFA- Outpatient First Non Face to Face

NF2FFUP- Outpatient Follow Up Non Face to Face

The local codes that could be used are constructed as follows:

A non-face to face outpatient follow up attendance that is single professional and non-consultant led would be
OPFUPNFTFSPNCL

If all the ‘attendances’ are single professional then that part could be left out e.g. OPFUPNFTFNCL

6 Arrangements for review of this protocol

This protocol is offered by the Cheshire & Merseyside Cancer Alliance as a common framework for use in all participating sites. It must be subjected to Trust internal governance processes and reviewed according to local policies.

The Clinical leads with responsibility for SSM FU will be responsible for monitoring the effectiveness of this protocol, reviewing and updating it as necessary in accordance with current legislation and practice.

It is recommended that this protocol will be formally reviewed by no later than March 2020.
Appendix 1: Example SSM FU Breast Pathway\(^5\) for ALL patients completing treatment with curative intent

End of treatment review with clinician (oncologist, Surgeon, ANP, CNS) 6-12 weeks post treatment
- Ensure no outstanding complications
- End of treatment summary to patient and GP including details of bone health surveillance required
- Details of follow up surveillance including SSM FU leaflet
- Ensure pt details sent to SSM FU support worker

Month 3-6 post treatment interview/workshop to include:
- Managing long term medication
- Signs and symptoms of recurrence
- Cosmesis/bra service/prostheses
- Coping strategies
- Details of surveillance programme
- Registration and access portal
- Contact details for team
- Health MOTs/HNA
- Healthy lifestyles/diet
- Physical activity - referral to programmes
- Local support groups including support for carers
- Management of lymphoedema
- Menopausal symptoms
- Sexual health
- Bone health

SSM FU support worker
- Register patient with database
- Schedule imaging as requested
- Introductory phone call/meeting with patient ensuring contact details available
- Ensure patient able to complete health MOT
- Organise (or check that it has already been organised) appointment for exit interview/workshop

Years 1-5
Routine annual mammograms as per NICE guidance
Normal results communicated directly to patient from radiology
Results reviewed by CNS to determine next step

Refer back to clinical team for discussion at MDT

If Normal or non-breast related problem, continue SSM FU as before, refer back to GP for further management of unrelated issues

Recurrent/metastatic disease or new primary seen in appropriate clinic for further management within 2 weeks

Abnormal mammogram - urgent clinical review of result, organise further imaging/biopsy. CNS to contact patient and arrange arrangements
New concern identified by pt or GP - triage by CNS and arrange appropriate imaging or clinic review

Year 5 Virtual MDT - review current health status (check for date of death).
Review treatment/guidelines to identify any patient to be seen or if appropriate, notify patient and GP any new recommendations

Discharge

NB:
In patients <45 years at diagnosis, mammograms continue annually until age 50.
For high risk patients MRI may substitute mammogram

Appendix 2: Example SSM FU Colorectal Pathway\textsuperscript{6}

\textsuperscript{6} Ref NICE Quality Standard 8 [https://www.nice.org.uk/guidance/QS20/chapter/Quality-statement-8-Follow-up-and-regular-surveillance](https://www.nice.org.uk/guidance/QS20/chapter/Quality-statement-8-Follow-up-and-regular-surveillance)
End of treatment review with clinician (oncologist, surgeon, ANP, CNS) 6-12 weeks post treatment
- Ensure no outstanding complications
- End of treatment summary to patient and GP
- Details of follow up surveillance including SSM FU leaflet
- Ensure pt details sent to SSM FU support worker

SSM FU support worker
- Register patient with database
- Schedule imaging/blood tests as requested
- Introductory phone call to patient ensuring contact details available
- Ensure patient able to complete health MOT
- Organise appointment for exit interview/workshop

Appendix 3: Current schedule of follow-up surveillance tests following curative colorectal cancer treatment

Following multidisciplinary discussion patients will be offered adjuvant chemotherapy where indicated. Follow-up will then be scheduled as follows unless:

Month 3-6 post treatment interview/workshop to include:
- Signs and symptoms of recurrence
- Stoma management
- Healthy bowel pattern
- Coping strategies
- Details of surveillance programme
- Registration and access to tracker
- Contact details for team
- Health MOTs/HNA
- Healthy lifestyles/diet
- Physical activity - referral to programmes
- Local support groups including support for carers
- Long term consequences of radiotherapy
- Sexual health

CT scan year 1, 2, and 5

Coloscopy: Within six months if incomplete prior to surgery. At one year if complete visualisation pre operatively. Then year 5 or according to polyp surveillance guidelines
- CEA: Three monthly for the first two years. Six monthly for years three and four. Yearly at year five.

Refer back to clinical team for discussion at MDT

Abnormal blood test/colonoscopy/CT scan - urgent review of result by CNS and arrange further imaging or clinical review as appropriate. CNS to contact patient and advise

If Normal or non - cancer related problem identified continue SSM FU as before refer back to GP for further management of unrelated issues

SSM FU registration and access to tracker
- COPING strategies
- Local support groups
- Healthy lifestyles/diet
- Long term consequences of radiotherapy
- Sexual health

Recurrence/metastatic disease or new primary see appropriate Clinician for further management within 2 weeks

Year 5 Virtual MDT check current status of patient (check for date of death)
- Review treatment/guidelines - arrange to see patients if required or notify patient and GP any new recommendations

Normal no new concerns on MOT - letter notifying patient and GP

Discharge
- Decision at MDT meeting is made for alternative management.
- Patient has stoma and consultant wishes to review until reversal.
- Patient declines follow-up.
- In clinical trial with alternative protocol.

<table>
<thead>
<tr>
<th>CT Scan. (Chest and abdomen)</th>
<th>CEA.</th>
<th>COLONOSCOPY</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 year post op</td>
<td>3 monthly for the first 2 years.</td>
<td>Within 6 months if incomplete prior to surgery.</td>
</tr>
<tr>
<td>2 years post op</td>
<td>6 monthly for years 3 and 4.</td>
<td>At 1 year if complete visualisation pre operatively.</td>
</tr>
<tr>
<td>5 years post op</td>
<td>Yearly at year 5.</td>
<td>In the case of polyps: according to BSG polyp surveillance guidelines</td>
</tr>
</tbody>
</table>

Appendix 4: Example SSM FU Prostate Pathway⁷ (adapted from TrueNTH STAR protocol)

⁷Ref NICE Prostate Cancer: Diagnosis and Management CG175 [https://www.nice.org.uk/guidance/cg175/ifp/chapter/Follow-up](https://www.nice.org.uk/guidance/cg175/ifp/chapter/Follow-up)
<table>
<thead>
<tr>
<th>Procedure</th>
<th>Monitoring and recall criteria</th>
<th>PSA &gt; 0.1: telephone, retest 6/52</th>
<th>PSA &gt; 0.2 or 3 consecutive rises consider recall</th>
<th>New onset LUTS, visible haematuria, bone pain</th>
</tr>
</thead>
<tbody>
<tr>
<td>Radical Prostatectomy</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Consider from 6 weeks post-surgery</td>
<td></td>
<td>PSU &gt; nadir + 2 ng/ml, or 3 consecutive rises</td>
<td>NB: In the case of &quot;clinical bounce&quot; consider retest 3/12.</td>
<td>Troublesome LUTS, visible haematuria, rectal bleeding, troublesome bowel symptoms, bone pain</td>
</tr>
<tr>
<td>PSA ≤ 0.1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Refer to decision aid 1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Radiotherapy</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Consider from 6 weeks post completion of treatment</td>
<td></td>
<td>PSU &gt; 4</td>
<td>Troublesome LUTS, visible haematuria, weight loss, bone pain</td>
<td>Consider testosterone testing on recall</td>
</tr>
<tr>
<td>PSA &lt; 2</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Refer to decision aid 2</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary Androgen Deprivation Therapy</td>
<td></td>
<td>PSU &gt; 20 or PSA doubling time &lt; 1 year</td>
<td>Troublesome LUTS, visible haematuria, weight loss, bone pain</td>
<td></td>
</tr>
<tr>
<td>Consider from 3 months post commencement of treatment</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PSA has responded to treatment</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PSA &lt; 4</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Refer to decision aid 3</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Watchful Waiting</td>
<td></td>
<td>PSU &gt; 20</td>
<td>Troublesome LUTS, visible haematuria, weight loss, bone pain</td>
<td></td>
</tr>
<tr>
<td>Consider commencement of watchful waiting</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PSA &lt; 20 and PSA doubling time of &gt; 1 year</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Refer to decision aid 4</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Active Surveillance</td>
<td></td>
<td>PSU velocity 1ng/ml per year</td>
<td>Change in DRE/MRI findings. LUTS/symptoms. Pt request.</td>
<td></td>
</tr>
<tr>
<td>Patient has been on active surveillance for at least 12 months.</td>
<td>PSA - Years 1 &amp; 2 after diagnosis = 3monthly</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient should have undergone template biopsy, repeat MRI and MDT discussion prior to remote follow up being considered if diagnosed on TRUS. If diagnosed on primary template, should have had a repeat MRI at 12mths and case rediscussed at MDT meeting. Stable PSA. Patient should be able to self-manage and agreeable to remote follow up.</td>
<td>Year 3 onwards = 6 monthly DRE Annual DRE in consultant clinic for first 5 years then every 2 years</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Appendix 5: Prostate Decision Aids

Radical Prostatectomy
Patient eligibility for Remote Surveillance

DEcision Aid 1 (v 0.1)

- Has the patient had surgery more than 6 weeks since the patient underwent radical prostatectomy?
  - No: Continue usual care
  - Yes: Review the patient for their eligibility for Remote Surveillance using either Radiation Therapy or Primary Androgen Deprivation Therapy protocols

- Has the patient received subsequent radiation therapy or primary androgen deprivation therapy?
  - No: Continue usual care
  - Yes: Consider issues such as expression and etiology, and address any of these issues

- Do you consider the patient to be functionally and emotionally suitable?
  - No: Document reasons for continued clinic follow up
  - Yes: Determine shared care plan with GP and make necessary referrals to address these issues

- Is it necessary for the patient to attend clinic to address any of these issues?
  - No: Document reasons for continued clinic follow up
  - Yes: Document reasons for continued clinic follow up

- Was it less than 30 months since the patient underwent radical prostatectomy?
  - No: Continue usual care
  - Yes: Introduce patient to RSTAR research evaluation

Note: Patients with high PSA proliferating tumors are not suitable for remote surveillance.
Radiotherapy Patient eligibility for Remote Surveillance

DECISION AID 2 v0.1

1. Has it been more than 6 weeks since the patient completed radiotherapy?
   - No: Continue usual care
   - Yes: Review the patient for their suitability for Remote Surveillance using primary Androgen Deprivation Therapy (ADT) module

2. Has the patient received subsequent primary Androgen Deprivation Therapy (excluding subsequent hormone therapy)?
   - No: Continue usual care
   - Yes: Discuss options with the patient and their family or carer

3. Does the patient have a PSA < 2?
   - No: Continue usual care
   - Yes: Consider issues such as progression and adverse events

4. Do you consider the patient to be functionally and emotionally stable?
   - No: Develop a shared care plan with GP and make necessary referrals to address these issues
   - Yes: Consider role of the support worker in care planning

5. Is it necessary for the patient to change plans prior to address any of these issues?
   - Yes: Document reason for continued clinic follow up
   - No: Continue usual care

6. Do you want to discharge the patient from Remote Surveillance?
   - Yes: Document reason for continued clinic follow up
   - No: Continue usual care

7. Has it been less than 24 months since the patient completed radiotherapy?
   - Yes: Introduce patient to STAR research evaluation
   - No: Continue Remote Surveillance
Primary Androgen Deprivation Therapy (ADT)
Patient eligibility for Remote Surveillance

DECISION AID 3 v0.1

- Has it been 3 months or longer since the patient commenced ADT?
  - No: Continue usual care
  - Yes: Do the patient have a PSA < 4, and has their PSA responded to ADT?
    - No: Continue usual care
    - Yes: Do you consider the patient to be functionally and emotionally stable?
      - No: Continue usual care
      - Yes: Is it necessary for the patient to attend clinic to address any of these issues?
        - No: Document reason for continued clinic follow up
        - Yes: Document reason for attended clinic follow up
          - Consider role of the Support Worker in care planning
            - This patient meets the eligibility criteria for Remote Surveillance
              - Develop shared care plan with GP and make necessary referrals to address these issues
                - Do you want to discontinue this patient from Remote Surveillance?
                  - No: Document reason for continued clinic follow up
                  - Yes: Has it been less than 30 months since the patient commenced ADT?
                    - No: Continue Remote Surveillance
                    - Yes: Introduce patient to CARFU program evaluation
                      - Continue Remote Surveillance

CMCA  SSM FU  protocol version 2.0 March 2019 Author MZ
Appendix 6: STHK Breast Process

STHK Administration pathway to support SSMFU programme

Post treatment MDT
Decision patient to go on SSMFU
Annual mammogram requested / identified for Clinical Trial.

Portal update (CSW)
Details added to portal inc. Mammogram, Heath MOT date (1st of each month)/ PROTOCOL checked by clinical team

Education Event (CSW/CNS)
Appointment for HWBC arranged
Hold appointment on HEARTS for breast care Fu

Cancer Support Worker (CSW)
Telephone Contact pt. reminder to do Heath MOT and Mammogram 1/52 prior to appointment for mammogram

Attends MAMMOGRAM

“Normal inform patient on report”

Pt. rang
Post Heath MOT if wishes to discuss concern

Abnormal
Contacted by radiology for further investigations / DPD

Letter
Generated from portal to pt. cc GP

Portal updated
Next Appointment (1st of month)

Red flag concern

5 years, patient discussed NDT
Discharge from care
No pt. under 40 on 10 year mammogram surveillance
Patients on clinical trials suspended per protocol

CSW informed CNS team SAME DAY
Clinical team advise CSW on outcome
1. Remove from SSMFU
2. Cancel future mammograms
3. Recommend SSMFU programme
Letter generated from portal to pt.cc GP with outcome

Draft 4 20/07/2016
Standard Operational Procedure

STHK Breast MDT

End of treatment review
6-12 weeks post treatment
- End of treatment summary to patient and GP
- Refer SSM FU programme via Cancer Support Worker
- Cosmetobra vacation/Prosthesis OPD

Interview/Workshop
Month 3-6 post treatment
- Details of surveillance programme
- Registration and access portal
- Contact details for team
- Discuss Health MOTM/HNA
- Healthy lifestyle铯
- Physical activity referral to programmes
- Local support groups including support for carer
- Referral health and wellbeing Clinic (HWC)

Living with and beyond cancer / Health and wellbeing Clinic
Month 4-6
- Managing long term medication
- Signs and symptoms of recurrence
- Coping strategies
- Healthy lifestyle铯
- Physical activity referral to programmes
- Local support groups including support for carer
- Management of lymphoedema
- Menopausal symptoms
- Health & Wellbeing clinic
- Consequences of treatment

SSM FU support worker
- Register patient on portal
- Schedule imaging as requested
- Introductory phone call with patient ensuring contact details available
- Organise appointment for exit interview/workshop

Red flag symptoms:
The signs and symptoms of local recurrence and metastatic breast cancer are described in this patient friendly fact sheet:

Years 1-5
Annual mammograms
(NICE guidance)
Annual Completion of Health MDT

Red Flag Symptoms
Clinical team informed
CNS contact patient to assess

Abnormal Mammogram
Radiology arranges urgent clinical review of result, if further imaging biopsy

Normal Mammogram +
No Red Flag Symptoms
Notify patient and GP within 2 weeks

If Normal or non-breast related problem, continue SSM FU
Refer back to clinical team for assessment within 2 weeks

Year 5 Virtual MDT
Review treatment guidelines
DISCHARGE
7 Equality Impact Assessment

EQUALITY IMPACT ASSESSMENT TOOL - To be completed for all new/revised policy, procedural and guideline documents.

Equality Impact Assessments (EQIAs) are a way of examining new procedural* documents to see whether they have the potential to affect any one group of people more or less favourably than another. Their purpose is to address actual or potential inequalities resulting from policy development. The duty to undertake EQIAs is a requirement of race, gender and disability legislation.

The word procedural is taken to mean all procedural documents i.e.: Policy, Procedure, and Guideline. (This does not include Patient Information)

<table>
<thead>
<tr>
<th></th>
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</thead>
<tbody>
<tr>
<td>Is this a new or revised document?</td>
<td>New</td>
<td></td>
</tr>
<tr>
<td>Area to which document relates</td>
<td>Specify whether Trust-wide, Division, Care Group or Department.</td>
<td>Cancer Services Merseyside and Cheshire Cancer Network</td>
</tr>
<tr>
<td>Name of person completing Assessment</td>
<td>Melanie Zeiderman, Programme Lead</td>
<td></td>
</tr>
</tbody>
</table>

STAGE 1 – INITIAL SCREENING
This stage establishes if the proposed change will have an impact from an equality perspective on any particular group(s) of people. See guidance notes on completion.

<table>
<thead>
<tr>
<th>Does the document affect one group more or less favourably than another on the basis of any of the strands of diversity?</th>
<th>Positive Impact Y/N/Neutral</th>
<th>Negative Impact Y/N/Neutral</th>
<th>Comments – Give details of concerns and evidence in the boxes below</th>
<th>Impact Level N/L/M/H</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>N</td>
<td>N</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Disability</td>
<td>N</td>
<td>N</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gender</td>
<td>N</td>
<td>N</td>
<td></td>
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<tr>
<td>Sexual Orientation</td>
<td>N</td>
<td>N</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Race &amp; Ethnicity</td>
<td>N</td>
<td>N</td>
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<tr>
<td>Religion or Belief</td>
<td>N</td>
<td>N</td>
<td></td>
<td></td>
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<tr>
<td>Culture</td>
<td>N</td>
<td>N</td>
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<tr>
<td>Other e.g. Mental Health, Geographic factors, Economic factors...</td>
<td>Y</td>
<td>N</td>
<td>Reduced hospital visits will impact positively on patients travel time and costs</td>
<td></td>
</tr>
</tbody>
</table>
Level of impact:
Taking into account the impact level for each group, circle one of the words in the boxes below to identify the overall impact level:

<table>
<thead>
<tr>
<th>NONE</th>
<th>LOW</th>
<th>MEDIUM</th>
<th>HIGH</th>
</tr>
</thead>
</table>

Significance
Is the positive / adverse impact significant enough to warrant a more detailed assessment (Stage 2) A full assessment will usually be required if the level of impact is above 'LOW' as identified above.

NO (delete as applicable)

If no give brief details of any action taken/information gathered to justify this decision:

Or give brief details of how the change will be monitored to assess the impact over a specified period of time:

IF NO POTENTIAL DISCRIMINATION HAS BEEN IDENTIFIED or THE IMPACT IS NOT SIGNIFICANT ENOUGH TO WARRANT A FULL IMPACT ASSESSMENT, PLEASE SIGN AND DATE BELOW.

(NOTE: A full impact assessment should be undertaken if initial screening demonstrates that there could be significant detrimental impact.)

I have assessed this document and found:

- no potential impact on any group

SIGNATURE:

M. Ziedeman

08/09/2016