

South West Cancer Network

Survivorship 'Recovery Package' Implementation Plan

Draft 22 September 2014

Background

The 'Recovery Package' is a combination of different interventions, which when delivered together, will greatly improve the outcomes and coordination of care for people living with and beyond cancer. It has been developed and tested by the [National Cancer Survivorship Initiative](#) (NCSI) to assist people living with a diagnosis of cancer to prepare for the future, identify their individual needs and support rehabilitation to enable people to return to work and or a near normal lifestyle.

1) Holistic Needs Assessment

a) Definition:

Holistic Needs Assessment (HNA) is a process of gathering and discussing information with the patient in order to develop an understanding of what the person living with and beyond cancer knows, understands and needs. Holistic Needs Assessment is focused on the whole person; their entire well-being is discussed – physical, emotional, spiritual, mental, social and environmental. The process culminates when the assessment results are used to inform a care plan.

b) Standard

- HNA should be considered an integral element of cancer care alongside surgery, chemotherapy, radiotherapy etc.
- Every patient should have a HNA carried out as soon after diagnosis as possible
- The HNA should be revised during treatment and again at the end of primary treatment

c) Notes

- Paper or electronic HNA can be used
- A variety of assessment scales are available for HNA both national and local. The electronic HNA is now available for implementation at all providers – even without piloting the paper version.
- Electronic HNAs via tablet devices will provide a simple way to demonstrate compliance with this standard.

2) Care Plan

a) Definition:

The care plan is based on the diagnosis and holistic needs assessment of the patient. The essential components will include needs and concerns identified by the patient related to the diagnosis. It prioritises the patients' issues and includes a statement on the specific goals, actions and approaches to address them. The assessment and care plan is consistent with the patients' needs and progress toward supported self-management.

b) Standards

- Every patient will receive a written Care Plan as soon after diagnosis as possible
- Every patient will receive a written Care Plan by the end of primary treatment
- Care Plans will include advice on the consequences of treatment

- Care Plans will be copied to GPs

3) Treatment Summaries

a) Definition

The Treatment Summary has been developed to support improved communication between cancer services and primary care. The Treatment Summary form is completed at the end of primary treatment by the hospital and sent to the patient's GP with a copy to the patient. The form also includes the READ codes for the diagnosis and treatment so that the GP can update their patient database.

b) Standards

- A Treatment Summary will be sent to the GP at the end of each primary treatment
- Treatment Summaries will replace current discharge letters
- Treatment Summaries will conform as a minimum to the content set out in the National Treatment Summary Template.

c) Notes

- Treatment Summaries are available electronically on the two main cancer information systems Somerset Cancer Register and InfoFlex Cancer Information Management System.
- The will provide a mechanism to demonstrate compliance with this standard.

4) Commissioning Holistic Needs Assessment, Care Plans and Treatment Summaries

- The Provider and Commissioner will agree a timetable for introduction of these three elements of the recovery Package (e.g. 4 common tumour types within year 1, remaining tumour sites year 2.)
- Treatment summaries will contain a care plan based on a holistic needs assessment. Treatment Summaries can therefore be used as an outcome measure for the introduction of these three elements
- The National Cancer Patient Survey will also be used as an outcome measure for the introduction of these three elements. A score of 50% should be achieved in the Care Plan question.
- Commissioners will pay £100 for the first treatment summary received. The treatment summary should contain a care plan based on holistic needs assessments.
- This will be funded by reduction in routine follow-up (see Section 8 - Stratified Pathways of Care).
- A quality incentive payment (CQUIN) may be suitable to support the introduction of these three elements.

5) Remote Monitoring

a) Definition

Remote monitoring is a term used to describe how the specialist can schedule and monitor surveillance tests for patients who have completed treatment for cancer, without the need for a face to face outpatient appointment to convey the result.

Its primary role is to support low risk patients treated with curative intent that is suitable for a supported self-managed pathway. Remote monitoring systems should hold sufficient information to enable the clinician to manage the patient without the need to access case notes.

b) Standard: Prostate

- Diagnostic Test - PSA Test

Eligible patients

- All new post-surgical patients from 12 months - excluding those in trials and very high risk patients. Clinical guideline to be produced by Urology Network Site Specific Group.
- All non-surgical patients 9-12 months post treatment with stable symptoms and PSA.
- Some men with a high PSA but negative prostate biopsies

c) Standard: Colorectal

- Diagnostic Test - CT Chest, abdomen and pelvis, CEA, Colonoscopy

Eligible patients

- Post-surgery patients treated with curative intent who have a stable Carcinoembryonic antigen (CEA)
- Post adjuvant chemotherapy patients who would proceed to surveillance
- Nature and frequency of surveillance tests needs to be agreed by the Colorectal NSSGs. See [NICE Guideline CG131: The Diagnosis and Management of Colorectal Cancer](#)

d) Standard: Breast

- Diagnostic Test - Mammography

Eligible patients

- All patients requiring annual mammography

Patient Support by Radiographer at surveillance mammography

- The development of additional patient support at surveillance mammography is recommended. Guideline will need to be produced by the Network Breast Groups.

6) Access to Service after Primary Treatment

a) Definition

It is imperative that patients, carers, GPs and those supporting in the community access advice, support and interventions quickly and responsively and avoid unnecessary delays. Professionals responding to contacts should be proactive in helping to resolve queries, taking responsibility for coordinating follow up actions on behalf of the patient where possible to do so.

b) Standards

- At the end of primary treatment and again on being discharged from routine follow-up each patient will receive information on Alert Symptoms that require contact with the cancer service and how to contact the service. This should include both signs and symptoms of recurrence and the likely consequences of treatment.
- Patients on routine follow-up should be advised not to wait for follow-up appointments if they have the symptoms described.
- Providers will see those patients who need to be seen within 2 weeks of the patient making contact.

c) Commissioning

- The Provider and the Commissioner will agree the route of access to specialist services, recorded on the treatment summary and shared with the patient.
- Commissioners and providers will agree the funding arrangements for both the information to the patients and the services accessed as a consequence.

7) Health & Wellbeing Advice

a) Definition:

Health and Wellbeing clinics are education and information events to enable people living with cancer and their families to take control and participate in their recovery, giving them necessary information, and promoting positive lifestyle change. They are designed to help people get support that improves the quality of their lives and ideally would be a 'one-stop-shops' where volunteers and professionals will play key roles; running the clinics, providing information, financial advice and expert medical care. People making the shift from treatment to life after cancer can talk to a broad range of individuals, including clinicians, complementary therapists and benefits advisers.

b) Standards

- At the end of primary treatment each patient will receive health & wellbeing advice. This will be both tumour specific and general advice. It will explicitly support self-management.
- Clinics should provide benefits and other financial support, how to get back to work, good diet, physical activity and lifestyle, the possible long-term side-effects of treatment, consequences of treatment, signs and symptoms of recurrence, local services, facilities and other opportunities available. The local authority should be involved in setting up Health & wellbeing clinics to ensure local services are represented and available to cancer patients.
- The advice given should be included in the Treatment Summary shared with the patient and GP.

c) Commissioning

- The Provider will demonstrate that 50% of cancer patients have received health & wellbeing advice.
- The commissioner will pay £25 per patient attending a Health & Wellbeing Clinic. This will be funded by reduction in routine follow-up (see Section 8 - Stratified Pathways of Care).

8) Stratified Pathways of Care

a) Definition

The transformed pathway of care for cancer survivors is based on a model of care for people with long term conditions. A [stratification process](#) will help to identify which care pathway is most suitable for each patient, based on the level of care needed for the disease, the treatment and the patient's ability to manage, and therefore what level of professional involvement will be required.

Stratified means that the clinical team and the person living with cancer make a decision about the best form of aftercare based on their knowledge of the disease, the treatment and the person. The three forms of aftercare are Supported Self-Management, Shared Care and Complex Case Management.

b) Standards

- The implementation of Remote Monitoring, re-access criteria, and health and wellbeing advice will mean that a number of patients will no longer need routine medical follow-up. Some patients will be discharged to supported self-management or require different forms of follow-up i.e. telephone
- Each Cancer MDT will review its pathways of care to agree which patients can be risk stratified to discharge from routine follow-up. This will improve service capacity to carry out other aspects of the Recovery Package i.e. HNA, treatment summary

c) Commissioning

- The Provider and Commissioner will agree the criteria for follow up and follow up plans for each MDT
- Funding for additional Survivorship activity will be funded from a reduction in routine follow-up

- National pathways of care have been tested. The Executive Summary can be found here, the pathways are embedded below



Breast_Pathway.pdf



Lung_Pathway.pdf



Colorectal_Pathway.pdf



Prostate_Pathway.pdf

d) Notes

- Criteria and follow-up arrangements will be informed by national specifications (from NHS England Clinical Reference Groups) and agreed locally at the Network Site Specific Group.
- All elements of the Recovery Package must be jointly commissioned and must be regarded as part of a cancer patient's treatment, starting at diagnosis.

9) Survivorship in Primary Care – Cancer Care Review

a) Definition

[The Quality and Outcomes Framework \(QOF\)](#) requires all patients diagnosed with cancer to receive a CCR by their GP within six months of the GP practice being notified that the person has a cancer diagnosis.

b) Standard

- The Cancer Care Review will happen after primary treatment, on receipt of the Treatment Summaries and Care Plan
- The Cancer Care Review will be face to face and will conform to the standards set out in the national Cancer Survivorship Initiative
- Practice nurses should play a role in cancer care reviews

c) Commissioning

- Practices currently receive approximately £69 per cancer patient from QOF (from two indicators)
- Funding for Cancer Care Review activities over and above that funded by QOF will be funded through a LES
- Practice nurse input to cancer care reviews should be supported through commissioning.

10) Additional Information

a) HNA Tools

- Sheffield Profile for Assessment and Referral for Care (SPARC)
- National Cancer Survivorship Initiative – Concerns checklist
- Distress Thermometer & Problem Checklist
- Pepsi-Cola aide-memoire

b) Cancer Care Review

Calculation of QOF Income for Cancer

Indicator	Points
CAN01	5
CAN03	6
Total	11
Mean practice size	6911
Mean number of new patients per year (from CAN03)	25
Mean income per QOF point for average practice (from BMA website)	£157
Mean QOF Income for Cancer	1726
Mean income per patient – (assuming all points achieved)	£69

97.8% of the Cancer QOF points are achieved in the SW	
Total points achieved in South West in 2012/13	6538
Total QOF Income for Cancer for the South West	£1,025,926