Personalised (stratified) follow up for cancer in the NHS England Long Term Plan

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Disclosure:

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Long Term Plan
Living With & Beyond Cancer – at a glance

- Deliver personalised care for all patients in line with the NHS Comprehensive Model for Personalised Care (2021)
- Transform follow up care (2023)
- All patients will have access to the right expertise and support
- Empower patients to manage their care and the impact of their cancer and treatment
- Maximise use of digital and community based support
- QoL metric

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What ‘Personalised Care’ means for people

- Choice and control over the way your care is planned and delivered
- Based on ‘what matters’ to you and your individual strengths, needs and preferences
- You are supported to stay well for longer
- Making the most of the expertise, capacity and potential of people, families and communities in delivering better health and wellbeing outcomes and experiences
A pathway that suits your needs

- Personalised Care & Support Planning
- Access to the cancer team at any time
- Support & information for self-management
- Referral/signposting to support services such as psychology, return to work, financial advice, managing long-term effects
- Information shared with you & your GP
- ‘Remote’ monitoring (for those on patient triggered follow up)
Personalised care and follow-up

Personalised Care and Support Planning based on Holistic Needs Assessments
Ongoing support for Health and Wellbeing

- Diagnosis
- Prehabilitation
- Treatment & Rehabilitation

Shared decision about follow-up

- Personalised Care & Support Planning
- Stratification criteria

Professional-led follow-up

- Patient-triggered follow-up

REMOTE MONITORING

- Support for self-management
  - End of Treatment Summary
  - Surveillance scans/tests
  - Rapid re-access to clinic
  - Telephone Support
  - Signposting or referral to support / advice / services
  - Monitoring for side effects
  - Cancer Care Review

Key
- Stage in pathway
- Personalised Care intervention
- Components of Follow Up
By March 2019  All Cancer Alliances should have in place clinically agreed protocols for stratifying breast cancer patients and a system for remote monitoring.

At mid Feb 2019  ~ 90% of trusts have protocols

2019/20 Planning guidance:  Ensure full implementation by the end of 2019/20, so that from April 2020 approximately two-thirds of patients who finish treatment for breast cancer are on a supported self-management follow-up pathway.
Breast Cancer – some examples

Aintree:
- Patients are told at diagnosis about patient triggered follow up
- 4 months after treatment - key worker introduces self-management

Royal Marsden:
- 61% of people in open access follow up had at least one unmet need and 18% had 5 or more needs

North Bristol:
- Mandatory, nurse-run, post-surgery follow-up group clinic runs every week. Patients are checked for complications, receive health and wellbeing information
- Financial arrangement with CCG
Transforming Prostate Cancer Follow Up

TrueNTH UK Supported Self-Management and Follow Up Care Programme

A man who enters the care programme is offered:

- Knowledge and skills to co-manage his health and well being
- A needs assessment
- Remote monitoring of his health and well being by the urology team
- Rapid access to his clinical team if concerned
Participant interview:

“I hate this issue of being in the dark all the time, as I said, we live from result to result, and that period in between, we are left in the dark.

I’m not any longer, I’m there, I’m with them [...] it’s like going to the board meeting isn’t it where decisions are being made and I can be part of those decisions being made.

I really feel I am now part of the team, if you like, and not waiting for the answers...”
Nottingham Radiotherapy Late Effects Service

- The effects of radiotherapy treatment can last a lifetime and can have very serious consequences for quality of life.

- Patients are living with consequences which are often ignored or not recognised by other health professionals.
Feedback

“She really gets it, I can see it in her eyes that she understands. Giving me a sense of relief.”

“Everything was explained in easily understood language and it was so good having someone listen, understand and explain without being dismissive. She was so kind.”

“Provided me with the motivation to carry on.”
Personalised care and follow up – Success factors for implementation

- Clinical leadership and Commissioning Support
- Project management and Monitoring/evaluation

- Flexibility of pathway - co-design with people affected by cancer
- Communication and Networking – primary care, other non-cancer services
- Personalised Care & Support Planning; End of Treatment Summary; Health & Wellbeing Support

- Workforce e.g. support workers/navigators
- Training e.g. recognising mental health issues; motivational interviewing
- IT

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