



NHS Improvement

Rapid review of current service provision following cancer treatment



Acknowledgement

NHS Improvement would like to thank all the clinical teams who completed the questionnaire and the cancer network teams who supplied additional local information which enabled this review to take place.

Introduction

NHS Improvement carried out a rapid review of current provision of services for breast, prostate and colorectal cancer patients following treatment during the summer of 2009 at the request of the National Cancer Survivorship Initiative (NCSI).

The purpose of this rapid review was two-fold;

- To provide a baseline across England to establish what services are currently provided to patients following their treatment for cancer
- To capture any innovative practice within the service.

The review was carried out via the cancer networks who were provided with a template questionnaire (appendix 1) to send to clinical teams and Primary Care Trusts (PCTs) to gather information. This was supplemented with further information at the review meetings with network directors, nurse directors, service improvement leads and/or survivorship leads.

The network approach was varied, with the questionnaires sent in the majority of cases to hospital providers, namely cancer managers, clinical Multi-Disciplinary Teams (MDTs) or lead nurses for cancer (usually Cancer Nurse Specialists (CNS')). A few sent them on to PCTs or network cancer specific clinical groups. One PCT returned the questionnaire uncompleted, commenting that they felt it needed to be targeted to secondary care organisations. One cancer network took the decision not to send out the questionnaire to any organisations.

The number of questionnaire responses used for the purpose of the review was; breast (84), colorectal (85) and prostate (75). All cancer networks participated in the review (24 by face to face meetings and 4 by conference call).

The report covers the following areas taken from the questionnaire; pathways of care and follow-up, key workers, patient assessment and care planning, rehabilitation and patient support services. Where examples of innovative practice have been identified in this report they are marked with a number that corresponds to their number in the list in appendix 2.

Pathways of Care

Most clinical teams who participated or their cancer networks indicated they did have pathways of follow-up care, but few examples were attached to the questionnaires as requested. Where there were pathways either at consultant or network level, these were generally very detailed up to the time of treatment, but the follow-up element was poorly articulated. There were, however, exceptions to this with some clinical teams having pathways or protocol driven follow-up in which patients chose the model of follow-up (acute or community led) in partnership with their clinician. Many services relied on consultant protocols for follow-up that are generally focussed on routine outpatient visits to 5 years and then the patient is discharged.

The pathways in general are very focused on the medical surveillance and follow-up with little information about meeting holistic needs. Referring to a survey in 2007, patients and professionals in hospital and primary care had identified the key reasons for follow-up being;

- To detect recurrence early
- To manage the early complications
- To manage the late effects of treatment.

From the questions some had commented “Depends on the patient” and others indicated “Follow-up as per consultant protocol”.

There was a wide variation from no follow-up, with rapid access, to lifelong follow-up visits combined with or without surveillance tests depending on the tumour site. Network representatives expressed surprise that the questionnaires showed variance from the agreed network pathway where these had been agreed. Since this review some networks are planning an audit of the agreed pathway and local practice.

Surveillance with the use of blood tests, radiological investigations or physical examination differed from tumour to tumour. Even within individual tumour sites variance from standard pathways is evident.

Breast	Colorectal	Prostate
<p>Mammography ranged from annually to 3 yearly until connected to screening programme. Differences within and across networks. Results were communicated by letter or throughout patient consultation depending on time of testing and local arrangements. For screening patients it was invariably by letter. For many, the pathway was managed by the breast surgeon irrespective of treatment, especially where patients were treated with curative intent.</p> <p>Physical examination at the time of follow-up was mentioned by many teams. There was some evidence, though patchy, of pathways that were based on patient need or clinical risk.</p>	<p>Surveillance included CT, MRI, CEA, colonoscopy, sigmoidoscopy and liver ultrasound at various intervals, depending on patient need. In general there was little consistency within and across cancer networks as to the pathway for the majority of patients. The precise pathway for patients was decided by the individual clinician, protocol or through the MDT. There were examples of practice where patients were stratified according to clinical risk and would either have a 'stock take' visit which would determine the model of follow-up care, this could range from a self management model with rapid access^{1,2} or face to face management.</p>	<p>Prostate surveillance was generally for life and involved regular PSA testing. Patients also have bone or MRI scans where deemed clinically appropriate. Pathways differed within and across networks to the frequency of surveillance and how it was managed. For many it was managed by hospital specialists and their teams. For some, after a period of time and where the patient appears clinically stable, surveillance was through Local Enhanced Service agreement and or shared care protocols with GPs.^{3,4} There was an example of remote PSA monitoring where the patient was sent a self assessment questionnaire at the time of testing and the test result and responses to the questionnaire combine to trigger an intervention or not.⁵</p>

Follow-up

Most patients experience the 'one size fits all' approach to clinical follow-up which is essentially medically led though surveillance or outpatient visits. There were differences in the frequency of follow-up and the content of the follow-up visit between clinical teams, organisations and across networks. Follow-up was usually for a defined period of time after which if problems arose, patients were re-referred to the service by their GP. The majority of follow-up for a defined period was hospital based with few examples of community led follow-up or surveillance. Some CNS's provide advice after patients had been formally discharged.

The majority of follow-up was provided within the hospital setting either at the local DGH or cancer centre. The method of follow-up was mainly through face to face outpatient clinics and, depending on the specialty, was either led by consultants or

clinical nurse specialists. One organisation is planning to test a new model of group follow up “big clinic” conference event for selected prostate patients in a non-clinical setting to reduce outpatient appointments.⁶

Breast	Colorectal	Prostate
<p>The frequency of follow-up ranged from 1 outpatient visit to 12 visits or more over a 5 year period. In general follow-up for primary tumours regardless of treatment was the breast surgeon. For some it was shared care between surgeon and oncologist. The CNS generally worked in support of the breast surgeon and in most cases were members of the surgical team. There were some examples of nurse led follow-up care. There were examples of low risk stratified patients having no follow-up following treatment but having rapid access should problems occur.^{7,8} This choice was often made jointly between the clinician and the patient in services where this was an option.</p>	<p>In general follow-up depended on the specialist in that treatment modality. Decisions were also made on who and what the follow-up should consist of through MDTs. Where combination therapy was given shared care between surgeons and oncologists prevailed. Generally follow-up was for 5 years then discharge. There were many examples of patients being followed up by the CNS⁹ freeing up the consultant to see the more complex cases. There were a few examples of nurse led follow-up services based on clinical risk stratification and patient involvement in deciding the frequency and type of follow-up in those organisations where choice was available.</p>	<p>Generally follow-up is for life with regular annual PSA testing for most patients. Unstable patients are generally managed by the consultant and stable patients by the CNS¹⁰ or the GP under shared care or as a Locally Enhanced Service^{11,12}(LES). In general the reason stated for follow-up was to give PSA results which were either done through a face to face meeting in an outpatient clinic or by telephone¹³ usually by hospital staff. In many cases the GP would be asked to arrange for the blood sample to be taken a week before the outpatient appointment at hospital. If problems arose between clinics the CNS either provided advice and support or arranged for appointments to be brought forward.</p>

Key Workers

The term ‘key worker’ is an issue for many organisations especially where the contact was otherwise known as the CNS, BCN, Senior Nurse, AHP, Macmillan Nurse, District Nurse or GP. Several say patients are often confused by the terminology and are unsure whom to contact. Key workers were generally assigned to patients at diagnosis and for the majority of patients the key worker was a nurse specialist where they were available, for others it was the consultant, contactable through the consultant secretary, or the GP. Several sites stated the key worker changed during treatment and some offered at least two names and contact details to ensure cover during leave etc. During office hours all offered telephone (most with answer phone) or bleep contact details. Services out of hours were very patchy with the default being primary care or A&E. One site is testing an out of hours

evening and weekend service via NHS Direct.¹⁴ Contact via email was proving increasing popular with patients and a number of sites offered weekly nurse led open access drop in clinics.

Patient Assessment and Care Planning

The following reflects the answers to the section in the questionnaire relating to assessment and care planning. It has four sub-sections that seek to establish the various tools in use, those used for screening and whether patient or professionally led and the use of care plans and whether patients had choice and control in their development and agreement.

Tools for patient assessment: There was an equal split between organisations that use tools for assessment and those that do not use any. Of the assessment tools in use over 20 different tools were cited. The most popular was the Distress Thermometer (DT). A few organisations have developed their own tools either for assessment or in order to document a care plan and others have developed checklists for staff to use as part of the assessment process.

Findings from a recent report from the National Cancer Action Team identified that 13 networks have proposed a network wide approach to the use of either the Distress Thermometer (7) PEPSI COLA aide memoire (2) SPARC (2) or a locally developed tool (2).

The tools used vary depending on patient need and a few are used for specific tumour groups. In breast cancer the DT and Pepsi Cola tool appear to be the tools of choice. Similar tools are used for colorectal cancer with the addition of the Malnutrition Universal Screening tool (MUST) tool. In prostate cancer the use of IPSS tool for the assessment of lower urinary tract symptoms (LUTS), continence assessment tools or sexual dysfunction tools were mentioned by a number of sites.

If the needs are psychological the use of the DT (sometimes referred to as the Concerns Tool) or Hospital Anxiety and Depression Score are used. A number of sites and especially those running research trials use 'Quality of Life' assessment tools such as the European Organisation for Research and Treatment of Cancer (EORTC). Most tools mentioned are appropriate for use with any type of patient and are not designed exclusively for cancer patients.

Screening tools; when asked whether screening tools are in use prior to a more in depth assessment 48% of those that answered this question say that they use a tool and of these 50% report assessment was professionally led, 11% say patient led and the remainder did not answer.

Care plans; slightly more organisations state they use care plans than do not. However, the term 'care plan' was interpreted in different ways - with the majority assuming it is a record of a planned action in the case notes rather than a more formal plan of care. There was very little evidence of written survivorship care plans in place. Some include a description of the planned care within the clinic letter and there were some excellent examples of hand held diaries¹⁵ in use with pockets to hold future investigation forms, correspondence and leaflets.

Some sites have developed their own local care plan documentation and a number use the screening tool document to record priorities and personal goals for patients. This was common for sites where the DT has been adapted to incorporate the care plan on the back sheet. It was not possible to assess from the answers provided whether patients were offered choice and control in developing their care plan.

A number of sites identified barriers to care planning around lack of access to appropriate space to undertake discussions, information technology issues or lack of CNS time. Some sites however have established assessment and care planning clinics where all patients completing their treatment have an appointment to discuss their needs.

Rehabilitation

This section in the questionnaire asked about rehabilitation services that are available to cancer patients. The questionnaire did not specify cancer specific or generic services but included questions relating to the nature of rehabilitation services provided, how they are integrated into the pathway of care, whether services are targeted at particular patients and whether they are “opt in” or “opt out”.

In the main, cancer specific rehabilitation programmes are not available. The majority of rehabilitation is accessed through referral or signposting from the CNS into local existing services. There seemed to be some discrepancies as to which services constitute “rehabilitation”, in some areas this seemed to be dictated by what was available rather than an assessment of need. Most commonly, patients were referred to physiotherapy and dieticians. Many respondents also mention referring to occupational therapy, palliative care, stoma care and lymphoedema services based on individual need and tumour site. Relatively few refer to prosthetics, wigs, complementary therapies and plastic surgery; only two specifically mentioned smoking cessation.

Some rehabilitation is done as part of a peer support,¹⁶ planned fitness programmes^{17,18,19} or survivorship groups²⁰; including one example of patients using a Wii Fit to support their physical rehabilitation in the home and encourage exercise within the family.²¹

It is worth noting however, that some teams responded to the effect that specialist or general rehabilitation is “not applicable” for their patients. This response was received from at least one respondent in each of the 3 tumour groups.

For the purposes of this review, psychological services are those that are provided as part of the clinical suite of services. Emotional support is generally provided by peer groups and 3rd sector provision including charities. It is of course recognised that the 3rd sector do provide professional services at all 4 levels of intervention.

Two of the networks have recognised the value of psychological support for staff and have taken steps to address the needs of staff through training and ongoing support.^{22,23} Some organisations have raised concern on behalf of clinicians that if there is a shift to more self managed care and a consequent reduction in follow up visits for well and stable patients the case mix in clinics will change and stress levels

on staff could increase. i.e. clinics will have a greater concentration of patients with complex needs and/or high levels of emotional and psychological need.

Most responded that referrals are made to services according to individual patient need, usually assessed by the CNS for the specific tumour site. However few stated a specific tool being used to assess need (later in the questionnaire). Services are usually “opt in” if a need is identified, rather than being provided as the norm on an “opt out” basis. The majority of respondents referred to the levels of support as outlined in the model of professional psychological assessment and support below (*NICE guidance for Supportive and Palliative Care (2004)*).

Self help and informal support	Level	Group	Assessment	Intervention
	1	All health & social care professionals	Recognition of psychological needs	Effective information giving, compassionate communication & general psychological support
	2	Health & social care professionals with additional expertise	Screening for psychological distress	Psychological techniques such as problem solving
	3	Trained and accredited professionals	Assessment for psychological distress and diagnosis of some psychopathology	Counselling and specific psychological interventions, such as anxiety management and solution-focused therapy, delivered according to an explicit theoretical framework
	4	Mental health specialists	Diagnosis of psychopathology	Specialist psychological and psychiatric interventions such as psychotherapy, including cognitive behavioural therapy (CBT)

In most responses rehabilitation does not seem to be integrated into the pathway of care, it is a referral to services if a need is identified and local services are available. There is evidence of joint discharge planning between the hospital and social services with community support from district nurses^{24,25} and community teams being an integral part of the pathway in some places, but this is not the norm.

Patient Support Services

The section on patient support services refers to questions related to getting back to work, benefits advice services, emotional support, independent living and healthier lifestyle management.

Getting back to work: There were three sub questions for this question to find out about what advice is given to patients to support them getting back into work, who provides this advice and what is the access time for this advice?

In general, most advice is given by the CNS or consultant and takes the form of verbal advice or written communication through leaflets such as those written by

Macmillan or Breast Cancer Care. Many sites refer patients to the Macmillan Cancer Information Service for specific advice regarding getting back to work services. One site specifically mentions that they ensure patients are aware of their rights under the Disability Discrimination Act and another site specifies that they support patients in phased return to work. In one of the other areas, there was evidence that there is ongoing consultation between employers and the local cancer network regarding patient and employer needs in going back to work.²⁶ Some organisations refer patients to their own occupational health departments. Access time for advice largely is dependent on the availability of the CNS. The majority of CNSs indicated that they are available “immediately” and at any time within working hours which is in general between 9am and 5pm Monday to Friday.

Benefits advice: Similar to the section above, there are 3 sub questions for this question, to find out about what advice is available, who provides this advice and what is the access time for this advice?

The provision for benefits advice appears to be fairly universal with good access to specialist benefits advisors, often based within Trust Cancer Information Centres or pods that are supervised facilities and now available in the majority of the acute providers. The information takes the form of verbal advice from the CNSs or the specialist Benefits Advisors or leaflets from Macmillan Cancer Support and Breast Cancer Support. Some areas have Citizens Advice Bureaus (CAB) on site with Welfare Rights Officers in place. There are some organisations where CAB domiciliary visits are made available, but this is not universally offered. The access times for benefits advice varied, however, in the main, appeared to be quite short and very often within a few days.

Emotional/psychological support services: The same sub-questions apply to the section on emotional psychological support services. Many respondents mention complementary therapies as part of rehabilitation, more often funded or provided by local 3rd sector organisations, especially where there is a local support centre such as a Maggie’s Centre.²⁷ This does not form part of the usual pathway of care but is an added service meaning that access is very variable as it is dependent upon location of the nearest support centre and the success of local charities.

The respondents to the questionnaire indicate that Level 2 emotional/psychological support services appear to be universally available through the CNSs. There is patchy provision of cancer specific counsellors within trusts however. There is evidence that counsellors are available through Maggie’s Centres, some hospices²⁸ or other 3rd sector support services, where available, within the area. Level 4 psychologist provision is available but could be described as very patchy with lengthy access times, in some places, and this was a concern expressed by a number of networks.

Some areas cited that the easiest route through to such services is referring back to the GP and getting referral to mental health services. Complementary therapies are cited as being a useful form of emotional support, again with patchy availability and some lengthy access times. One trust has contracted out their psychological support services as they were unable to recruit through the NHS.

Independent living and healthier lifestyles: This section has 2 sub-questions, with questions asking if there was support available to encourage independent living, who coordinates this, and how is it aligned to the assessment and care planning process?

The majority of respondents said that there was support available. The coordination of this support varied widely, from the CNS and ward nurses within the acute sector, to the district nurses, physiotherapists, occupational therapists working in the community and hospital setting. Some respondents referred to supportive self management courses, information²⁹, groups and peer support groups to help patients to live with and beyond cancer provided by the NHS, national or local charities. For those sites participating in the Enhanced Recovery Programme for colorectal patients, there was an emphasis on supporting patients to be as independent as possible pre-operatively. The Expert Patient Programme was specified on some occasions. It was difficult to ascertain if this support was aligned to the assessment and care planning process as many respondents did not answer this aspect of the question.

Patient information is available from various places including the cancer team, information centres and sources within and without the hospital, the internet and is often in large chunks and developed as a pack given at a specific point in the patient journey. Some trusts are developing information prescriptions and one network also has a network breast cancer patient information pathway.³⁰

Discussion

Models of Follow-up

The variation in follow-up modes, rationale and access indicates that a clinical review of follow-up to standardise practice against current evidenced best practice would contribute to improved quality, productivity and outcomes. Recognition that current models cannot be sustained given the predicted increase in cancer survivors over the coming years is required and this, combined with addressing general survivorship issues will require a change in attitude towards new models of follow-up.

Assessment and care planning

The introduction of formal assessment tools and written care plans is currently being tested. The provision of care plans is very patchy and may need to be reinforced nationally in order to ensure all patients have informed choice and control during their cancer journey and on into survivorship.

Pathways of care

The variation in pathways of care identified has been immense, within networks and even within trusts. It would be useful for all networks to audit the actual patient journey against the network pathway regularly in different tumour sites to ensure consistency and compliance. This could form part of the peer review process for tumour sites to ensure that their rationale for the mode of follow-up is risk stratified,

adhered to and reviewed regularly against new developments in local services and policy.

Support Services

There was a wide variation of support services across the networks, depending on geography, commissioned and charity services available. This inequity of services needs to be considered and availability standardised where appropriate. Some networks reported being unwilling to complete holistic needs assessments with patients knowing that services may not be available to meet the needs identified.

National Cancer Survivorship Initiative (NCSI)

Review of Current Cancer Follow-up/Survivorship Services in England

Tumour site: **Breast / Colorectal / Prostate** (delete as appropriate)

Organisation: _____

Profession of person completing questionnaire: _____

(May be an individual or MDT)

Pathway of care

	Yes	No
1. Do you have a follow-up/survivorship pathway(s) in place? Could you please attach a copy of each pathway.	<input type="checkbox"/>	<input type="checkbox"/>
	One	More

2. Are there one or more pathways for follow-up care and support? If more than one pathway does this reflect a). Different approaches due to stage of disease/treatment given b). Management by different healthcare groups? E.g. clinical pathway, rehab pathway, primary care etc) (Please explain if pathway not available).	<input type="checkbox"/>	<input type="checkbox"/>
	a	b
	<input type="checkbox"/>	<input type="checkbox"/>

3. What surveillance tests are undertaken for patients following treatment for cancer and how are the results communicated to patients?

	Yes	No
4. Do patients have a key worker/coordinator of care/primary contact and what are the access arrangements?	<input type="checkbox"/>	<input type="checkbox"/>

Mode of follow-up

	Yes	No
5. Are patients given the choice between different follow-up options?	<input type="checkbox"/>	<input type="checkbox"/>

a. Hospital clinic follow-up

Frequency (Pathway timelines e.g. year 1: 3/12, Year 2: 6/12, Year 3; Annual)

By whom (Again relate to pathway timelines)

Purpose of the follow-up visit (To assess, give results of investigations, advice and support)

If problems arise between follow-up appointments or when there is no follow-up, what are the access arrangements and who coordinates this? (CNS, GP, Consultant secretary etc)

Are there separate arrangements for surgeon, physician, oncologist GP follow-up or is it coordinated?

b. Community follow-up

Yes No

Frequency (Pathway timelines e.g. year 1: 3/12, Year 2: 6/12, Year 3; Annual)

By whom (Again relate to pathway timelines)

Purpose of the follow-up visit (To assess, give results of investigations, advice and support)

c. No formal follow-up but rapid access should problems arise

Yes No

Primary contact for the patient to access the service

d. Supportive self management programme

Yes No

Who leads on this?

What does the programme consist of?

e. **Do you offer 1:1 and/or group follow-up?** (Please describe) Yes No

Patient Assessment and care planning Yes No

6. What tools are used for patient assessment and are they based on meeting patients needs?

7. Do you use a screening tool to identify need, which leads to further in-depth assessment where need identified? Yes No

8. If you use a screening tool is it patient or professional led? Patient Professional

9. Do patients have an individualised care plan that they have had choice and control in putting together? Yes No

10. Do patients have a **key worker/coordinator of care/primary contact** and what are the access arrangements? (delete as appropriate)

Rehabilitation services

11. What rehabilitation services are provided?

12. How is this integrated into the pathway of care and support?

13. What is the format of the rehabilitation service and who is involved?

14. Is participation in rehabilitation an opt in/out service or is it targeted at specific groups?

Patient support services

Getting back to work

15. What advice and support is available to patients?

16. Who provides the advice and support?

17. If support and advice available what is the access time?

Benefits advice

18. What advice and support is available to patients?

19. Who provides the advice and support?

20. If support and advice available what is the access time?

Emotional/psychological support

21. What supportive services are available?

22. Who provides the support?

23. If support and advice available what is the access time?

Independent living

24. Is there support available to encourage independent living following treatment? Yes No

25. Who coordinates and supports this and how is it aligned to the assessment and care planning process?

26. What support and advice is provided around healthier lifestyle management?

27. Who provides this advice and support?

Information

28. What information are patients provided with following treatment?

	Yes	No
29. Is the information targeted at individual needs at particular points in the pathway?	<input type="checkbox"/>	<input type="checkbox"/>

	Yes	No
30. Are patients sufficiently informed about their future living with and beyond cancer to be able to take control and have informed choice regarding how, where and by whom they are followed up including supported self management?	<input type="checkbox"/>	<input type="checkbox"/>

Clinical Trials

31. What are the arrangements for patients involved in clinical trials?

Any other comments

Please give any further comments you have regarding current or possible future follow-up/survivorship services for those living with and beyond cancer

Thank you for taking the time to complete this questionnaire

Innovation

APPENDIX TWO

There were examples of innovation in breast, colorectal and prostate cancer follow-up care with new models, technology, information and access arrangements being trialled, tested and developed across England, some of which are listed below. The first column indicates the page number on which the example is referred to.

Further case study examples will be available from the NHS Improvement Adult cancer survivorship website :

www.improvement.nhs.uk

Ref:	Site/Network	Tumour Group	Description	Contact name
1	Pan Birmingham Cancer Network	Colorectal	Discharged to GP at 6 week follow up visit	Mark.chapman@heartofengland.nhs.uk Catherine.Price@heartofengland.nhs.uk
2	Avon, Somerset and Wiltshire Cancer Network (Taunton NHS Trust)	Colorectal	Risk stratification to determine appropriate follow up pathway	Nicola Forsyth Lead Colorectal Nurse Specialist Nicola.forsyth@tst.nhs.uk
3	East Midlands Cancer Network	Prostate	Shared care scheme - Kettering with local LES agreement	Contact Trudi Cameron – East Midlands Cancer Network Trudi.cameron@leicestercity.nhs.uk
4	South West London	Prostate	Croydon, Richmond and Kingston shared care community follow up scheme. Local LES agreement with selected GPs with external supervision/advice to GPs from secondary care, Croydon PCT - £50K savings in first 6 months	Julia.Ozdilli@smpct.nhs.uk
5	Royal United Hospital Bath, ASW Cancer Network	Prostate	Where the patient is clinically stable, surveillance was through Local Enhanced Service agreement and or shared care protocols with GPs.	mary.barnes@aswcs.nhs.uk
6	3 Counties (Worcester)	Prostate	Annual 1/2 day 'conference' event planned for April 2010 supported by prostate database (interfaced with PAS and diagnostic systems) to ensure robust surveillance. Event will replace OP follow up for selected prostate patients.	anne.sullivan@worcester.nhs.uk
7	South West London	Breast	Patient Managed Follow up care - (just starting) based on Hillingdon model with patients discharged after treatment to self management scheme	Julia.Ozdilli@smpct.nhs.uk
8	North West London (Hillingdon Hospital)	Breast	Self triggered follow up following treatment supported by mammogram surveillance and open access via CNS within 2 weeks	Contact: Nadine.teuton@thh.nhs.uk Elizabeth.patterson@thh.nhs.uk terry-anne.leeson@thh.nhs.uk

9	Mid Essex Hospitals	Colorectal	Nurse led surveillance plan programme for patients treated with curative intent	Anna Wordley, Nurse Consultant (GI) Colchester Hospital University NHS FT anna.wordley@nhs.net
10	Colchester Hospital	Prostate	Nurse led surveillance with telephone follow up	Lucy.Powell@colchesterhospital.nhs.uk
11	Pan Birmingham Cancer Network	Prostate	Community based follow up post treatment	Alan.Ferguson@westmidlands.nhs.uk
12	Arden Cancer Network	Prostate	Shared Care Service with selected GPs in Warwickshire	Susan.Webster@coventrypct.nhs.uk John.strachan@swh.nhs.uk
13	Kent and Medway Cancer Network	Prostate	Consultant telephone follow up service to avoid OP clinic attendance	andrew.jackson@kentmedway.nhs.uk
14	East Midlands Cancer Network	All	24/7 access to CNS via NHS Direct (inpatient cancer programme). Trial underway to ascertain demand out of hours.	Contact Trudi Cameron – East Midlands Cancer Network Trudi.cameron@leicestercity.nhs.uk
15	North West London Cancer Network	Colorectal	Patient held dairies with care pathway, contact information, support networks.	North West London Cancer Network bonnieyandall@nhs.net
16	Lancashire and South Cumbria Cancer Network	Prostate	Peer Support Group, Morecambe Bay	George Niven (Chairman) Tel: 01524 32736 george@edencote.plus.com
17	Royal Bournemouth & Christchurch NHS Foundation Trust	All	Active Wellness Programme - Bournemouth After Cancer Survivorship Project (BACSUP) project - linking exercise rehabilitation with improved health and well being. Based at local fitness centre patients attend 12 week course	Rachael.Rowe@ferndown.nhs.uk
18	North Trent Cancer Network (Sheffield)	All	Prostate support group for patients post treatment with primary focus on exercise Sheffield University are leading a study on evaluating the effect of an exercise management programme on patient fatigue. Report to be published in palliative care journal	denise.friend@ntcn.nhs.uk Denise Friend - North Trent Cancer Network
19	Humber and Yorkshire Coast Cancer Network	All	Developing a gym based rehabilitation programme delivered in local gyms by health trainers	Trish Rawnsley Hull & Yorkshire Coast Cancer Network trish.rawnsley@hey.nhs.uk
20	3 Counties (Gloucester)	All	Back on Track' Nurse led Programme for cancer survivors o Offer 1:1 Or small group follow up in place o Tai chi teacher runs sessions, BCN attends to support the session o Annual breast cancer care support conference around healthier lifestyles and survivorship – running over last 3 years	Jane Fide, Lead CNS Breast Care Nurse Cathryn.fide@glos.nhs.uk
21	Peninsula Cancer Network	All	Exercise rehab project using Wii technology in patients homes	Linda Bedford, Service Improvement Facilitator Linda.bedford2@nhs.net

22	North of England Cancer Network	All	Psychological support service for consultants and other clinicians	Bill Richardson, North of England Cancer Network SIL Bill.Richardson@sotw.nhs.uk
23	Greater Midlands Cancer Network	All	Psychological support service for consultants and other clinicians	Amanda Dell Greater Midlands Cancer Network Amanda.dell@rwh-tr.nhs.uk
24	North Trent Cancer Network (Doncaster)	Colorectal	District Nurse provides standard follow up visit post completion of treatment in order to assess needs and arrange community support services. Has started with colorectal but plan to make available to all pelvic radiotherapy patients.	denise.friend@ntcn.nhs.uk Denise Friend - North Trent Cancer Network
25	Mount Vernon Cancer Network (Luton PCT)	Prostate	Community CNS led assessment and care planning for patients completing pelvic radiotherapy treatment	Sue Semper, Luton Primary Care Cancer Survivorship CNS Sue.semper@nhs.net
26	North Trent Cancer Network	All	"Employ Charter" launched on October 2008 to guide employers and employees around issues regarding return to work following treatment	denise.friend@ntcn.nhs.uk Denise Friend - North Trent Cancer Network
27	North West London (Imperial College Healthcare Trust)	Prostate	8 week programme for post treatment prostate patients based at Maggie's Centre, now developed into peer support group	Rachel.Sharkey@imperial.nhs.uk Macmillan CNS Urology
28	North West London Cancer Network	All	Health Pod PILOT - St Johns Hospice. Comprehensive assessment of well being using a number of assessment tools to give a comprehensive profile of the physical psychological and emotional stresses experienced by patients and their ability to cope with these. The pilot was for 3 months with a tailored programme of interventions following each assessment. e.g. pilates, dietician relaxation etc. Results were very positive including improved fatigue index.	Simon.Shepard@hje.org.uk
29	North West London Cancer Network	Breast	Network 'What Next' booklet covering nutrition, exercise advice, warning symptoms, Lymphoedema, managing stress etc plus contact information, support networks. Seeking ongoing funding as currently sponsored by pharmaceutical company	Christina.papadopoulou@eht.nhs.uk
30	East midlands Cancer Network	Breast	Network wide breast cancer patient information pathway	Contact Trudi Cameron - East Midlands Cancer Network Trudi.cameron@leicestercity.nhs.uk



NHS Improvement

With ten years practical service improvement experience in cancer, diagnostics and heart, NHS Improvement aims to achieve sustainable effective pathways and systems, share improvement resources and learning, increase impact and ensure value for money to improve the efficiency and quality of NHS services.

Working with clinical networks and NHS organisations across England, NHS Improvement helps to transform, deliver and build sustainable improvements across the entire pathway of care in cancer, diagnostics, heart, lung and stroke services.

NHS Improvement

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