National Cancer Survivorship Initiative

Self Management Support Workstream

Position Paper

April 2009

National Cancer Survivorship Initiative

‘Support for Self Management’ Workstream report: March 2009

1. Summary

Self management support as a philosophy and approach defined as: “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 and clinical and other outcomes”1 is now the guiding principle for organising services for individuals living with long term conditions. It was agreed that the potential for this approach to be adopted in services supporting cancer survivors should be assessed as part of the work undertaken for the National Cancer Survivorship Initiative. As a result of the work to date the Self Management workstream has developed a framework based on available evidence by which support for self management could be provided as part of ongoing support for cancer survivors. It is recommended that the framework is adopted for the NCSI and evaluated in service models designed to allow for disinvestment in current traditional approaches to follow-up after cancer treatment. Since self management support entails a fundamental shift in approach to the professional –patient relationship, it is recommended that the philosophy and approach required to underpin support for self management is adopted for the NCSI as a whole.

2. Policy Context: Self management

The drive to design and re-organise services around the needs of patients has been a central thrust of current government policy. The NHS Plan in 2000[2] set out proposals for ‘creating a patient centred service’, in which patients and their representatives would be fully involved in decisions relating to their care. The importance of engaging patients and the public was re-stated in 2002 with the publication of the Wanless report, *Securing Our Future Health: Taking a Long Term View.*[3] Wanless concluded that high quality care depended on the public’s full engagement in health improvement. In this “*fully engaged scenario*” the public is expected to be taking an active role in all aspects of its health and illness. In a follow up report Wanless re-iterated the importance of *self care* to his “fully engaged scenario”, but also stated that in order to make health decisions, individuals would need to be supported by appropriate information and professional advice.

Patient engagement and in particular *self management* has been particularly strongly emphasised and supported in the reform of care for people with long term conditions, with self management as an important element of long term conditions care.[4] The growing burden of chronic and long term conditions has exposed significant limitations in traditional models of care delivery which are reactive, curative, and focused on acute, episodic illness.[5] Over the past 10 years government policy has shifted persistently towards self management as an important element of long term conditions care.[6] [7] This has been realised in the implementation of a disease/care management approach, based on a holistic model for

[1] Adapted from The Health Foundation, Co-creating Health Programme 2008

[2] Department of Health, The NHS Plan, London: DoH 2000

[3] Derek Wanless, Securing our Future Health: Taking a Long Term View, (London, Department of Health 2002)

[4] Department of Health, Towards a DH/NHS Strategy to support Self Care. DoH 1996

[5] Jo Ellins, Angela Coulter, How Engaged are People in their Health Care? Picker Institute, 2005

[6] Department of Health, Towards a DH/NHS Strategy to support Self Care. DoH 1996

[7] Skills for Health, Skills for Care, Common core Principles to support Self Care. 2008

chronic disease management, and where the active participation of people with the long term condition is integral.[8] [9] [10] Various initiatives have been taken to encourage and empower people to manage their own long term conditions on a day to day basis including:

- *The Expert Patient's programme*, a self management education course aimed at increasing the person's confidence and efficacy to self manage;
- *"Better Choices, Better Health*" outlined a programme of action to improve access to high quality information
- Patient accessible electronic records and care plans
- The right to personalised care planning signalled in the Darzi review, and due to come in to effect in April 2009.[11]

3. Achievements of workstream to date

Workstream membership

Members were recruited to the workstream with expertise both in respect of cancer services from the perspective of NHS delivery and commissioning, and third sector provision of supportive services for cancer survivors; and specifically in respect of long term conditions, and self management development expertise from both the Department of Health, and university based research and research based testing. Specific long term conditions and self management expertise has been provided by the following members:

Angela Hawley	Department of Health, Self care Lead, Long Term Conditions, Directorate of Commissioning and Systems Management.
Mary Simpson	Department of Health, Deputy Director, Patient and Public Empowerment,
Dr Kate Lorig,	Director, Stanford Patient Education Research Centre, Stanford University, Palo Alto, California. Developer of Chronic Disease Self Management Course(EPP ins UK terms)
Andrew Donald	Birmingham East and North PCT, Chief Operating Officer. Author of commissioning guidance for commissioning self care support for PCTs.
Dr Anne Kennedy	University of Manchester, National Primary Care Research and Development Centre, Reader.

[8] Department of Health, Supporting People with Long Term Conditions,2005

[9] Department of Health, Supporting People with Long Term Conditions to Self Care, 2006

[10] Department of Health, Generic Choice Model for long Term Conditions, 2007

[11] Department of Health, Supporting People with Long Term Conditions, Commissioning Personalised Care Planning, London 2009

	Lead researcher for self management interventions for long term conditions across whole systems.
Dr Claire Foster,	University of Southampton, Macmillan Research Unit. Head of Department. Lead researcher on self care behaviours of cancer survivors, and systematic reviews on cancer self management support.

4. Tasks undertaken by the group

(i) Scoping of developments in self management, and consultation with experts

Considerable effort has been taken to explore in some detail the range of developments on a national and local basis which are driving the reform and transformation of care for people living with long term conditions, and where possible, for cancer survivors.

Experts and developments in the field of long term conditions and self care,	
The Health Foundation, Natalie Grazin, Ast Director, Co-creating Health Programme	Whole systems approach to implementing self management for long term conditions, 8 national pilots.
University of Manchester, National Primary Care Research and Development Centre, Professor Anne Rogers, HoD	Whole systems approach to implementing self management in primary care. RTC evaluating the pilot phase of the EPP in England.
Picker Institute, Dr Angela Coulter, Chief Executive	Effectiveness of strategies for informing, educating and involving patients.
Pfizer Health Solutions, Dr Iain McNeill, Medical Director, John Proctor , Head of PHS.	Telephone based self management support: projects for cancer patients at Guys& St Thomas, and Birmingham East and North PCT.
National Diabetes Support Team Diabetes UK	“National Year of Care”, redevelopment and redesigning personalised approach, including support for self management for people with LTCs. Starting with diabetes.
Strategic health Authorities, Long Term conditions leads PCTs, Long term conditions leads	The position of cancer self care and self management in relation to support services for people with LTCS.
University of Coventry, Health and Lifestyles Interventions, Applied Research Centre, Dr Julie Barlow, HoD	Self management education, evaluating the intervention
Expert Patient Programme, Community Interest Company. Jim Phillips	National developments for self management education
The Young Foundation, “Health Launchpad” with NESTA	Accelerating innovative service development for LTCs

University of Stirling, Cancer Research Centre, Dr Gill Hubbard	Developing cancer services: patient and carer experiences
Cancer Council South Australia, Kerri Beckmann	Self management education programmes for cancer patients – modifications of the CDSMC

(ii) A mapping review of some examples of self management interventions in a range of Trusts was completed in 2008, with the aim of gaining a 'snapshot' of what was going on in cancer services for survivors in some way focused at self management. Exploring and following up on a some of the key national initiatives in long term conditions care was also undertaken.

(iii) A review of the evidence base for self management support for cancer survivors, (and including evidence from self management support for people living with long term conditions) was commissioned in 2008 from the Macmillan Research Unit, University of Southampton, and completed and delivered in February 2009.

(iv) A systematic review of outcome measures for self management support interventions has been commissioned from a consultant researcher most lately employed on the cancer PROMS review at the Department of Public Health and Primary Care, University of Oxford, and with the provision of expert advise by Professor Ray Fitzpatrick head of the above department. Due to report in April 2009.

(v) A guidance document has been commissioned, which aims to provide commissioners of health and social care services with the information and support they need in order to fulfil their obligations to embed self management in services for people living with long term conditions – in this case, for people surviving cancer. It supports World Class Commissioning, and the aims of the National Cancer Survivorship Initiative vision. Due to report in May 2009.

(vi) Early and systematic engagement with key policy and strategic leads in relation to self care and self management for long term conditions was commenced in August 2008. In the DH the lead for self care sits in the Directorate of Commissioning and Systems Management. Self Care Lead Angela Hawley is a work stream member and had been and invaluable source of advice and influence, facilitating changes and additions to NHS Choices resources for self care(*Your Health Your Way*) to include self care cancer survivors alongside resource for self for other long term conditions. Consultation with Strategic Health Authority self care leads, is leading to more local awareness of the need for cancer self management support.

5. Framework for Self Management Support

A framework of the processes and interventions which enable self management to take place effectively and which should be made available to cancer survivors, has been established through the evidence review and scoping work, and agreed by the workstream members.

The elements of this framework includes:

People in control of their long term condition
Assessment and survivorship care planning
Transformation of the professional patient relationship
Health professional training
Self management education for patients – the 'activated' patient
Integrated care programmes – 'whole systems approach'
Assignment of a consistent 'supporter'

- **People in control of their long term condition.**
  Population surveys in England in 2005, [12] and updated in 2007[13] demonstrated an appetite and interest by people in both practicing self management and leading a healthy lifestyle. Of those with long term conditions(including cancer) 87% were interested in more actively managing their condition. In a long term study of supporting people to change their diet, it is demonstrated that cancer survivors are prepared to adopt self management approaches over a long period if they are appropriately supported.[14]

- **Assessment and survivorship care planning**
  Assessment for a survivorship care plan can be facilitative of self management, if it includes the skilled facilitative practitioner, and the 'activated' person engaged in collaborative goal setting, action planning, monitoring, and coaching. The workstream supports the thrust of the principles of personalised care planning as set out in the recent guidance to the NHS on commissioning personalised care planning for people with long term conditions,[15] and recommends that all cancer survivors have personalised assessment and care planning by skilled facilitative practitioners as requirement for their post treatment care, such care planning:

  - **Puts the individual, their needs and choices that will support them to achieve optimal health and well being** at the centre of the process;
  - **Focuses on goal setting and outcomes** that people want to achieve, including carers
  - **Is planned, anticipatory and proactive** with **contingency** (or emergency) **planning** to manage crisis episodes better(for those with complex needs);
  - **Promotes choice and control** by putting the person at the centre of the process and facilitating better management of risk;
  - **Ensures that people** especially those with more complex needs or those approaching the end of life, receive coordinated care packages reducing fragmentation between services;

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[12] Picker Institute, Jo Ellins, Angela Coulter, How engaged are people in their health?

[13] Department of Health, Self Care: A national view in 2007 compared to 2004-05, June 2007

[14] Pierce, J.P. et al., Influence of a diet very high in vegetables, fruit, and fibre and low on fat on prognosis following treatment for breast cancer: the Women's Healthy Eating and Living (WHEL) randomized trial. JAMA, 2007. 298(3), 289-98

[15] Department of Health, Supporting People with Long Term Conditions, Commissioning Personalised Care Planning, 2009

- **Provides information** that is relevant, timely and accredited to support people with decision making and choices(eg supported by an **Information Prescription**);
- **Provides support for self care** so that people can self care/self manage their condition(s) and prevent deterioration(eg support by ***Your Health, Your Way***);
- **Facilitates joined-up working** between different professions and agencies, especially between health and social care; and
- **Results in an overarching, single care plan**, that is owned by the person but can be accessed by those providing direct care/services or other relevant people as agreed by the individual, eg their carer(s). This may be a written or electronic document or may be something that is recorded in the person's notes. **The important aspect of this is that the care planning discussion has taken place with an emphasis on goal setting, equal partnership, negotiation, and shared decision making. (***note that the self management workstream would want these features to be strongly evident in the assessment framework being developed by the assessment and care planning workstream)*

Assessment and survivorship care planning using this framework entails a significant shift in philosophy, approach, skills and competencies on the part of health professionals and consideration needs to be given as to how such a shift could be achieved.

- **Relationship between patient and health care professionals**
  Helping patients to enhance their self management will include moving away from traditional relationships between patients and health care professionals to think more broadly about the social context in which the patient lives, and the wide range of support which would reflect an holistic model of support. Evidence from the Health Foundation suggest that for self management to be truly effective a new approach needs to be taken.16 This is referred to as "co-creating health". The difference between this principle and those used in the Expert Patient Programme is that co-creating health is an active and collaborative partnership between patients and their health professionals. Key points are:

- The agenda is set by patient and clinician collaboratively
- Decisions about what skills and knowledge are needed are decided together
- Clinicians and patients understand that health behaviour change is brought about by the belief in the ability to change (self efficacy) and not by knowledge alone
- The patient believes they have an active role in bringing about their own health improvement
- Goals are set by patients and supported by clinicians.
- Decisions are made as a patient-clinician partnership

- **Health professional training:**

  In order for cancer survivors to become effective self managers, there is a need for professionals to be able to support and encourage self management, arguably a quite different skill set from the current cancer professional skill set. The context of having had cancer and surviving it, leads to the need for support to adapt to a new and

[16] Angela Coulter, Jo Ellins, Patient focused interventions: a review of the evidence, 2006, The Health Foundation.

changed life. A range of training models for improving the communication skills of professionals to support self care is being trialled in long term conditions care, as well as in cancer services. One notable example of such a model is part of the Co-creating Health Programme . A training programme for health professionals to support cancer patients and carers in self action was seen as producing significant benefits in a study by Hopkinson.17 The workstream believes that a major workforce training programme similar to or even as an additional component to the advanced communication skills programme may be required if self management support is to become a feature of support for cancer survivors.

- **Self management education for patients – "the activated patient"**

  Self management education for patients helps participants strengthen their health behaviours. It does this by developing health literacy, building an appreciation of peer support, developing collaborative decision making skills, and building knowledge of self management techniques as well as participants self confidence in using these techniques. Recent literature suggests that co-facilitation by a clinician and an 'expert patient' or trained survivor, creates a strong model of partnership and collaboration.[18] [19] The aim is to help participants to build knowledge and skills for their medical condition, as well as self management skills such as problem solving, and action planning. Targeted programmes are more successful to bring about change than generic programmes. Alongside self management courses, there is a need to have a variety of support materials, which may be written, web based, CDs or other, as appropriate to the target group.

- **Integrated care programmes – 'whole systems approaches'**

  Self management courses alone are of limited effectiveness if they are isolated from main stream health and social care services. Programmes for people with chronic illness such as diabetes have been under development for many years. Integrated care programmes are those which combine self management support and patient education, with structured follow up and case/care management. A summary of approaches to development using 'whole systems' models are at Appendix 1.

- **The assignment of a consistent 'supporter'**

  Feeling 'abandoned' following completion of primary treatment is a near universal complaint by cancer survivors. A finding in the Health Foundation report on self management in chronic illness was that although the objective is to give patients greater autonomy and control over their health, many of the studies point to the importance of regular contact between patients and those supporting them. Although patients do in the main have access to clinical nurse specialists, there appears to be a

[17] Hopkinson J.B. How people with advanced cancer manage changing eating habits, Journal of Advanced Nursing, 2007, 59(5) 454-62

[18] Griffiths C. Taylor S. et al. Self management education by lay leaders for people with chronic conditions, Cochrane Data Base Systematic Review 2008

[19] Greenhalgh T. Patient and public involvement in chronic illness: beyond the expert patient. BMJ, 2009; 338 b49

range of reasons why this is not always as effective as it may be, especially as time goes on. Approaches which have evidence for effectiveness in long term conditions, including case and care managers, and which have supported self management as integral, have potential utility to replace current follow up models. This does not need to be in a face to face situation, but can also be through telephone and internet based approaches, or a mix of all three.

6. Testing and evaluation

The workstream is now moving in to the phase of designing and testing of self management interventions in the context of service improvement and redesign, initially within a current NHS Improvement test community, and subsequently in two or more other sites. The design of the interventions will learn from the work of the Health Foundation in Co-Creating Health. Pilots will consist of three strands of work which together will provide a whole systems based approach and will consist of, a self management education programme for survivors. A development programme for clinicians/supporters improving their communication skills and teaching them how to provide self management support. Third is piloting the framework for self management support in the context of a new approach to follow- up in the first instance for breast cancer patients incorporating telephone based care management, community based case management, and where there will be the opportunity to include service changes designed to enhance self management. Subsequent pilot sites will focus on colorectal and prostate cancer.

7. Evaluation and outcome measures

The evidence base for cancer self management support is limited, therefore evaluation of such interventions is crucial. Outcome measures that have been used to measure effectiveness in self management interventions have included: disease status, symptom management, health related quality of life, self efficacy and self management behaviours, functional status, psychological well being, medication use, coping skills, health service utilisation, patient satisfaction with quality of interaction with professionals. A systematic review of outcome measures for self management interventions is currently in production and the findings will be incorporated into the evaluation of the pilot initiatives. The evaluation for the pilot sites is currently being designed.

8. Current workstream activity

The workstream has moved in to the phase of selection of one or more pilot initiatives using the framework for enabling self management support which can be supported by NCSI. The minimum criteria for selection would include:

- The ability to launch quickly
- Able to adopt the framework- ie the whole systems approach, support model, workforce development programme, and self management education for survivors
- Desire to replace traditional follow up or to test supported self management as an adjunct to follow up
- Readiness to take up an opportunity of working in partnership with Macmillan and other potential partners, to pilot approaches for self management support based on the framework described in this paper.

- Involvement and commitment of local commissioners
- Commitment to robust evaluation.

The opportunity has presented for a first site for piloting the self management support framework to be the NHSI test community of Birmingham East and North PCT and its partners.

Timescales for pilots

Activity	Timescales
Birmingham East and North: Co-design/development of models of post treatment supported self management: education for survivors; support materials for survivors; information prescriptions; service model for support – telephone care management; workforce development programme(communications skills)	Achieved Aug 09
Commence interventions with the launch of the test community follow up pathways.	Sept 09
Selection of additional sites – one or two with different tumour groups, geographical location, cultural and ethnic mix	July 09

9. Summary and Conclusions

For the workstream, the vision is of a local health and social care community where cancer survivors are supported from an early stage post primary treatment in services that are designed around the support for self management framework as outlined in this paper. Individuals are supported to find sources of information they need in a way that makes sense to them. They can find and join support groups and networks, and are routinely offered self management skills training. In this scenario health professionals receive appropriate training and education so that they understand and can practice the principles of self management while also providing ongoing monitoring and early intervention for problems that may arise. At every contact and part of the survivorship framework, professionals ask themselves “am I doing as much as I can to enable this person to manage their condition and its effects as independently as possible”? Self management is not about professionals handing over all responsibility to individuals, but a two way communication, negotiation and decision making process in which both the individual and professional contribute to the care planning process to achieve the best possible outcomes. Commissioning and organisational processes that shape services underpin and facilitate this process.

It is envisaged that should the pilot models of post treatment support based on the framework for self management, for example using telephone based care management demonstrate that they are cost effective and enhance health outcomes for cancer survivors, these approaches would be recommended by NCSI in replacing costly and ineffective traditional models of follow-up.

The workstream is recommending that:

- The NCSI adopts support for self management as a guiding philosophy and approach for all services for cancer survivors following primary treatment for cancer.

- For the cancer action and policy team to take account of the needs for the preparation of professionals to enable cancer survivors to self manage. This is relevant in the context of the *'Connect'* programme.
- NCSI considers the implications of supporting and enabling self management through the assessment and care planning framework, and strengthens this aspect of the framework.
- NCSI recognises the necessity of alignment around the agenda for self management of cancer as a long term condition. This could be explored and strengthened at national policy, and local strategy levels.

Lynn Batehup and Jessica Corner

Self Management Workstream

March 2009

Appendices.[20]

[20] Appendices: Appendix 1, Whole Systems Models; Appendix 2, Workstream Targets; Appendix 3, Benefits of self management support for cancer survivors.

Appendix 1

Whole Systems models

Name of model and authors	Elements of model	Applications
Chronic Care Model, Bodenheimer T. Wagner EH. Improving primary care for patients with a chronic illness: the chronic care model, Part 2, JAMA 2002:288:1909-1914. Components of the model are based on research evidence(see *Living with Long-Term Conditions. A review of UK and international frameworks*, University of Birmingham HMSC, and the NHS Institute for Innovation and Improvement. 2006)	Community resources and policies Health care organisation Self management support Delivery system design Decision support Clinical information systems	Has been applied to the development of managed care approaches for people living with long term conditions(diabetes, arthritis, chronic heart and lung conditions, depression etc) where the majority of care is provided in primary and community settings, and self management is a major element.
WISE – Whole System Informing Self-management Engagement. National Primary Care Research and Development Centre, University of Manchester.(includes supporting evidence for elements of the model) Kennedy A Rogers A Bower P. *Support for self care for patients with chronic disease,* BMJ, 10 Nov, V,335, 968-970	Informed patients Trained professionals Healthcare system geared up to be responsive to patient's needs	Whole systems perspective to self care within the context of the management of long term conditions in primary care. Has been tested in interventions with patients living with Chrohns disease, ulcerative colitis, irritable bowel syndrome, depression and anxiety. For example: Providing patients with an information guidebook based on current best evidence; Training clinical professionals in patience centred consultation skills to establish a collaborative approach to decision making; Changing service organisation to allow patient open access to OP clinics appointments and other sources available.
Integrated care programmes for chronically ill patients. Ouwens M. Wollerheim H. Hermens R. Hulscher M. Grol R. *Integrated care programmes for chronically ill patients: a review of systematic reviews*, International Journal for Quality in Health Care, V17, 2; 141-146 Evidence from review indicated a core set of integrated care	Patient centredness – care organised around the needs and preferences of patients, patients actively involved in decisions about their own care Multidisciplinary care – optimal collaboration of all professionals and patient,	Research reflected the full range of long term conditions, with the most common components of 'integrated care programmes' being; Self management support and patient education Structured clinical follow up and case management A multidisciplinary patient care team Multidisciplinary clinical pathway and

components, in line with the Chronic Care Model of Wagner and Bodenheimer(see above)	Organisation of care – seamless and continuous care is given with optimal coordination and organisation of the total care process	feedback Reminders Education for professionals
Integrated care for patients with cancer. Ouwens M. Hulscher M. Hermens R. Faber M. Marres H. Wollersheim H. Grol R. *Implementation of integrated care for patients with cancer: a systematic review of interventions and effects,* International Journal for Quality in Health Care, 2009, 1-8 This work builds upon the first review above, and applies it to cancer interventions.	Patient centredness Organisation of care Multidisciplinary care	Research reflected the following cancer types: breast, lung, colorectal, prostate, bladder, gastric – specifically, and a range of mixed cancers generally. No study within the dates of the review used all three elements of integrated care. Concluded that a multicomponent intervention programme that maintains all three principles of integrated care, is required if it is to improve care.
Co-creating Health A whole system approach to embed self management support in to mainstream health services. The Health Foundation, Briefing, May 2008 Co-creating Health. Based on a widespread review of national and international literature, evidence and best practice, and builds on the Wagner model of Chronic Care.	Patient – self management support for patients. Informed, empowered patients Professionals – skilled in collaborative and patient centredness Service improvement – organisation systems and process changes	Interventions delivered for people living with long term conditions: diabetes, COPD, depression, musculoskeletal pain.

Appendix 2 workstream targets

Workstream Target	**Completion Date**
Self management support: a review of the evidence. This will be a working document, and will be updated as is seen necessary.	Q1: February 2009
Review of outcome measures for self management support for cancer survivors (but will also draw on the long term conditions measures): Recommended suite of self management outcomes measures.	Q2: May 2009
Guidance for commissioning cancer self management support	Q2: May 2009
Co-Design/development of models of post treatment support: self management education course and support materials for survivors; service model for support – key worker/care/case management; professional training models	Q3: August 2009
Establish demonstration sites for post treatment support based on principles of supported self management: First site established with Birmingham East and North PCT/HoE NHS Trust/Pan Birmingham Cancer Network.	Ongoing

Appendix 3 – Benefits of self management support for cancer survivors

Potential benefits for cancer survivors	
Potential Benefit	**Achieved through self management by:**
• Supported goals to regain healthy, independent life. • People learning about the likely consequences of treatments in the short, medium and long term, and how they can manage them. • People learning about their condition and how it will impact on their lives.	Having someone in partnership to carry out an assessment and self management plan, which includes a discussion about their full needs. This recognises that many things can affect health and well being, including psychological, emotional, physical and social issues. Focusing on outcomes and goal setting, such as healthy eating, returning to exercise, returning to work /education. Providing people with timely tailored information in a way that they can understand, and support self care and self management.
• Empowered individuals who recognise their own self efficacy and with more confidence and ability to self manage their condition. • Individuals having the information they need to make choices and be in control of their support and treatment. • Better adherence to treatment and understanding of risks.	Providing access to self management education programmes which support and/or enhance people's self efficacy, goal setting, problem solving and action planning, and knowledge and understanding to manage effects of cancer and treatments.
• Co-ordinated and 'joined-up' support • More support for cares/supporters enabling them to meet their outcomes.	Having a consistent person to lead on care planning, service coordination, can have a positive impact on the person and their carer/supporter, particularly for people with a range of complex health and social care needs – progressive disease, late effects, with a range of co-morbid conditions, for example
• Reductions in: • Crisis episodes and unnecessary admissions to hospital • Late recognition of life threatening symptoms • Unnecessary GP visits • Unnecessary outpatient visits	Having a contingency plan, eg who to contact, what to do in a crisis episode Having a care manager who can provide advice and guidance, and coordinate appropriate referrals. Increased selfcare and self management – there is evidence of reductions in GP and OP appointments. Supporting people to be independent, and better management of risk.
Potential benefits for commissioners, providers and the workforce	
• Improved patient experience and outcomes for cancer survivors, services provided in the right place, and when	Focusing on personalisation, choice, and outcomes, through the self management care

needed. • Supporting achievement of World class commissioning, including a number of WCC competencies • Better management of risk	plan. Meeting all needs, through true partnership discussion should promote more choice. Information from care plans can inform and support needs assessment
• Value for money, clinical and cost effectiveness • Efficiency savings resulting from reductions in use of specialist services, OP appointments, GP visits, and avoidance of unnecessary complications due to poor management of co-morbid conditions	Having contingency plan – eg who to contact, and what to do in an emergency/crisis Increased self care and self management there is evidence of reductions in GP and OP appointments Supporting people to be independent, better management of risk.