

Draft Business Case

Self-management pathway - Cancer Services

Executive Summary

The primary purpose of follow-up is to detect for cancer recurrence and identify and treat late effects of treatment. The traditional model follows a standard regime of outpatient appointments and surveillance tests over several years. Patients can be seen by any member of the clinical team.

Increasing incidence of cancer (currently 3% per year) alongside increased survival rates are putting huge pressure on outpatient resources and impacting on the quality and efficiency of services provided. Both patients and professionals have identified that many appointments are unnecessary, add no value and incur unnecessary costs for patients.

The (*insert team*) have reviewed their current clinical pathways and propose the introduction of a self- management or open access pathway option for low risk patients, offered soon after the completion of treatment and when the short term effects of treatment have subsided. Key enablers to support this pathway are an effective assessment process to identify and manage individual needs and a remote monitoring system to ensure surveillance tests are safely monitored.

A number of options were considered to support this approach:

	Option	Description
1	Do nothing	Standard follow up regime continues (tests and face to face outpatient appointments) for all patients with specialist team over five years irrespective of risk. No formalised review of care needs after completion of treatment.
2	Supported self- managed pathway - specialist monitors surveillance tests	Specialist led scheduling and monitoring of surveillance tests for low risk patients without the need for face to face appointments. Assessment of need, a care plan and treatment summaries completed.
3	Self- managed pathway - primary care monitors surveillance tests	At end of treatment low risk patients referred to GPs for monitoring surveillance tests. Assessment of need, a care plan and treatment summaries completed prior to referral. Referral back to specialist for abnormal results.
5	Self- managed pathway - external provider monitors surveillance tests	At end of treatment low risk patients referred to an external provider for monitoring surveillance tests. Assessment of need, a care plan and treatment summaries completed prior to referral. Referral back to GP or specialist for abnormal results.

Option 2 is the preferred option. This option is favoured over other models because:

- It offers higher patient safety. A robust IT solution built specifically for this purpose ensures no patient slips through the net;
- Higher rates of referral to open access pathway are expected as patients remain under specialist watch rather than in primary care or external service;
- There will be easier access to MDT or specialist advice for equivocal or abnormal results;
- Patients are more likely to accept the self-management pathway choice if remaining under ‘specialist supervision’;
- The ‘do nothing’ option will rapidly need new resources (Consultant sessions and outpatient space) as demand exceeds capacity.

Benefits of a specialist led open access pathway:

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|---------------------------|---|
| To patients: | Follow-up model based on choice;
Reduced personal costs associated with outpatient attendances;
More rapid re-access/recall to specialist if needed |
| For providers: | Improved access times for new referrals;
Increased time in clinic for those with complex needs;
Fewer overbooked clinics; and
Released outpatient capacity. |
| For commissioners: | More effective use of local outpatient capacity;
Improved quality of service for local population;
Improved communication between specialist and community teams;
Safer service - fewer patients ‘lost to follow up’; and
Monitoring surveillance tests remains under ‘specialist watch’. |

This solution is expected to take 6 months to implement. Investment in a remote monitoring system and other qualitative initiatives are required to safely implement this option. The pathway will offer a return on investment within (insert time).

The capital costs of set up is (insert year 1 capital costs) and has (£ insert) on-going revenue implications.

This proposal has the full support of *(insert directorate and or commissioning group)*.

1. Introduction

This business case proposes the introduction of a supported self-management pathway within *(insert cancer specialty areas)*. This solution requires investment in a remote monitoring solution and a more formalised approach to needs assessment and care planning to ensure that patients offered this pathway are informed and confident to manage their condition without regular face to face contact with the specialist team. The solution enables the release of outpatient capacity and aligns with the local strategy to improve the efficiency and effectiveness of outpatient services.

2. Background Information

There are estimated to be around 2 million (2008) people in the UK living following a diagnosis of cancer. This number is rising by approximately 3% per annum and expected to reach 3 million by 2030 as incidence increases and survival rates improve.

Locally as the number of (*insert specialty*) cancer survivors increase, so does the number of patients requiring follow up. Without a change in approach further significant investment in resources (clinical, space, support teams) will be required.

The quality, innovation, productivity and prevention agenda calls upon all organisations within the health service to identify and implement more efficient ways of working. Providers and commissioners are required to work across health systems to reduce unnecessary use of resources.

With regard to cancer follow up, while some appointments are clinically indicated, a large proportion are not required and alternative models of care can be delivered whilst still complying with NICE Guidance (*Insert reference*) .

Supporting patients to self-manage develops their ability to actively participate in their follow-up care empowering and building confidence so they have the ability to make decisions concerning their recovery within a supported environment. Patients on an open access pathway are more likely to act promptly to report concerns than those on traditional follow up who often wait for an appointment before reporting abnormal signs.

3. Current position

(*Insert trust*) sees approximately (*insert no.:*) new referrals per annum. Following treatment the follow up regime involves (*insert number*) follow up attendances over (*insert number*) years. There are approximately (*insert number*) patients in follow up. The annual cost to commissioners of follow up within this specialty is (*insert*).

On-going surveillance tests (*insert*) are timed to coincide with follow up appointments where the results are shared with the patient. The health care professional discusses the result with the patient and confirms when the next test and follow up appointment is due. After (*insert number*) years, surveillance tests cease and the patient is discharged to primary care.

4. Proposed service change

Studies within NHS Improvement test sites¹ and elsewhere have found that with appropriate investment in quality initiatives such as needs assessments and care plans, information and education, approximately (75% prostate, 45% colorectal, 30% prostate) of patients are suitable for a supported self- management pathway.

The (*insert directorate*) proposes the same approach. At the end of treatment or at each follow up appointment patients will be triaged, based on agreed criteria, to either a supported self-management pathway or continue to be followed up by the specialist team. For patients stratified to a self-managed pathway, surveillance tests will be scheduled and monitored remotely with results conveyed to the patients and their GP without the need for a face to face appointment.

At the time of decision to transfer to a self-management pathway the patient will be 'enrolled' to a remote monitoring system. Patient dataset and diagnostic data will be drawn into the remote monitoring solution from trust existing IT systems. The health care professional will ensure information such as diagnosis, treatment history and other relevant information such as co-morbidity or social circumstances are recorded. They will enter the date/s that the surveillance test is next due setting individual upper limits where appropriate to do so. The next test due date is reset each time a test is completed.

Operationally the responsibility for managing this group of patients rests with the (*insert specialty*) MDT with delegated responsibility under protocol to the (*insert role e.g. Clinical Nurse Specialist*) for the day to day management of patients.

5. Option Appraisal

The following options for offering a self-managed pathway have been considered

	Option	Description and key issues
1	Do nothing	The standardised follow up model of care continues with surveillance tests at the hospital before/at time of clinic visits. Limited opportunity exists for needs assessments after treatment completion and consequent referral to support services. Patients remain dependent on the specialist team. Increased pressure on access times for new and follow up appointments and reduced time for those with complex needs. Increasing volume of unnecessary appointments. Potential for patients to be lost to follow up.
2	Specialist led open access	For low risk patients an open access pathway allows the specialist to schedule and monitor surveillance tests without the need for face to face appointments. An initial assessment of need, a care plan and treatment summary helps to improve knowledge, understanding of disease and on-going surveillance plan. There is no impact on primary care. Rapid re-access systems to specialist if required.

¹ NHS Improvement - Stratified Pathways of Care . from Concept to Innovation. Executive Summary. May 2012

3	Primary care led follow up	Low risk patients are assessed at end of treatment are referred to primary care who schedule and monitor all test results. Requires on-going investment in education as treatment and salvage options change. Potential for patients to be 'lost to follow up'. Often lacks consensus amongst GPs, patients and specialist teams. Capacity issues in primary care.
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6. Preferred non-financial option

Based on the following criteria the preferred non-financial option is *(insert preferred option)*.

Options were scored 1-5 *(as a team insert your own assessment scores and weightings)*.

Key Criteria	Weighting	Option 1 Do Nothing		Option 2 Specialist led		Option 3 GP led		Option 4 Other provider	
		Score	weighted score	Score	weighted score	Score	weighted score	Score	weighted score
Clinical safety	35	3	105	etc.					
Impact on cancer waits	25	1	25						
Patient experience	20	1	etc.						
Access to specialist	10								
Patient choice	10								
TOTAL	100								

7. Benefits appraisal

The following is an example only. The same cost benefits analysis is required for each option. Seek help from local finance to complete.

7.1 Option 2

Year	0	1	2	3	5
Costs					
IT set up*	£10,000.00				
IT interface*	£5,000.00				
Licenses and server	£2,000.00				
IT maintenance and development		£5,000.00	£5,000.00	£5,000.00	£5,000.00
Remote Monitoring - CNS band 7 (2.5 hrs. per week)	£2,500.00	£2,500.00	£2,500.00	£2,500.00	£2,500.00
Needs assessment and care planning - CNS grade 7 (4hrs per week)	£3,500.00	£3,500.00	£3,500.00	£3,500.00	£3,500.00

Admin and clerical support - Band 3 (2 hours per week)	£1,400.00	£1,400.00	£1,400.00	£1,400.00
Lost income through reduced OP tariff cost	£0.00	£3,000.00	£4,000.00	£5,000.00
Total Costs	£24,400.00	£15,400.00	£16,400.00	£17,400.00
Benefits (to providers)				
Opportunity costs - released slots for new activity	£0.00	£10,400.00	£15,000.00	£20,000.00
Total benefits	£0.00	£10,400.00	£15,000.00	£20,000.00
Net Cash Flow	-£24,400.00	-£5,000.00	-£1,400.00	£2,600.00
PV	1	0.96	0.93	0.90
NPV	-£24,400	-£4,800.00	-£1,302.00	£2,340.00

NB. The IT costs will depend on the remote monitoring solution selected for which a separate Business case may be required.

7.2 Assumptions (draft examples)

- The current follow up regime is consistent across all specialty clinicians;
- There is 80% take up of needs assessment at end of treatment;
-% of total new patients are stratified to self-management pathway in year 1;
- Released OP capacity is available to offer new services/opportunities;
- Some released capacity used to extend clinic times for complex patients;
- No medical staff savings (through released OP slots) transferred to nursing budget;
- Surveillance tests costs covered through block contract not within OP tariff;
- Commissioners wish to purchase new activity; and
- No costs have been included for education events or self-management programmes.

The introduction of a specialist led self- managed pathway supported by remote monitoring systems offers quality, safety and efficiency benefits for patients and commissioners. Whilst there will be a consequent reduction in income to provider organisations there will also be opportunity costs arising from released capacity to the wider benefit of the local population.

7.3 Funding source – (if applicable) either known or suggested should be identified and an indication of the certainty of funding being made available when required.

7.4 Other benefits of the specialist led self-management pathway

Patient experience and quality:

- Longer appointment times available for those with complex needs;
- Reduced personal cost to patients associated with outpatient appointments (average £350/5 years); and
- Personalised information and education, written care plans and treatment summaries support self-management and increase self-confidence.

Operational Efficiency:

- Released capacity will improve access times for new referrals;

- Potential for application within other specialties in future

Staff benefits:

- Fewer overbooked clinics with less pressure on staff;
- Increased capacity and satisfaction to deliver high quality care to those with complex needs; and increased training opportunities for junior medical staff in managing complex patients.

8 Risks Analysis

The following risks and mitigating actions have been identified

1 (low) to 5 (high)

Ref:	Risk	Probability	Impact	Risk score	Mitigation
1	No new activity is commissioned as outpatient capacity is released.	1	4	4	Demand for new services increasing. Unless capacity released additional Consultant post required within 3 years
2	Commissioners will transfer monitoring of tests to primary care in the future	2	2	4	Investment in IT will be utilised to support other specialties where primary care monitoring is not suitable
3	Etc.				

9. Project management arrangements

Once business case approval is agreed a small project team will be established led by (insert named project lead). Members will reflect the IT component of the project as well as clinical and operational staff representatives. Patients will be co-opted to advise on process and documentation to support system. The project will report to (*insert appropriate steering group*) group.

Baseline data and on-going measures will be collected to ensure the changes proposed have made an improvement to the patient experience and efficiency of services. A project initiation document will be developed. (*Insert high level plan with key components and milestone dates as appendix*)

The new pathway will be operational within (*insert time based on resources available*) of approval to proceed.

10. Conclusions and recommendations

The introduction of self-management pathways will improve the efficiency and effectiveness of follow up care for cancer patients. Enabled by a robust remote monitoring solution it will release significant outpatient capacity. The recommendation for a specialist led self-management pathway is cost effective and meets the needs of commissioners.

