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NHS Borders Transforming Care After Treatment (TCAT) Phase 3

Project Evaluation

January 2019

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Background:

With the number of people predicted to be living with cancer in the UK rising to 4 million by 2030, the Transforming Care after Treatment (TCAT) Programme tested new models of care that would support the unmet needs of people surviving cancer and pave the way for stratified care processes (Health Improvement Scotland, Macmillan Cancer Support & Scottish Government, 2013). Learning from TCAT Projects was shared widely through local, regional and national cancer forums.

NHS Borders (NHSB) was an early implementer of the TCAT Programme in 2014, successfully testing a new model of care that offered key elements of the Macmillan Recovery Package to people surviving cancer:

1. Holistic Needs Assessment (HNA) with personalised care plan
2. Health and Wellbeing Events (H&WBE)
3. End of Treatment Summaries (EOTS)

The Project ran over 3 time periods (Figure 1): (i) Phase 1: TCAT Pilot, a new model of care in a Locality, (ii) Phase 1 Roll Out: Applying the TCAT model across all NHS Borders, (iii) Phase 3: Spreading and Embedding TCAT into business as usual.

Figure 1:

Phase 1: New TCAT Locality Pilot - 2014-2015
Financially supported by TCAT
• Pilot Test and successful implementation of a new Model of Care: Incorporating key elements of the Macmillan Recovery Package, in a Locality for people having completed cancer treatment in NHS Borders:
• Consultation with service users, financial, health care, social, community, charitable and third sector partners.
o Second largest town, with the highest rate of social deprivation, in a rural community.
o Introduction of Holistic Health Needs Assessments with individualised care plans
o Introduction of Health and Wellbeing Events
o Creation of Locality Service Directory
o End of Treatment Summary templates explored.
(Phase 2: Separate Borders Reablement Community and Social TCAT Project ran by a separate Project Group, financially supported by TCAT- 2016-18)
Phase 1 Roll Out: TCAT across NHS Borders - 2016-2017
Financially supported by a Scottish Government Opportunity
• NHS Borders TCAT model was successfully rolled out for people having completed Cancer Treatment, living in the rest of NHS Borders.
• Development of End of Treatment Summaries for people receiving SACT in NHS Borders.
• Review systems of work to support patients without a CNS locally.
• Borders wide service directory
• Promote local TCAT services locally and regionally
• Share TCAT outcomes with Public Members, Patients and those involved in the pilot

• Sustain Stakeholder, Community and Regional networking
Phase 3: **Spreading and Embedding TCAT - 2017-2018**
Financially supported by TCAT
• Further development of End of Treatment Summaries, including non-SACT Cancer Treatment completed in NHS Borders.
• Improving Regional Cancer Pathway Processes
• Creation of a Central Hub
• Collaboration with Phase 2 Borders Community and Social TCAT Project
• Transfer of local service directory information to ALISS national directory system
• Embedding NHS Borders TCAT model of Care across NHS Borders
• Planning ahead

Collaboration with multiple agencies across health, social, community, financial and charitable organisations throughout the Project, facilitated the development of a Borders Service directory and highlighted the need to raise the profile of the vast support network to service users and care givers.

All elements of the TCAT model were evaluated positively by service users and stakeholders. People reported an improved sense of confidence in managing their own care; knowing who to contact, when, and what to expect going forward. Wider stakeholders reported positive outcomes about relevant cancer survivor engagement, improved access to their service and feeling better informed about how to manage or support the needs of people surviving cancer.

Implementation and sustainability of the comprehensive TCAT model was achievable for people who had access to a local CNS. However the outcome was not the same for people who did not have a local CNS, whose cancer pathway was unclear or who did not receive an EOTS after treatment.

The Specialist Cancer Team within the Borders Macmillan Centre consists of; a nurse led systemic anti-cancer therapies (SACT) day unit, 2 visiting oncologists, acute oncology service, physiotherapist, pharmacist, cancer information and support service (CISS), nurse consultant, 2 Advanced Nurse Practitioners (ANPs) and specialist nursing teams. Clinical Nurse Specialists (CNS) co-ordinate and deliver specialist cancer services for people who are affected by breast, colorectal/hepatobiliary, gynaecology and lung cancers. People living with haematology and urology cancers are supported by ANPs. The Cancer Information and Support (CISS) team support people with other cancers who are referred into their service.

A Phase 1 baseline audit found that most people see their GP for any concerns after cancer treatment and so an enquiry was raised with Edinburgh University Health Economist team to determine whether a study exploring the reason for these GP consultations, after cancer treatment, might be possible. We were advised that this type of data is not currently collected and the question would involve a large, independent and funded study. The enquiry was not explored further.

An independent ‘Phase 2 TCAT, Borders Reablement Project’ ran simultaneously with the NHSB TCAT Project and is reported as a separate initiative.

This report provides an evaluation of NHSB Phase 3 TCAT outcomes and should be viewed as a follow up document to NHSB Phase 1 TCAT Evaluation (NHSB, 2015).

Introduction:

Applying the TCAT model of care to all patient groups was difficult where people with cancer were not known to a local CNS or Cancer Information and Support team (CISS) or where treatment was given out with the NHSB SACT service.

The Phase 3 TCAT Project focussed on addressing the challenges of maintaining the sustainability of TCAT in every day practice:

1. People without a local CNS or CISS support did not access the TCAT package
2. People who had treatment out-with the Borders Macmillan Centre were difficult to detect
3. Some Cancer pathways across local and regional networks were unclear
4. HNA tools created an increase in activity for the CNS
5. Low recruitment of people to H&WBEs
6. Maintaining ongoing engagement with other health and social care teams
7. EOTS: Only people receiving SACT in NHSB were receiving EOTS leaving a gap for people:
    a. Who received SACT treatment out-with NHS Borders, surgery or radiotherapy
    b. Where their treatment regime stopped or changed before the planned completion date

Project Aim:

The overall Project aim was to embed the Macmillan recovery package, as business as usual by further developing the TCAT model, to ensure care is consistent, equitable and sustainable, for all people living within the NHSB area who have completed cancer treatment.

Project Objectives:

- To capture all people living within NHS Borders who have completed cancer treatment
- Increase the number of people accessing the TCAT package: HNA, H&WBE and EOTS
- Map all Cancer Pathways to identify gaps and forge links with key stakeholders
- Development of a ‘Central Hub’, based on current resource in the Borders Macmillan Centre
- Develop and Implement EOTS for non-SACT treatments
- Provide education on the TCAT model to key stakeholders
- Identify local and regional TCAT champions to act as a link for ongoing communications and education
- Embed TCAT into every day practice

Methodology:

Qualitative Methods:
Patient Reported Outcome Measures (PROMS): questionnaires, verbal user feedback

Staff reported outcomes: face to face interviews

Quantitative Methods:
Quantitative work on numbers of HNAs and care plans delivered and outputs as well as implementation of systems for delivering EOTS for all Borders patients.

Continued from Phase 1, a realistic and appreciative inquiry provided the basis of integrated approach to developing TCAT support services, by engaging with key stakeholders from existing healthcare, social care, community and charitable service providers. GP and public involvement groups were consulted and fundamentally, patient experience explored.

Governance:

The Project board included representation from health and social care to allow sharing of information, avoidance of duplication and identification of opportunities. Integrated representation on the project board enabled the team to build on work from other local, regional and national TCAT Projects. The Project Team, funded from the TCAT Grant, had specific ring fenced hours for the Project and consisted of a Project Support Officer and expert cancer clinical staff.

Local Governance was achieved via local CNS Team, TCAT Project Team and Project Board meetings. TCAT Project Board minutes were reported via Cancer Services Clinical Governance Group which in turn reports to BGH Clinical Governance and NHS Borders Governance Groups.

Regional and National reporting was achieved by submission of Project Highlight Reports to the SCAN TCAT Regional Board and National TCAT Programme Board.

A Project Initiation Document (appendix 1) was produced giving a clear project plan from the outset.

Stakeholder Engagement:

The Phase 1 communications strategy was revised to incorporate the revised key actions and identify relevant stakeholders for communication and engagement with staff, patients and stakeholders for the next steps in NHSB Phase 3 TCAT Project (appendix 2), with objectives being to:

- Inform stakeholders of TCAT Project development and outcomes
- Ensure key messages are communicated in relation to TCAT
- Keep stakeholders updated and engaged in the work of TCAT

Throughout the life of the Phase 3 Project stakeholder engagement included:

- Collaboration with health, social care and third sector partners
- Partnership working with Phase 2 TCAT Borders Reablement Project
- Linking with multidisciplinary teams and co-ordinators involved in Cancer Pathways
- Liaising with other regional and national TCAT projects
- Local team meetings and on-site training in HNA with care plan and EOTS
- Work with e-health colleagues to develop EOTS for wider treatment groups

Holistic Needs Assessments (HNAs):

The impact of HNAs and common themes were evaluated during Phase 1 (NHSB 2015) and within the Edinburgh Napier National TCAT Evaluation so not explored further in Phase 3.

HNAs have been adopted by NHSB Cancer CNS and CISS teams, as routine, at 4-6 weeks after the end of cancer treatment and subjectively throughout other points in the cancer pathway. However, ANPs felt unable to maintain consistency and sustainability in delivering and following up HNAs due to the demand of clinical priorities.

To identify people who did not have access to a local CNS or CISS and improve consistency and equality in HNAs, the following steps were undertaken:

- Creation of a Central Hub
- Mapping activity for unclear cancer pathways
- Monitoring of HNA engagement
    - HNAs distributed
    - Return rate

Data for HNA's completed at other points throughout the cancer pathway were not recorded.

To incorporate individual preference and ensure a timely HNA process, HNAs can be implemented either face to face, over the phone or by post with a follow up phone call. When postal HNAs have not been returned by 4-6 weeks, one phone call is made by the CNS or CISS team, to provide an opportunity to engage with the process. The HNA timeline is adapted for some people; e.g.: head and neck cancer causing severe post treatment side effects. People are given verbal and written instruction on how to complete an HNA, including reporting "no issues". HNA activity and return rate includes those reporting no issues.

A total of 235 HNAs were initiated with a return/completion rate of:

- Breast: 68% (57 out of 83)
- Lung: 46% (14 out of 30)
- Gynaecology: 46% (13 out of 28)
- Colorectal/Hepatobiliary: 21 % (7 out of 33)
- CISS: 56% (34 out 61)

HNA Return Rate – October 2017-October2018 (Figure 2)

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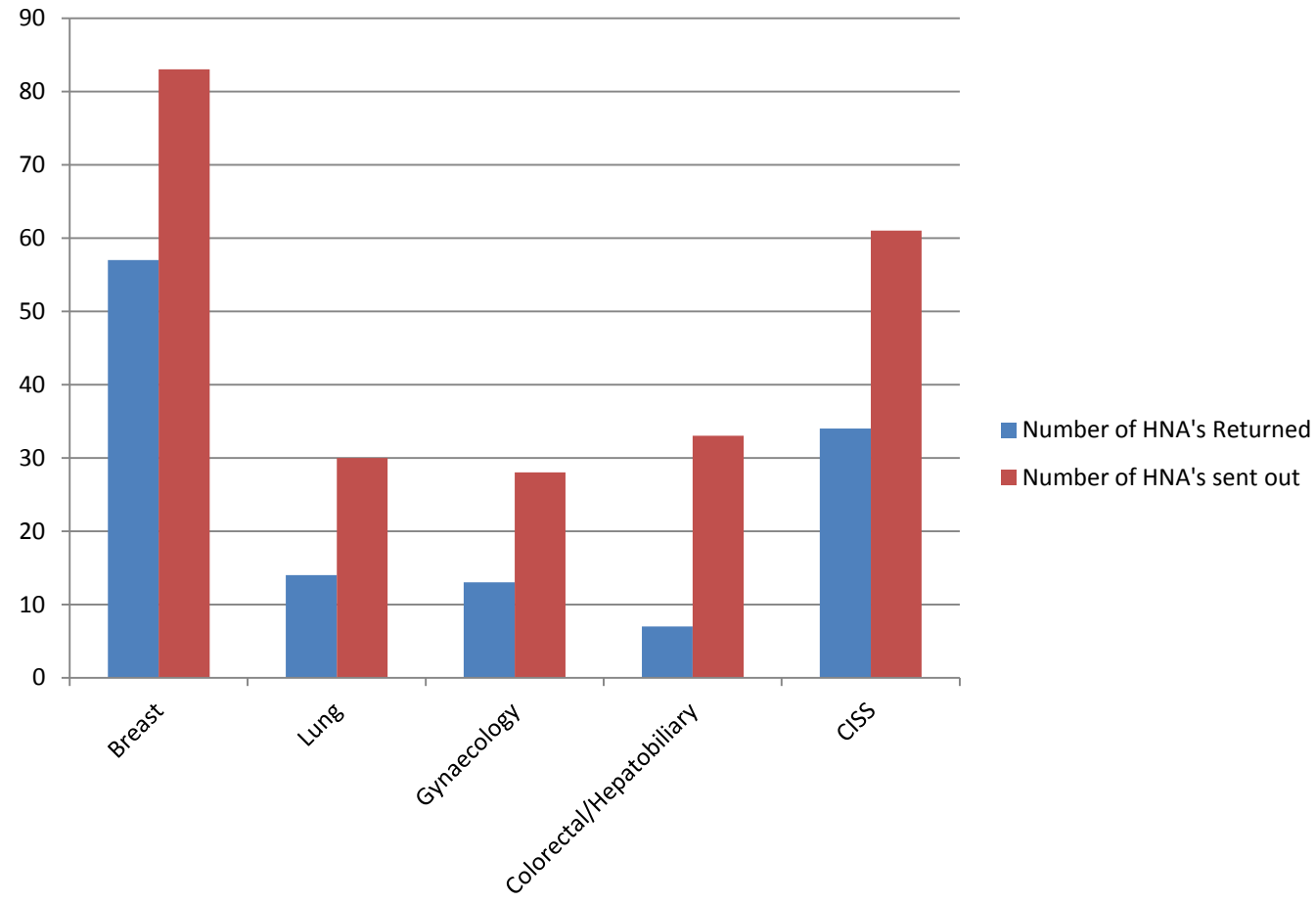


Consistent implementation of the HNA process varied between CNS/CISS teams and specific cancer groups with reasons being:

- Time constraints of CNSs/ANP, prioritising clinical demands
- Lack of CNS/ANP confidence using the HNA tool and signposting options
- Some people with cancer declined the opportunity to complete an HNA

ANPs in particular found it difficult to allocate time to undertake an HNA using the concerns checklist, highlighting the medical emphasis on this type of specialist role. Embedding a new model of care into business as usual required ongoing education and support for staff not quite confident with the process.

Challenges to sustaining HNA implementation:

- Adjusting to a new way of working
- Prioritising clinical demands
- People who completed treatment out with NHSB or who did not have a CNS locally were difficult to identify
- Reduced staffing due to absence or vacancy

People opting not to participate with the HNA process was more common with colorectal cancer patients. We did not explore further why people with certain tumour sites were less likely to engage with the process.

Central Hub:

A Central Hub was created to address the challenges in sustaining HNA implementation within existing resource. The aim of the Central Hub is to facilitate comprehensive delivery of the TCAT/recovery package for people in every cancer group. The Central Hub sits within the existing CISS service and is co-ordinated by the CISS manager.

Central Hub Development Process:

Development involved:

- Mapping Cancer Pathways
    - Identifying gaps in pathway processes
    - Establishing links with key personnel
    - Creation of 2-way communication channels

- Communication and engagement with regional MDT Colleagues

- Agreeing points in pathway for HNAs

- Strengthen collaborative working relationships and communication channels with local and regional cancer teams

- Development of Standard Operating Procedures
    - Liaison within cancer pathways
    - HNA triage
    - Referral processes

- Consideration of how the role of a Band 4 Cancer Assistant Practitioner could facilitate and support delivery of the TCAT model

Outcomes:

- Integration of cancer pathways into CISS and Central Hub Policy

- Safe and timely transfer of information between local and tertiary centres, including
    - MDM outcomes
    - New patient clinic letters sent to CISS and NHSB

- Every patient diagnosed with cancer who does not have a CNS or ANP, is identified and contacted by CISS to be:
    - offered an HNA with care plan
    - invited to a Health and Well being event

- Every person diagnosed with cancer and their families are offered support services at the point of cancer diagnosis

- Referral guidelines to Cancer MDMs across NHS Borders and NHS Lothian Health Boards including key cancer team contact details are available on NHS Borders intranet

- Proposed job description for a Band 4 Cancer Assistant Practitioner (appendix 3)
    - Triage HNAs and signposting
    - Co-ordination of health and wellbeing events
    - Supporting the cancer specialist team in delivering holistic care

- Enlisting TCAT champions across pathways out-with NHSB proved difficult.

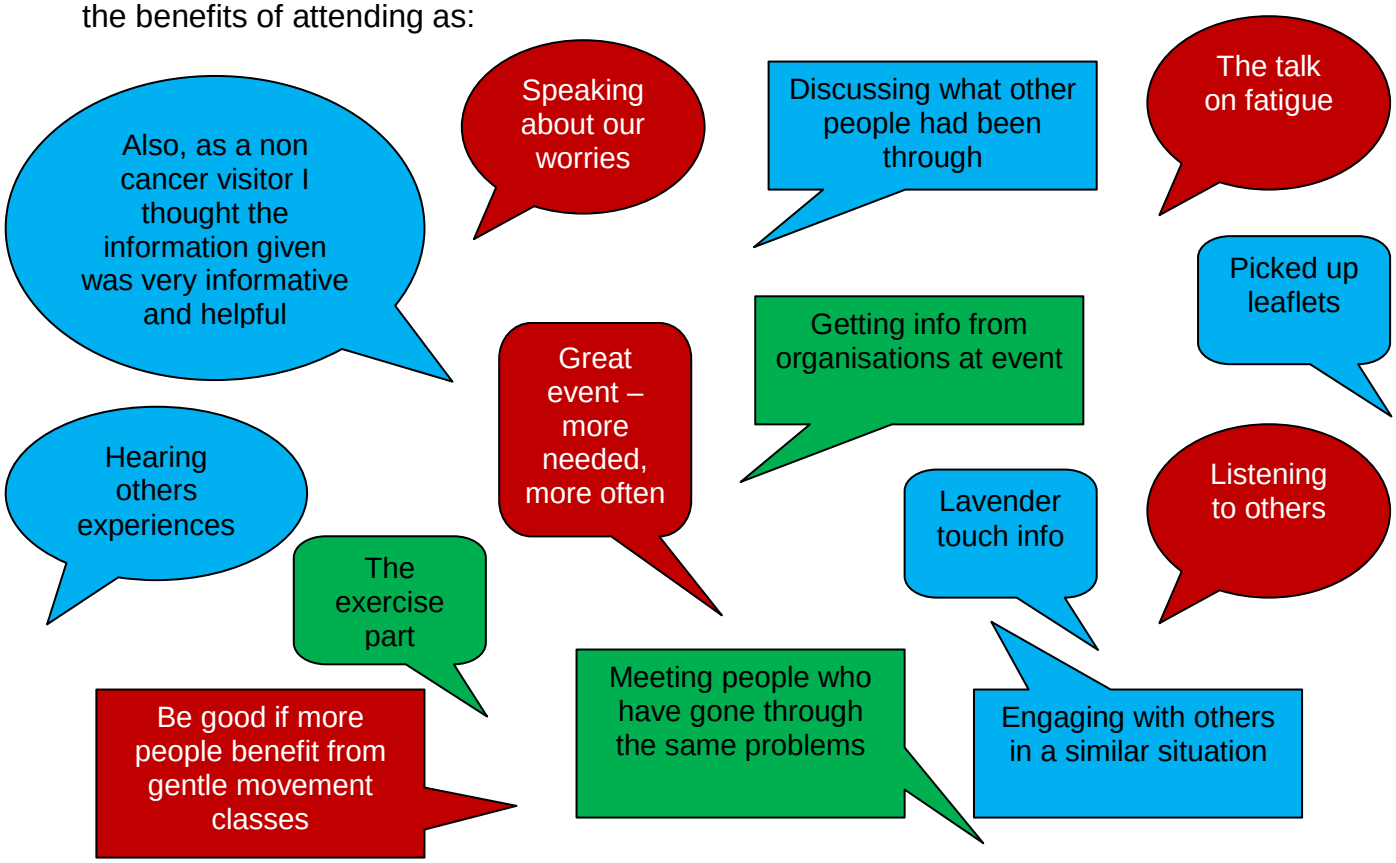
Creation of the Central Hub facilitated a new way of working that identifies people diagnosed with cancer who do not have a local CNS or ANP, improving consistent access to TCAT components of care for everyone.

Future development of the Central Hub will test a central triage point for every HNA with the aim to further increase the number of people accessing the recovery package, improve HNA return rate and reduce the impact of TCAT on specialist clinical staff. Funding has been secured from Macmillan to support a 2 year project, testing the role of the Band 4 Cancer Assistant Practitioner in the Central Hub.

Health and Well Being Events:

H&WBE's events are promoted from diagnosis by the cancer team, with people being encouraged to bring a friend, relative or carer and are held in a selection of community venues to encourage people towards independence, focusing less on hospital services.

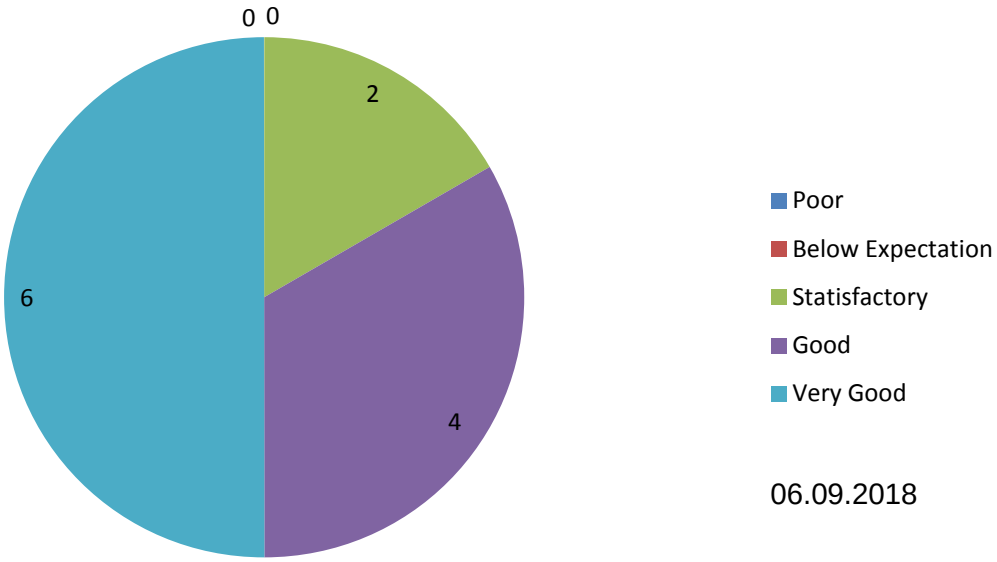
All H&WBEs were evaluated positively by both attendees and Market stall holders. People reported feeling more confident following the event, knowing what to expect, who they can contact and what relevant services are available to them. Attendees expressed some of the benefits of attending as:



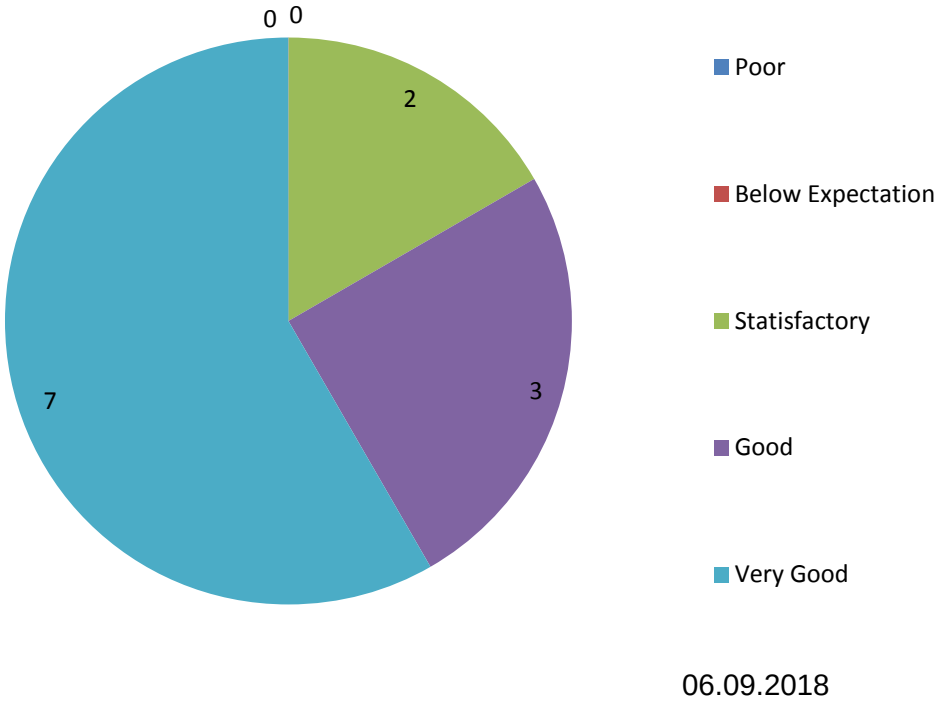
Attendee and market stall holder feedback from each H&WBE is used to inform future sessions.

Collaboration with Market stall holders facilitated ongoing constructive working relationships, creating a 2-way information sharing process that raises awareness of services across the Region and informs further service development. Market stall holders could not commit to more than 2-3 H&WBE per year due to their own service demands.

How Helpful Did You Find The Group Session?



How helpful did you find the event?



Everyone attending the H&WBE evaluated the sessions positively. People commented that they gained far more than expected.

Although H&WBEs continue to be evaluated positively, recruitment was low. Reasons people gave for not attending a H&WBE were:

- “returned to work so no time off”
- “didn’t think the event was for me”
- “don’t like groups”
- “know where to go if need help”
- “forgot about the event”
- “the date wasn’t suitable”
- “the venue wasn’t suitable”

When the venue for the most recent H&WBE was held on hospital premises, recruitment improved. Collaboration with Phase 2 Reablement Project continues to promote future events.

End of Treatment Summaries (EOTS):

EOTS were developed during the transitional period of Phases 1 and 3. Stakeholder consultation informed EOTS development, Patients, GPs, CNS, Oncology Consultants, SACT Nurses, CISS and IT department.

Agreed templates were trialled in the Borders Macmillan SACT outpatient setting. Pre-populated templates for each chemotherapy regime were uploaded to TRAK (n:47) and additional relevant information populated by the Oncology Treatment Team and Pharmacist at the penultimate treatment; an example of the EOTS and EOTS Standard Operating Procedure (SOP) can be seen in appendices 4 & 5.

Questionnaires were sent to all GPs whose patients received EOTS (appendix 6). Feedback was positive:

- 100% of GPs felt having a copy of the patient’s EOTS gave them clear information on:
    - Diagnosis
    - treatment aim
    - treatment side effects
    - when to refer back to specialist services
    - who to refer back to and patient follow up plan

- 100% of GPs felt the EOTS gives their patient clear and appropriate information

A questionnaire (appendix 7) was also sent to 21 people who had received an EOTS with a response rate of 62% (n:13). Two people could not remember receiving an EOTS. Everyone who remembered receiving an EOTS (n:11) said the document:

- Had clear information
- Was easy to read
- Is easy to understand

- Contained relevant information
- Helps them understand the aim of treatment
- Helps them understand what side effects to look out for
- Helps them know who to get in touch with for what
- Explains follow up
- Gives them confidence in understanding and self managing care

A small survey (n:15) looking at patient preference between the developed EOTS Template or structured clinic style letter used by other Health Boards was undertaken (Appendix 8) with the following results:

- Response rate 66%
- 80% of people asked felt the EOTS Template was clearer in providing information on treatment aim, long term effects, who to get in touch with, and follow-up after treatment
- 20% of people who preferred the structured letter gave no rational apart from preference on the layout of the form
- All responders did not think any information was missing

Introducing SACT EOTS improved understanding about cancer treatment and what to expect; for both people with cancer and their GP. Further EOTS were developed for people whose surgery was undertaken in NHSB. Surgical EOTS are populated on TRAK by a CNS or CISS around 4 weeks after hospital discharge.

Service Directory:

TCAT Directories were developed and rolled out across the whole of NHSB in Phase 1. During Phase 3 systems were created to transfer the NHSB TCAT Directory onto the new ALISS National Directory System.

Discussion:

Overall, the impact of the TCAT model was evaluated positively, with people feeling better informed and able to pro-actively seek appropriate help or advice at the right time.

The constructive work undertaken to map cancer pathways was invaluable, not least for forging productive multi-disciplinary relationships and processes across diverse settings but for creating a reliable system that identifies all people living in NHSB who have been diagnosed with cancer, to the cancer specialist team. This resulted in an increase in the number of people given the opportunity to access the Macmillan recovery package.

A robust system for EOTS is embedded in the local SACT setting for people who have completed cancer treatment however, more work needs to be done to ensure the delivery of the same information for people who are on maintenance SACT and for all local surgery. As the National TCAT Program evolves, EOTS developments can be shared to inform further improvements and to support teams not yet on board with EOTS development.

The development of a Central hub within CISS has been successful in facilitating the TCAT process for people who do not have a CNS and creating a system that aims to support future risk stratified care. In addition, collaboration with the TCAT Borders Reablement Project achieved a shared vision to create referral processes for the wide variety of services necessary to meet the holistic needs of people with cancer. Further education and collaboration is required across health, social, community, financial and other services to maintain and further develop a holistic person centred approach.

Recommendations:

1. Encourage all health care professionals looking after people with cancer to adopt a holistic approach to assessment and care planning

2. Consideration of a Primary Care TCAT Project, should further TCAT or cancer funding opportunities become available

3. EOTS for maintenance SACT

4. Further IT collaboration on EOTS and potentially HNAs

5. Continued development of Central Hub

6. Band 4 Cancer Assistant Practitioner Project

7. Better marketing and user engagement of H&WBEs

Conclusion:

CNSs are key to co-ordinating care and supporting people with cancer, through a seamless pathway, involving sometimes multiple local and regional Services. Implementing the TCAT model where the CNS is a consistent presence within the pathway was initially achievable. With the increasing demand on CNS and ANP services, the addition of a Band 4, Cancer Assistant Practitioner pilot post, aims to test an HNA triaging system and to explore possible ways in which the CNS and ANP teams can be supported to ensure everyone diagnosed with cancer gets the right support at the right time.

The TCAT model of care facilitated the implementation of the Macmillan Recovery Package in NHS Borders. This resulted in a new way of working which empowered people living with, and beyond cancer to live a healthy life, with confidence outwith the hospital setting. This was achieved by identifying their holistic needs and providing timely access to the most appropriate services. Ongoing collaborative multi-agency working, across the boundaries of health and social care, is required to further shift the focus of living with cancer away from illness and reliance on hospital services, towards living well with and after cancer.

Whilst cancer specialist teams are now familiar with the TCAT concept, education across the wider health and community care settings is required to fully incorporate the TCAT model into every day practice. A change in health care culture is required to shift the focus

of us all towards empowering people to recognise and manage their health needs with support from the right service at the right time.

Acknowledgements:

We would like to thank all the patients and carers who shared their experiences and participated in this piece of work.

In addition thanks go:

- Macmillan Cancer Support and SCAN TCAT Programme Board
- All staff locally and regionally who supported the project and adapted systems of work

Appendix 1: Phase 3 PID

TRANSFORMING CARE AFTER TREATMENT:
Implementation of Phase 3

PROJECT INITIATION DOCUMENT

Approved

Date: 9th January 2018

Authors: TCAT Project Team

Owner: Judith Smith

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Document History

Version	Date	Author	Comments
1.0	19.07.18	Project Team	
2.0	09.01.18	Project Team	Agreed as final version
Approved			

Approval History

Role	Name	Signature	Date
Project Manager	Judith Smith		
Project Owner	Judith Smith		
Project Team	Lynda Taylor, Rachel Johnson, Kirsty Smith, Alison Smail		09.01.18
Project Board			

1 Introduction

This document has been produced by the TCAT Project Team to outline the proposed Phase 3 project within the Scottish Borders.

The PID outlines:

- What the project is aiming to achieve
- The scope, constraints, risks and control mechanisms and who will be involved in managing the project and what their roles and responsibilities are
- How and when the arrangements discussed in this PID will be implemented

When approved by the Project Board, this PID will provide the "baseline" for the project.

The PID will be referred to whenever a major decision is taken about the project and used at the conclusion of the project to measure whether the project was managed successfully and delivered an acceptable outcome for the Project Sponsor and Project Board.

1.1 Project Background

NHS Borders successfully completed a phase one TCAT project in 2016. Over a 12 month period, the project successfully tested the following package of measures via a locality base approach:

- Completion of Holistic Needs Assessment (HNA) consistently at key points in pathway
- Creation of Patient Individual Care Plans based on HNA, which will involve discussions with primary care and other AHPs
- Locality based patient education and support networking events at the end of treatment ("Moving on" Health and Wellbeing Events)

All the above objectives were met and evaluated positively.

Further funding was made available to implement recommendations from phase one, namely:

- Roll out of HNA's and Health and Well Being Events across all localities
- Pilot of End Of Treatment Summaries (EOTS) in the chemotherapy setting

To date there has been an increase in patients receiving HNAs and attending the health and well being events. The EOTs have been evaluated very positively by both patients and GPs.

Based on the learning from Phase One and the Rollout Project it is proposed that a central hub is developed for the return of HNA's. This would support all patients having a HNA and care plan as well as facilitating access to health and wellbeing events. It also provides linkage to the Phase Two work as appropriate referrals would be made from the central hub to regarding neighbourhood link schemes following triage of the HNA.

1.2 Overall aim of Project

The overall **aim** of this project is to enhance patients' health and wellbeing throughout the Scottish Borders by providing integrated support which is relevant to individual needs and promotes independence and healthy lifestyles: and supports possible future changes to risk stratified follow-up.

Specifically the project will aim to:

- Promote health and well-being, after treatment, by providing support tailored to individual needs in developing a central hub for the return of HNAs. This would support all patients having an HNA and care plan as well as facilitating access to health and well beings events and appropriate referrals to the neighbourhood links scheme

- To increase the number of health and social care professional's familiar with the concept and benefits of the recovery package and facilitate use of HNAs and EOTs

- Establish EOTs and aim to roll these out to all areas treating patients with cancer from the Scottish Borders

1.3 Project Objectives and Outcomes

Over an 18 month period the project will focus on developing systems that will facilitate the use of HNAs and EOTs and embed into everyday practice.

This would be done through the following steps

- Map pathways to identify key areas and people involved in treating Borders patients with cancer
- Develop a central hub based on current resource in the Borders Macmillan Centre
- Develop a referral process to the central hub and systems for triage of HNAs
- Develop and deliver education sessions on the recovery package and the central hub to key stakeholders identified through the pathway mapping
- Identify TCAT champions within the pathways to act as a link for ongoing communications and education
- Develop a continuing communications strategy for key areas and stakeholders to ensure benefits of this work is communicated back and the profile of TCAT work is raised.
- Continue work with e-health colleagues to build on the work with chemotherapy EOTs and translate that to wider groups such as surgery and radiotherapy

Outcomes

<u>Service Users</u>
People affected by cancer will:

- be actively involved in planning and managing their own care
- be able to access support systems in a timeously manner that help to address any physical, emotional and financial difficulties that may develop through their cancer treatment
- have their individual needs met
- have improved health and wellbeing

- through supporting self management, this will lead to a reduced demand for specialist and primary care services
- report a high level of satisfaction

Service Delivery
Cancer services are:
- tailored to meet the needs and preferences of people affected by cancer
- provided through an integrated care pathway that creates links at local level with statutory and voluntary sectors, primary and secondary care, patients, carers and professionals

Service Delivery
Health and Social Care Services
- Opportunities for joint working are identified and developed, and information resources shared
- Duplication of service provision is avoided
- Two way flow of information so that patients can access a full range of health and social care services where relevant and appropriate

1.4 Development Evaluation

The project would be evaluated against a baseline using a variety of measurement tools including:

- **Patient Reported Outcome Measures** (PROMS) – these will take the form of patient feedback, case studies and patient questionnaire
- **Quantitative Methods**- Quantitative work on numbers of HNAs and care plans delivered and outputs as well as implementation of systems for delivering EOTS for all Borders patients
- **Staff reported outcomes**: these will take the form of staff feedback using face to face interview or questionnaire

1.5 Project Scope, Exclusions, Links & Assumptions

1.51 Scope & Exclusions

The project will not include
- Patients under 16 years of age
- Patients without a cancer diagnosis

1.5.2 Links

The project outcomes will be communicated back to the Macmillan TCAT Project Board via Highlighted Reports.

The project outcomes may also be communicated to stakeholders via a monthly newsletter.

Other links will include:

- Primary and Community Care Service

- Social Care Service
- Secondary Care
- Tertiary Care

1.5.3 **Assumptions**

Principal assumptions underlying the project are:

- Support for the project throughout NHS Borders, Scottish Borders Council and Primary Care, SCAN
- Strong leadership and support from within Cancer Services
- Effective continuous project management

2. Project Governance

2.1 **Project Lead(s)**

Nurse Consultant in Cancer Care

The Project Lead(s) is responsible for ensuring that the desired project objectives are delivered and will act as a single focal point of contact with the Project Team for the day-to-day management of the project. The Project Lead(s) will provide the interface between project ownership and delivery.

The Project Lead (s) will:

- Chair the Project Board
- Ensure that the project is focused on the desired project outcomes and that these are fit-for-purpose
- Direct implementation efforts in a manner that supports NHS Borders Corporate Objectives
- Direct implementation efforts in a manner that supports Macmillan Cancer Care core aims and objectives
- Ensure the project progresses in accordance with the agreed PID.
- Communicates with organisational management and reports on project progress and any problems that need upward referral
- Provide advice and support to the Project Team

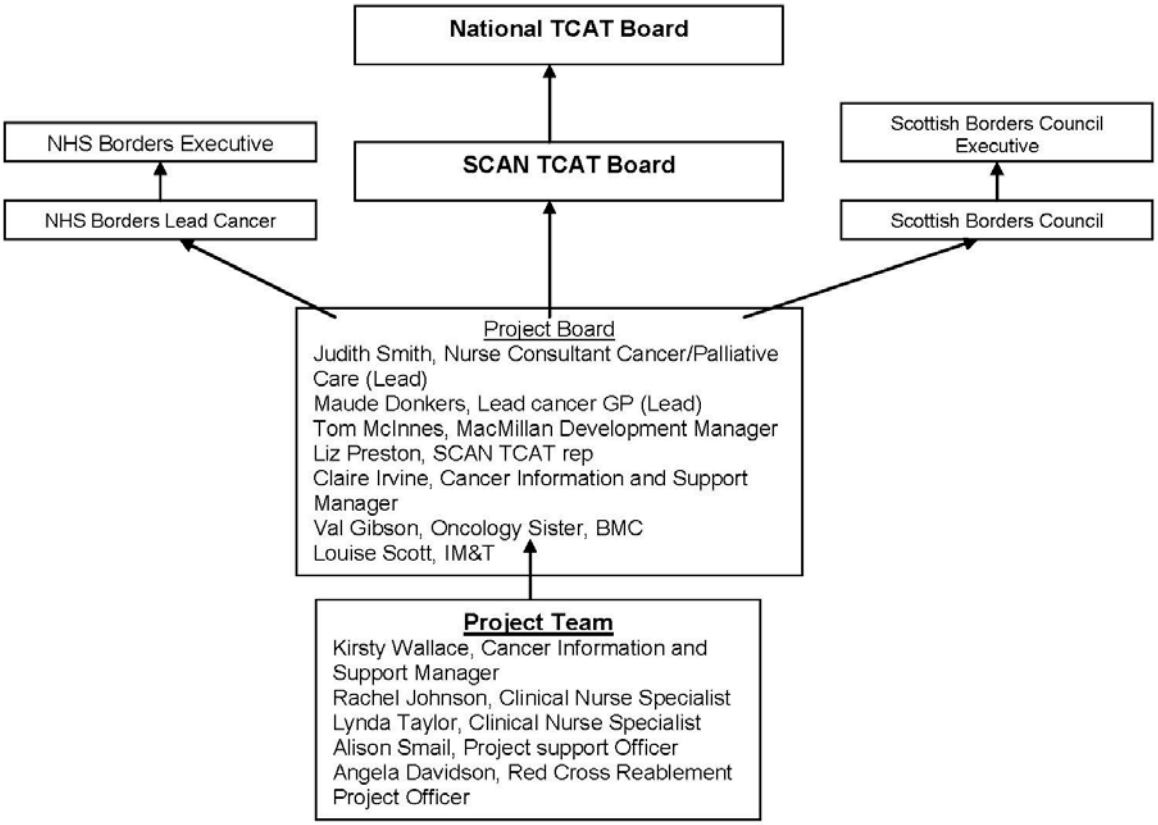
2.2 **Project Team**

The Project Team is accountable to the Project Board, and will operate within agreed reporting structures. They are responsible for:

- Designing and applying an appropriate project management framework for the project (using relevant project standards), incorporating the project review process if required.
- Managing the production of the required deliverables.
- Planning and monitoring the project- both within NHS Borders and Macmillan
- Adopting any delegation within agreed reporting structures.
- Preparing and maintaining the Project Plan throughout the life of the project.

- Manage project risks and issues, including the development of contingency plans.
- Liaison with any other related projects, to ensure that work is neither overlooked nor duplicated.
- Overall progress and use of resources, initiating corrective action where necessary.
- Implement change control procedures as changes in the project arise.
- Reporting through agreed reporting lines on project progress through Highlight Reports and key stages.
- Identifying and obtaining any support and advice required for the management, planning and control of the project.
- Managing project administration.
- Conducting end project evaluation, to assess how well the project was managed and preparing an end-project report.
- Preparing a Lessons Learned report.
- Preparing any follow-on action recommendations, as required.

2.3 **Project Structure**



2.4 Project Board

The Project Board will act as the forum where representatives come together to make decisions on the project. The Project Board will provide overall direction, guidance and advice to a project. This means that they:

- Are accountable for the success of the project
- Have responsibility and authority for the project within the remit that they have been given
- Are responsible for dissemination of information about the project
- Are responsible for making sure that the project remains on course to deliver its final outcome

2.5 Reporting Arrangements

Reporting mechanisms will include the following:

- The PID will be submitted to the Project Board for approval and the project will be monitored by the Project Board and Macmillan TCAT Project 3 Monthly. A quarterly highlight reports generated by the Project Lead for the Project Board. This will detail progress against;
    - The agreed project plan, including milestones
    - Change Management Any proposed changes to the Project PID
    - Risk and Issue Management and Mitigation strategies in place.
    - Stakeholder communication
    - Financial management
- Proposed changes to the Project PID will be submitted to the Project Board for agreement
- A Project Close Out report following the end of the project
- A Lessons Learned report following the end of the Project

2.6 Project Plan

NHS Borders Transforming Care After Treatment (TCAT) Phase 3																		
Project Plan																		
Tasks	**Jul 17**	**Aug 17**	**Sept 17**	**Oct 17**	**Nov 17**	**Dec 17**	**Jan 18**	**Feb 18**	**Mar 18**	**Apr 18**	**May 18**	**Jun 18**	**Jul 18**	**Aug 18**	**Sep 18**	**Oct 18**	**Nov 18**	**Dec 18**
Draft PID	x	x	x	x														
Sign off PID	x	x		x														
Establish project team	x																	
Establish project board	x																	
Agree outcome measures and tools	x	x	x	x	x	x												
Establish baseline measurement	x	x	x	x	x	x												
Establish communication with key stakeholders	x	x	x															
Establish Key Pathways	x	x	x	x	x	x												
Develop &sign off processes for EOTS (Local SACT)	x	x	x	x	x	x												
Build EOTS for other Modalities						x	x	x										
Non chemo EOTS feedback and comments							x	x										
Non chemo EOTS on TRAK								x	x									
SOP non chemo EOTS								x	x									

Launch use of non chemo EOTS										x								
Development of referral processes to Central Hub					x	x	x	x	x									
Management of referrals to Central Hub								x	x									
Communication and Marketing strategy for Central Hub								x	x	x	x	x						
Evaluation of project										x	x	x	x	x	x	x	x	X

2.7 Constraints

The project has 18 months funding and must be completed during this time.

Lack of dedicated time commitment for project board members

2.8 External Dependencies

The following stakeholders will require to be engaged with the project:

- Patients
- Public Involvement Team
- Primary Care
- Scottish Borders Council Social Care
- Lead Cancer Team
- Macmillan Centre Administration Staff
- Macmillan Centre Treatment Room Staff
- IT specifically TRAK Care Team
- Medical and Clinical Oncologist
- Lead Site Specific Clinicians
- Specialist Palliative Care Team
- Site Specific Clinical Nurse Specialists
- Pharmacy
- Audit
- 3rd Sector
- Healthy Living Networks

3 Risk and Issue Management

3.1 Process Overview

The following key activities will be undertaken in order to manage the issues and risks on this project:

A risk is an event that may occur and if it does will impact on the successful Delivery of the project

An issue is a situation that if left unresolved will impact on the successful delivery of the project

- **Identification**. These can be identified by any member of the Project team. A log of potential risks and issues facing the Project will be maintained by the Project Manager.
- **Quantification**. All risks and issues will be evaluated against the risk and issue matrix to assess their impact and likelihood and this will be conducted by the Project team
- **Action Planning** Project team will assess what can be done to deal with the identified risk and issue, with clear ownership and an agreed course of action.
- **Monitoring and Control.** The issue and risk log will be reviewed weekly by the Project Manager

3.2 Project Risk Register (as at Project Initiation)

Ref No.	Description	Likelihood of Occurrence	Severity of Impact	Risk Assessment	Risk Management		
					Action	Who	When
3.2.1	Lack of engagement by stakeholders	Possible	Major	Moderate risk	To identify, meet and inform stakeholders of the purpose of the project Ongoing communication regards progress of project	Project Team	Ongoing
3.2.2	Non delivery of project	Possible	Major	Moderate Risk	Regular Project team meetings to monitor against project plan Early identification of problems in meeting targets/milestones	Project team Project Board	Ongoing
3.2.3	Merger of Borders Trak Care & Lothian Trak Care	Possible	Major	Moderate Risk	Escalated to Clinical Lead, Local Cancer Governance Team, Regional Cancer Planning, SCAN Group		

3.3 Risk and Issue Scoring System

Likelihood	Consequence				
	Negligible	Minor	Moderate	Major	Extreme
Almost certain	LR	MR	HR	HR	HR
Likely	LR	MR	MR	HR	HR
Possible	VLR	LR	MR	MR	HR
Unlikely	VLR	LR	LR	MR	MR
Remote	VLR	VLR	VLR	LR	LR

In terms of grading risks, the following grades have been assigned within the matrix.

- Very Low Risk (VLR)
- Low Risk (LR)
- Moderate Risk (MR)
- High Risk (HR)

4 Project Resources Required

Clinical Audit for advice, access to case notes and some assistance with data evaluation throughout
Access to key stakeholders for information
Office space for project team
Laptop

4 Communication Plan/Strategy

The specific objectives of the communication plan are to ensure that the project team are engaged with and can share key messages with stakeholders, updating them in a timely manner and facilitating smooth implementation of the project

Who	Method of Communication	Frequency
Project Board	Face to face meetings, Email	Monthly
Other Management Boards within NHS B and SBC	Project Highlight Reports	2monthly
National TCAT Board	Project Highlight Report	As requested
GPs and Primary Care	Face to Face, News letter	Pre project then two monthly and on completion
Population of Scottish Borders	Newsletters Local radio Local papers	
Project Team	Face to face	Weekly meetings
SCAN TCAT Board	Face to face , emails	2 Monthly and as necessary out with
Public Involvement	Questionnaires, face to face, focus groups	Throughout life span of project as necessary
Clinicians and Clinical teams	Face to Face, Newsletters	Prior to start of project and throughout lifespan of project as necessary
Public Health	Via Project Board Members	Monthly
Central Hub Comms	Face to face, email, highlight report, via project team/project board	As required throughout project

Appendix 1 - Project Self Assessment Checklist

Project Title: Transforming Care after Treatment
Project Lead: Judith Smith Nurse Consultant

1. **Project Infrastructure**

Project Board established?Yes
Project Sponsor Katie Morris
PID developed? Yes

PID signed off by _____

Project plan in place? Yes

Have there been any issues in achieving project deadlines/timetable?

No

2. **Data Analysis**

Please provide details below of the data that has been reviewed, who has produced the data and results of the data analysis.

Data prepared by	Results of analysis	Issues arising

3. **Staffing**

Will the project involve a change to existing staffing levels?
All staffing funded on a non recurring basis. Aim is to embed practice within current resource

Have staffing levels been signed off by the management team and Finance?
Yes

Please detail any issues relating to staffing below
Nil

4. **Finance**

Have any other revenue or capital costs been approved by Finance?
No

Please detail any issues relating to Finance

Project funded by Scottish Government Non Recurring Funding

5. **Engagement/Consultation**

Is a communication plan in place?
Yes

Is regular communication taking place with key stakeholders?
Yes

If appropriate, has the Scottish Health Council Service Change Criteria been completed?
N/A

Please detail any issues relating to engagement/consultation

6. **Capital Works**

Will the project require alterations or building work to be completed?

NO

Are there any issues relating to capital works which may affect the timescales for completion of the project? Please list below.

7. **Project Linkages**

Does the successful delivery of the project rely on work being carried out in other areas?
No

Are there any issues relating to this work? If so please list below

8. **Any other issues**

Please list below any other issues which may affect the delivery of the project which have not been highlighted elsewhere in the checklist

Appendix 2: Communications Strategy

COMMUNICATIONS STRATEGY

Transforming Care After Treatment (TCAT)
Phase 3 - 2018

Version	Sponsor	Date
1	TCAT Project Board	24.04.2018
2	TCAT Project Team	01.05.2018

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This Communications Strategy sets out the key actions to be undertaken to communicate and engage with staff, patients and key stakeholders about NHS Borders Transforming Care After Treatment (TCAT) Phase 3 project.

AIMS

The TCAT Project Board recognises it is essential to communicate, engage and involve a range of stakeholders when planning our TCAT project. This document outlines the communications activities planned to:

- Inform stakeholders of TCAT phase 3
- Ensure key messages in relation to TCAT are communicated

BACKGROUND

This TCAT communications plan has been prepared as part of the NHS Borders TCAT phase 3 project.

Communication internally and externally to staff, stakeholders, across health and social care, patients and members of the public will be pivotal to the effective delivery of this project and the success of TCAT phase 3.

The increasing numbers of people living with and beyond cancer is widely recognised. Estimates for 2020 indicate that 50% of the population will be diagnosed with cancer, with nearly 40% of those going on to survive their cancer diagnosis and die from other causes. While increasing survival rates are positive there is a need to be cognisant of the growing evidence base which indicates that many patients are left experiencing a range of problems, both physical and emotional, following cancer treatment making it difficult for them to return to full health.

The consequences of this changing picture on both patients and services has been acknowledged nationally, regionally and locally with acceptance that the standard care pathways and working practice require remodelling if we are to meet patient need and service demand in the future.

In the current economic climate there is a recognised need for integration of health, social care and 3rd sector groups to avoid duplication of work and make best use of resources to ensure service provision in the future benefits patients enabling them to engage in their own care and maximise their health.

The National Cancer Survivorship Initiative (NCSI) enabled a body of work and evidence base to be developed around new ways of working and integrated programmes of care/support, which address individual patient need from diagnosis onwards and supports self management programmes, including risk stratified pathways of follow up care for some groups of patients, reflected in the Macmillan Recovery Program. Macmillan Cancer Support has set up the Transforming Care After Treatment Programme to deliver these new ways of working

The Transforming Care After Treatment Programme (TCAT) is a major component of the Scottish Cancer Taskforce work plan, which is being delivered in partnership with the Scottish Government, Regional Cancer Networks, Health Boards, Local Authority and the Voluntary Sector.

Macmillan Cancer Support provided £5 million to NHS Boards, from 2013-2018to facilitate the development and implementation of models of care that:

- Enable people affected by cancer to play a more active role in managing their own care.
- Provide services which are more tailored to the needs and preferences of people affected by cancer.
- Give people affected by cancer more support in dealing with the physical, emotional and financial consequences of cancer treatment.
- Improve integration between different service providers and provide more care locally.

NHS Borders were successful in their bid to Macmillan to take forward a local TCAT pilot project to develop and role out of a new model of care that can be incorporated into normal business. Phase one TCAT focused on the development and testing of the TCAT model of care in a locality. Considering learning and recommendations from Phase one, Phase 3 TCAT will focus on embedding the TCAT model of Care for all people in the Scottish Borders.

OBJECTIVES

Accurate identification of stakeholders and the appropriate use of communication and engagement tools and processes are essential to ensuring high quality engagement and communication.

Our objectives are:

- To maintain a high level of awareness and commitment to TCAT
- To ensure consistent messages about TCAT are communicated within NHS and amongst wider stakeholder groups
- To ensure stakeholders have opportunities to be engaged and involved in the work of the TCAT
- To ensure accurate and accessible information is made available to stakeholders

Achieving these objectives will be measured by:

- Increase in positive messages about TCAT to all stakeholders;
- Stakeholders display improved understanding of TCAT and support for the project

KEY MESSAGES

The key message themes are:

- Project background, TCAT phase 1 and TCAT Phase 3
- Increase in unmet patient need
- Increase in cancer survivorship
- Need for integration of services to best provide new model of patient care, avoiding duplication and making best use of resources
- Enabling patients to take a more active role in managing their own care
- Holistic Needs Assessment (HNA)
- Health and Well Being Events
- End of Treatment Summaries (EOTS)

Key messages need to develop at each project stage to ensure stakeholder do not disengage with the process.

AUDIENCES

To help ensure wider engagement with TCAT phase 3 communications needs to be meaningful and appropriate. A stakeholder analysis helps ensure we identify all relevant stakeholders and use the most appropriate methods of communications and engagement.

Particular efforts will be made to make sure we communicate and engage with stakeholders in a method that is suitable to them, and to communicate and engage with 'hard to reach' groups

The following stakeholders have been identified:

- Patients
- Visitors/Public
- SCAN
- Macmillan
- Staff – across whole organisation, not just BGH site
- NHS Borders Board members
- Community Pharmacists
- Public Involvement Network
- Scottish Health Council
- Media
- Borders Community Groups
- Hard to reach groups – by location and accessibility
- Third sector / voluntary groups and organisations

COMMUNICATIONS METHODS

The selection of the appropriate delivery method is directly related to the content of the message and also the aim of the communication.

- Briefing/interview sessions (in person or by telephone)
- Internal NHS publications
- Staff briefings – globals/line manager briefs
- Use of Stakeholder/partner publications – e.g. SBConnect magazine to all Borders households
- Use of partner agencies communication tools – e.g. voluntary sector newsletters (Elder Voice; Red Cross etc)
- Use of internet
- Use of intranet
- Development of communications materials – leaflets, postcards, pop-ups
- Display/information stands
- Consider hard to reach groups including different languages/accessibility issues
- Social media (Facebook)
- Health and Well Being Events
- Local agencies/partner organisations
- Project Reports

We do not expect to involve the media to a large extent. However, should we need to increase the promotion of TCAT phase 3 we would aim to involve NHS Borders Communications Team, Macmillan Communications Team and the media to help promote TCAT across the whole of the Borders.

Appendix 3: Band 4 Job Description

JOB DESCRIPTION

1. JOB DETAILS

Job Title:	Macmillan Cancer Assistant Practitioner
Responsible to:	Cancer Information and Support Service Manager,
Department & Base:	Cancer Services, Borders Macmillan Centre, BGH
Date this JD written/updated:	August 2018

2. JOB PURPOSE

The Cancer Assistant Practitioner will work as an active member of the Cancer Services Nursing Team to provide a high quality, efficient and effective service for people living with cancer.

The Assistant Practitioner will assume delegated responsibility for a clinical caseload and will provide care for these patients working within relevant legal and ethical frameworks and in accordance with organisational protocols and policies.

The post holder will adopt a partnership approach to working in order to empower the patient and carers.

The Cancer Assistant Practitioner will undertaking independently holistic needs assessments, following stratified care pathways, to plan, co-ordinate and evaluate care, referring on/escalating to the most appropriate service when required.

Working in collaboration with the Specialist Cancer Nursing Team, the post holder will use skills and knowledge to support the delivery of specialist clinical services.

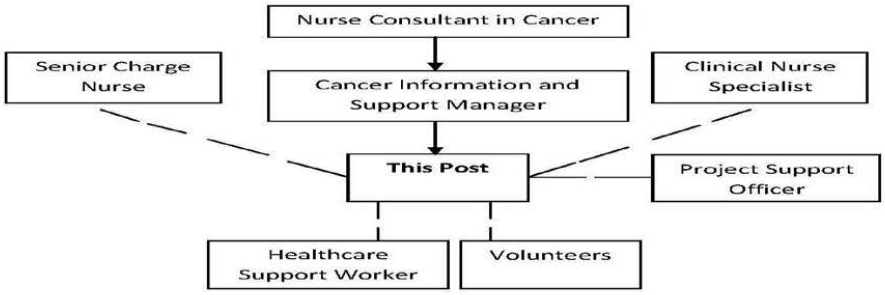
The Cancer Assistant Practitioner will be competent to work across professional disciplines, including external agencies as required.

The post holder will mentor and supervise Macmillan Volunteer workers and other junior health care support workers.

The post holder will communicate with empathy, understanding, diplomacy, honesty and integrity.

The Assistant Practitioner will be competent, confident and adaptable and will require minimal supervision from the registered professionals within the team.

3. ORGANISATIONAL POSITION



4. SCOPE AND RANGE

This post sits within Cancer Services and based in Borders Macmillan Centre.

The post holder:

- Will work collaboratively with members of the Cancer Team to deliver robust, safe and quality services for people across NHS Borders.
- Will work independently, with indirect supervision, to assess and triage the needs of people living with cancer, within existing clinical governance and organisational frameworks.
- Will give patients, families and carers advice and support throughout their cancer journey.
- Co-ordinate and promote Cancer Events for people living with and beyond cancer.
- Will work collaboratively with colleagues across health, social, community and voluntary organisations to foster multi-agency working and address the needs of the local population.
- Will be expected to travel and hold a clean driving licence.
- Is not responsible for managing the budget but needs to be aware of the resources available and the need to work within financial constraints.

The post holder's primary post will be within the Cancer Services Day Unit at Borders General Hospital but may be required to work in other areas of NHS Borders when required as service needs dictate.

5. MAIN DUTIES/RESPONSIBILITIES

- Independently plan, prioritise and organise own workload, working within set protocols, polices and standards and within the remit of the cancer assistant practitioner role, to ensure the needs of the patient are met.
- Carry a caseload and use identified tools to assess holistic needs of patients, identifying, initiating and evaluating programmes of care, including appropriate referral to clinical nurse specialists, other health care professionals, community, social, financial or voluntary agencies.
- Triage incoming calls or drop-in encounters and following a risk assessment framework, initiate an appropriate response according to protocols and individual care pathways.

- Follow up patients whose needs may not have been met by contacting the patient or relevant services.
- Display empathy, providing practical and emotional support, communicating with people who have complex and sensitive cancer needs.
- Act as an advocate and facilitator to resolve issues that may be perceived as barriers to care or support.
- Maintain effective communications both verbally and in writing, through accurate record keeping, with patients, relatives and other members of the health care team.
- Maintain own personal development, including training and competency assessments required to support the provision of specialist cancer services in line with local policy.
- Have a sound knowledge of operating procedures and standards within the department and an ability to recognise associated risks, escalating risk and acting appropriately in the event of an adverse event.
- Support data collection and production of reports for audit purposes.
- Participate in clinical education of other staff and within are of expertise as required.
- Provide mentorship and supervision for health care support workers and volunteers.

6. SYSTEMS AND EQUIPMENT

The post holder will require IT skills for:

- Maintaining timely, accurate patient records and documenting interventions
- Health and safety systems for example DATIX reporting: inputting information
- TRAK: Accessing and inputting clinical information
- Internet: to access resource, information and policy
- Intranet: to access, and upload where required, local policy and information
- Microsoft office, including but not exclusive, outlook email, calendar, excel, word, PowerPoint, access
- Departmental network drives
- Learning resources
- Documentation and audit collection tools: input and produce reports as required.

Resuscitation equipment as required.

Clinical equipment for example; dynamap, thermometer, height, weight and BMI scales

Assessment tools and patient information literature.

Laptop or PC

New systems may be introduced as the organisation and technology develops however training will be provided.

7. DECISIONS AND JUDGEMENTS

The post holder will:

Work without direct supervision on a daily basis with onsite guidance and support available at all times from a Registered Professional.

Be required to assess the care needs of patients, identifying, initiating and evaluating programmes of care including appropriate and timely referral to health care professionals or other agencies.

Prioritise own delegated caseload, independently organise, prioritise and plan workload taking into account the service as a whole.

Triage incoming calls using a risk assessment framework and escalate clinical concerns to the appropriate clinician.

Assess the holistic needs of people living with cancer and provide relevant information, advice and signpost to other services as required.

Make judgements regarding the current condition and status of the person being assessed, escalating clinical or emotional concerns in line with local policy.

Be able to respond to unpredictable and emergency situations by taking effective action.

Participate in discussion with members of the Cancer Services team to inform and advise on development of service.

Recognise the level of competence required for the role as well as own ability and limitations and identify these to your line manager.

8. COMMUNICATIONS AND RELATIONSHIPS

The post holder will:

Be required to communicate on complex and sensitive issues to patients, families and carers on a daily basis.

Be required to reassure people who may be distressed, anxious, worried, terminally ill or have cognitive impairment and communication problems.

Provide advice, education and encouragement to individuals and their families to empower people to live as independently as possible.

Ensure accurate, clear and timely communication of patient needs and outcomes to professionals, across the boundaries, involved in the care pathway, required for the benefit of the patient.

Liaise with third party agencies, for example Macmillan, for ongoing support and feedback.

Engage with service users in consultation as required with the guidance o line manager and local policy. Contribute to Service evaluation to inform ongoing health care improvement.

9. PHYSICAL DEMANDS OF THE JOB

Lifting, carrying and transferring a range of equipment to and from locations.

Manual handling on an occasional basis of patients who may need a wheelchair, assistance to transfer of in an emergency situation.

High levels of concentration are required, on a daily basis, to assess, interpret, analyse and process patient' clinical, emotional or social concerns.

Communicating daily with people who are emotionally distressed, anxious or frightened, including in the terminal stages of illness.

Manual dexterity required to carry out clinical procedures.

Regular need to be flexible to the unpredictable demands of the service.

Act quickly to escalate concerns to registered health care professionals.

Travel between locations in the course of duties.

Sitting for the majority of the shift, variable when engaging with stakeholders and attending cancer events.

Potential exposure to episodes of verbal and physical aggression from patients, relatives or carers. Occasional exposure to body fluids.

10. MOST CHALLENGING/DIFFICULT PARTS OF THE JOB

The emotional demands of constantly caring for patients and relatives suffering from malignant disease, including those in the terminal phase of their illness, and supporting team members who are also exposed to this constant emotional demand.

Prioritising and meeting competing demands from patients, relatives and other team members.

Establishing effective working relationships with multi-disciplinary and multi-agency teams.

Gaining confidence of patients/carers and staff in this new role.

The ability to work flexibly, being able to respond to local priorities and a changing work environment.

Maintaining the level of clinical competency and skill underpinned by a sound knowledge base required to carry out the role safely.

Minimise risk to yourself and others by reporting and escalating areas of concern.

11. Knowledge, Training and Experience

ESSENTIAL

1. 2 years experience in working as a health care support worker, caring for people with complex cancer needs.
2. Experience of working in an cancer care environment with evidence of undertaking a range of clinical competencies to SVQ 3
3. Ability to undertake and achieve a relevant programme of learning at SQCF level 8 and relevant Macmillan training programs, or have equivalent experience
4. Have the ability to be able to prioritise own workload

5. Evidence of collaborative working within a specialist team
6. Motivated to develop skills and knowledge to support service improvement
7. Have a good working knowledge of IT systems, such as Microsoft Office, internet/intranet browsers.
8. Practice as a responsible, enthusiastic, calm, kind and empathetic practitioner.
9. Car Driver

DESIRABLE

1. HNC in Health Care
2. Cancer or counselling qualifications

This job description is not definitive and may be subject to future amendments following negotiation and consultation.

Appendix 4: EOTS Example

Treatment Summary

Insert GP Contact Details
Address

Dear Dr **X**

Re: Add in patient name, address, date of birth and CHI number

Your patient has now completed their initial treatment for cancer and a summary of their diagnosis, treatment and ongoing management plan are outlined below. The patient has a copy of this summary.

Diagnosis: **Breast Cancer**	**Date of Diagnosis:**
Summary of Treatment and relevant dates: **FEC/Docetaxel**	**Treatment Aim:** **To increase the chance of cure after surgery** **To shrink cancer prior to surgery** **To improve symptoms and prolong life** **To eradicate cancer for a prolonged period** **To eradicate all cancer with the aim of cure**

Possible treatment side effects and/or late effects:

For 6 weeks after completion of chemotherapy, please continue to contact the Cancer Treatment Helpline if you have a temperature, feel unwell or require advice about chemotherapy side effects.

Longer-term side effects of chemotherapy:-

Tiredness

- You should see a gradual improvement but can take up to 6 months (or longer for some people) until you feel back to normal.

Numbness/tingling in hands/feet

- Can sometimes get worse for a few weeks after completing chemotherapy.
- Should slowly improve over a number of months but can sometimes be permanent.

Nail Changes

- Nail changes should grow out over a number of months. Occasionally nails come off but they will grow back.
- Protect your nails by wearing gloves for household chores and gardening and keep your nails short.
- It is fine to wear nail varnish but do not wear false nails until nails are back to normal.

Contact your GP if the above side effect is troublesome or not improving.

Hair loss

- You should see hair re-growth within a few weeks of completing your treatment.
- Hair tinting, perming or chemical treatments should be avoided until the scalp is healthy and hair growth is at least 3 inches (7.5 cm) long. Seek advice from a professional hairdresser who is experienced in styling hair re-growth after chemotherapy.

Diet

- Wait 4-6 weeks before taking the foods you were told to avoid during chemotherapy.

Fertility and contraception

- Pre-menopausal women can have an early or temporary menopause. Speak to your breast care nurse if you experience troublesome menopausal symptoms.
- Non-hormonal contraception should be used for at least 1year after completing treatment to avoid pregnancy.
- Discuss with your Oncologist if you are thinking about getting pregnant.

More information about chemotherapy side effects can be found in your chemotherapy pack or on the Macmillan Website/Chemotherapy section: https://www.macmillan.org.uk/information-and-support/treating/chemotherapy

Alert Symptoms that require referral back to specialist team: Any new breast lump or change in breast or nipple appearances. A lump in the armpit or neck. A swelling in the arm or hand. A persistent new pain. A cough or shortness of breath which does not improve. Early morning headaches. **See your GP if you experience any of the above symptoms and also inform your Clinical Nurse Specialist.**	**Contact for re referrals or queries relating to your diagnosis:**
Secondary Care Ongoing Management Plan: (tests, appointments etc) You will now have a course of radiotherapy. Oncology appointment 6-8 weeks after completing radiotherapy. Further appointments will be arranged by Oncologist. You will have yearly mammograms. If you need to have hormone therapy after your chemotherapy this will initially be prescribed by your Oncologist thereafter your GP.	**Other service referrals made: (delete as nec)** District Nurse Physiotherapist Social Worker Dietician Clinical Nurse Specialist Psychologist Benefits/Advice Service Lavender Touch Cancer Info and Support Service (CISS) Other
Further action requested for GP:	
Summary of information given to the patient about their cancer and future progress:	
Additional information including issues relating to lifestyle and support needs: Please complete and return the holistic needs assessment (HNA) to help identify any support needs. Next Health and Wellbeing Event on …….. There are many local services available to you during and after treatment. Information is available from your Clinical Nurse Specialist or on NHS Borders Website, TCAT section: http://www.nhsborders.scot.nhs.uk/patients-and-visitors/our-services/general-services/transforming-care-after-treatment-(tcat)	

Completing Health Professional: Signature: Date:

Appendix 5: EOTS SOP

Title	Cancer End of Treatment Summary for Surgery/Radiotherapy
Document Type	Procedure
Issue number	BMC 01/01
Version number	Version 1
Approval/Issue date	Draft
Review date	
Approved by	
Prepared by	Rachel Johnson Louise Lackie
Developed by	NHS Borders TCAT project team
Reviewed by	
Equality & Diversity Impact Assessed	

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Roles and Responsibility Page 3

Procedure Page 3

Introduction
National and local evidence confirms that people who have completed cancer treatment often do not know what to expect after treatment ends. This includes potential treatment side effects, what symptoms should be reported, who to contact if they have any concerns and how to get back to a normal life.
End of treatment summaries (referred to hereafter as EOTS) are a key component of the Macmillan Recovery Package and aim to provide patients and their GP with the above information.

Intent
The purpose of this document is to provide staff with instructions on how to access, complete and distribute patient individualised EOTS.

Roles and responsibility
Staff roles and responsibilities are explained in the procedure below.

Procedure for patients who have completed Surgery/Radiotherapy

Populate EOTS after the has finished treatment

1. The EOTS should be populated on TRAK by clinical nurse specialist / CISS once treatment is known to have finished.

2. Process for accessing EOTS on TRAK
    a. Access TRAK
    b. Select Episode Enquiry
    c. Enter patient CHI
    d. EPR
    e. Questionnaires
    f. Select New
    g. Select correct EOTS
    h. Check the patient details at top of EOTS are correct
    i. Populate EOTS
    j. Update

3. The patient's CNS/CISS will access the EOTS on TRAK and print 2 copies of the EOTS.

4. One copy given to patient.

5. Other copy given to Administrative staff to file in patient's blue medical notes.

6. Administrative Staff will:

    a. Scan and email document to GP administration box and CNS with the following message "Please find attached EOTS for your patient on completion of their treatment"
    b. Place a paper copy in the blue medical notes
    c. Send a paper copy to the lead consultant responsible for this episode of care.
    a. Update the list of patients who have received an EOTS and send a copy of this list to Alison Smail monthly.

Appendix 6: EOTS GP Feedback Questionnaire

Borders General Hospital
End of Treatment Summary – GP Evaluation

We would like your views on our End of Treatment Summary (EOTS) that have been developed to improve information given to patients and at the same time, improve communication about treatment aims, outcomes and follow up action for primary and secondary care. The EOTS is a patient held record with a copy being filled in the patient's medical notes and another sent to their registered GP.

Since August 2016 we have been testing the EOTS for people finishing Chemotherapy treatment in Borders Macmillan Centre. **Your feedback therefore will be extremely valuable**. To help you access your patient's EOTS, the Name and CHI number is included on your individual questionnaire.

Thank you for participating in this survey.

Name:_____
CHI:_____

1. Do you feel having a copy of the patient's EOTS for this treatment episode, gives you clear information about the following?

   a. Diagnosis YES/NO
   b. Treatment aim YES/NO
   c. Treatment outcome YES/NO
   d. Treatment side effects YES/NO
   e. When to refer back to specialist services YES/NO
   f. Who to refer back to for specialist cancer services YES/NO
   g. What your patient's follow up plan is? YES/NO
   h. What action is required in Primary Care after completion of cancer treatment YES/NO

   Comments……
   ……

2. Do you feel the EOTS gives your patient clear and appropriate information? YES/NO
   Comments:……
   ……

3. Did you find the pharmacy comments / instructions useful? YES/NO
   Comments:……
   ……

4. Do you think the EOTS reminds health care professionals about:

a) Patient's attendance at NHSB Health and Wellbeing Events after treatment? YES/NO
   Comments:……
   ……

b) Use of Holistic Needs Assessments (HNA) and care planning? Patient's attendance at NHSB Health and Wellbeing Events after treatment? YES/NO
   Comments:……
   ……

5. At present the only IT option available for us to send EOTS to Primary Care is via email. If there were no IT limitations what would be your preferred method to receive EOTS?

   a. Email YES/NO
   b. Mail YES/NO
   c. SCI Store YES/NO
   d. No preference YES/NO

6. Is there anything that you feel is missing from the EOTS? YES/NO
   Comments:……
   ……

7. Is there anything that you feel should not be included the EOTS? YES/NO
   Comments:……
   ……

8. What did you feel was helpful about the EOTS?
   ……
   ……

9. Any other comments
   ……
   ……
   ……
   ……

Thank you for completing this questionnaire.

Please complete by 31st March 2017 and return to:

Alison Smail
Borders Macmillan Centre
Borders General Hospital
Melrose
TD1 3BS

Appendix 7: EOTS Patient Feedback Questionnaire

Borders General Hospital
End of Treatment Summary Evaluation

We would like your views on which End of Treatment Summary (EOTS) you prefer looking at design, clarity and information.

The End of Treatment Summaries have been developed to improve information given to you and your GP at the end of your treatment.

We would welcome your feedback on which you prefer either Template or Structured Letter.

This questionnaire is anonymous and we welcome your participation.

Thank you for participating in this survey.

1. Where is the site of your tumour?

   ……

2. On which EOTS is the information clearer to you?

   ……

3. On which EOTS is the information easier to read?

   ……

4. On which EOTS is it easier to find the information?

   ……

5. On which EOTS is the information for you easier to understand?

   ……

6. Which EOTS helps you understand the aim of your treatment better?

   ……

7. Which EOTS helps you understand which side effects to lookout for?

   ……

8. Which EOTS identifies to you who to get in touch with and for what?

   ……

9. Which EOTS tells you when to expect your next appointment or test for follow-up after your treatment has finished?

   ……

10. Is there anything you do not like about the template EOTS?

……
……

11. Is there anything you do not like about the Structured Letter EOTS?

.
……
……

12. Is there anything you especially like about the template EOTS?

……
……

13. Is there anything you especially like about the template EOTS?

……
……

14. Is there anything that you feel is missing from the template EOTS?

……
……

15. Is there anything that you feel is missing from the Structured Letter EOTS?

……
……

16. Is there anything that you feel should not be included in either of the EOTS?

……
……

17. In your personal opinion which EOTS do you prefer?

……
……

Thank you for your time.

Appendix 8: Patient Questionnaire EOTS v Clinical Letter

Borders General Hospital
End of Treatment Summary Evaluation

We would like your views on which End of Treatment Summary (EOTS) you prefer looking at design, clarity and information.

The End of Treatment Summaries have been developed to improve information given to you and your GP at the end of your treatment.

We would welcome your feedback on which you prefer either Template or Structured Letter.

This questionnaire is anonymous and we welcome your participation.

Thank you for participating in this survey.

1. Where is the site of your tumour?

   ……

2. On which EOTS is the information clearer to you?

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3. On which EOTS is the information easier to read?

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4. On which EOTS is it easier to find the information?

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5. On which EOTS is the information for you easier to understand?

   ……

6. Which EOTS helps you understand the aim of your treatment better?

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7. Which EOTS helps you understand which side effects to lookout for?

   ……

8. Which EOTS identifies to you who to get in touch with and for what?

   ……

9. Which EOTS tells you when to expect your next appointment or test for follow-up after your treatment has finished?

   ……

10. Is there anything you do not like about the template EOTS?

……
……

11. Is there anything you do not like about the Structured Letter EOTS?

.
……
……

12. Is there anything you especially like about the template EOTS?

……
……

13. Is there anything you especially like about the template EOTS?

……
……

14. Is there anything that you feel is missing from the template EOTS?

……
……

15. Is there anything that you feel is missing from the Structured Letter EOTS?

……
……

16. Is there anything that you feel should not be included in either of the EOTS?

……
……

17. In your personal opinion which EOTS do you prefer?

……
……

Thank you for your time.

Treatment Summary

Insert GP Contact Details
Address

Dear Dr **X**

Re: Add in patient name, address, date of birth and CHI number

Your patient has now completed their initial treatment for cancer. A summary of their diagnosis, treatment and ongoing management plan are outlined below. The patient has a copy of this summary.

Diagnosis:	**Treatment Completion Date:**
Summary of Treatment and relevant dates:	**Treatment Aim:**
Patient – possible symptoms and / or side effects:	
Patient Contacts: **In Hours:** Chemo Helpline (for chemo symptoms up to 8 weeks after treatment) – 0800 9177711 GP for any new symptoms – please phone your GP surgery receptionist CNS for general queries or concerns – via BMC reception 01896 826888 CISS for information or support – 01896 826835 **Out of Hours:** Chemo Helpline (for chemo related issues for up to 8 weeks after chemo treatment) – 0800 9177711 NHS24 (for queries not relating to chemo treatment or after 8 weeks) – 111	
GP - Alert Symptoms that require referral back to specialist team:	
Secondary Care Ongoing Management Plan: (tests, appointments etc)	**Other service referrals made: (please tick)** District Nurse AHP Social Worker Dietician Clinical Nurse Specialist CISS Benefits/Advice Service Palliative Care Other
GP - Further action requested	
Additional information including issues relating to work, lifestyle and support needs:	

Completing Health Professional: Signature: Date:

A template Suggested structured letter

Date: <insert date>

Dear Dr <insert GP's name>

Re: <insert patient's name>

Your patient has had the following diagnosis and treatment for cancer and received a summary and ongoing management plan as outlined below. They have been offered/received a copy of this summary.

Diagnosis:

Date of diagnosis:

Staging:

Summary of treatment and relevant dates:

Treatment aim:

Possible treatment toxicities and/or late effects:

Alert symptoms that require referral back to specialist team:

Secondary care ongoing management plan: (tests, appointments)

Recommended GP actions: (e.g. medication, osteoporosis/cardiac screening)

Summary of information given to the person living with cancer:

Additional information including issues related to lifestyle, physical activity and support:

Advise entry onto primary care palliative or supportive care register: (Yes/No)

DS1500 application completed: (Yes/No/N/A)

Prescription charge exemption arranged: (Yes/No)

Contact for re-referral or any queries:

In hours:

Out of hours:

Yours sincerely

<insert clinician's signature>

<Insert clinician's name>

CC: <Insert patient name>

Please take this document with you to your GP practice appointment where your diagnosis and cancer care will be reviewed with you.