

**WE ARE  
MACMILLAN.  
CANCER SUPPORT**



**WELCOME!**

# **Post-Treatment Follow-Up Workshop**

20<sup>th</sup> April 2010

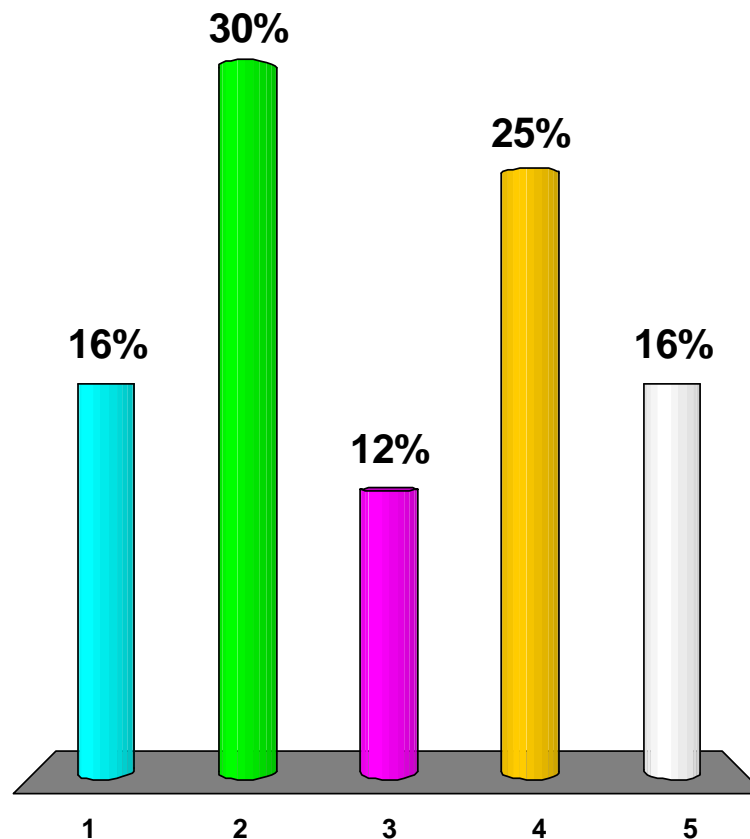
**Chairman's Opening Remarks**

**Dr Michael McBride**

**Chief Medical Officer, DHSSPS**

Which of the following best describes the capacity in which you are attending this workshop today? Choose **ONE**

1. Doctor
2. Nurse
3. Allied Health Professional
4. Service Manager
5. Other



**“Living With and Beyond Cancer”**

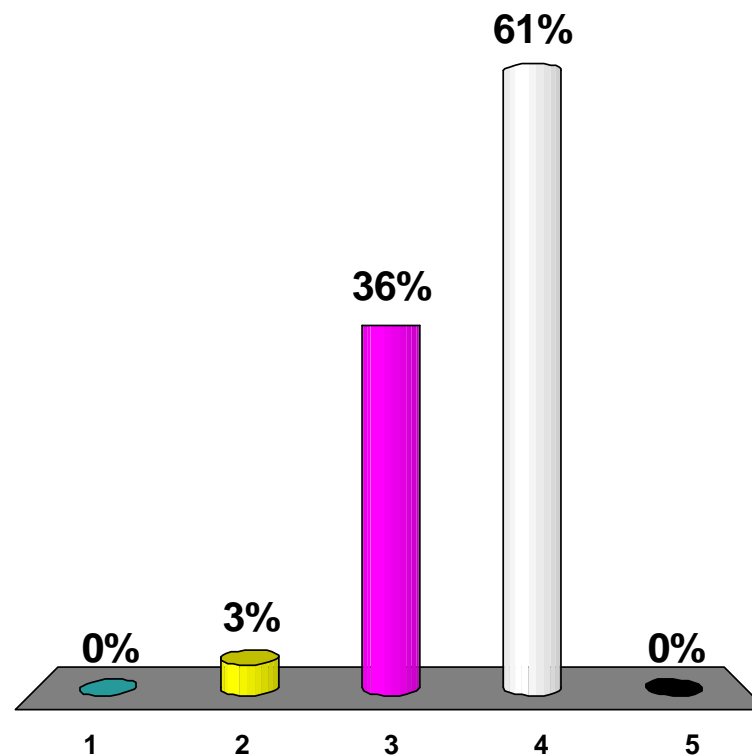
**Mr Munier Abdalla**

**Reporter, Downtown Radio**

**“Living With and Beyond Cancer”**  
**Time...**

Many cancer patients describe feeling “detached and lonely” after treatment has ended? What should be done to alleviate feelings of despair during this vulnerable time? Choose **ONE**

1. Ongoing assessment
2. Better information
3. Tailored support
4. All of the above
5. None of the above





# **Session 1**

## **Challenges & Limitations of Current Follow-Up Arrangements**

**“Surgical Follow-Up”**

**Mr Patrick Keane**

**Consultant Urologist  
Uro-oncologist**

# Surgical Follow Up

- **Purpose**
- **Outcome**
- **Cost effectiveness**
- **SHO**
- **Nurse**

# Telephone Clinic

<b>Helpful</b>	<b>92%</b>	<b>8%</b>
<b>Enough Time</b>	<b>94%</b>	<b>6%</b>
<b>Preference</b>	<b>64%</b>	<b>18%</b>
<b>Do it Again</b>	<b>84%</b>	<b>11%</b>

**Ambulance cost in Belfast £150**

# Surgical Follow Up

## Validated

715

534

924

791

865

**Total 3829**

2005

2006

2007

2008

2009

## Telephoned

238

489

368

374

583

**Total 2052**

# Surgical Follow Up

Reviewed

Tele Rev

90

2005

72

156

2006

113

236

2007

121

85

2008

85

273

2009

157

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**Total 604**

**548**

# Surgical Follow Up

**Procedures**

**Discharged**

**4**

**2005**

**284**

**92**

**2006**

**626**

**133**

**2007**

**555**

**7**

**2008**

**227**

**76**

**2009**

**273**

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**Total 312**

**1965**

# Surgical Follow Up

- The Future
- Primary Care
- Protocol driven
- Internet
- Survivorship

**“Follow Up of Cancer Patients –  
An Oncological Perspective”**

**Dr Martin Eatock**

**Consultant Medical Oncologist  
Northern Ireland Cancer Centre  
Belfast HSC Trust**

# What are the Objectives for follow-up following cancer treatment?

- Following potentially curative treatment
  - Detect local or distant recurrence following potentially curative treatment
    - potentially curative options for treatment
    - early treatment of relapse even if not curative
  - Monitor Long term sequelae of treatment
    - Side effects
    - Impact on QOL
  - Re-assurance
  - Physician Morale

# What are the Objectives for follow-up following cancer treatment?

- In those with incurable Disease
  - Monitoring disease progress
  - Interventions
    - Oncological
    - Palliative
  - Transitions in care

## What happens in Practice?

- Patients seen by multiple specialties
- Appointments rarely on schedule
  - Cancer access targets take priority
- Patients often travel long distances for short appointments
- Poor communication between specialties and between primary/secondary care.

# Current follow up practice

- Lacks integration
  - Follow up often by multiple professionals for same condition
  - Causes confusion
  - Often poor communication
- Often lacks logic
- Few written local guidelines

# In an ideal world.....

- Follow up would be:
  - evidence based
  - undertaken by appropriately trained professional/s
  - Individualised
    - Based on risk assessment
    - Based on further treatment options
    - Based on patient need
  - Sensitive
  - Cost effective

**“Post-Treatment Follow-Up,  
A Primary Care Perspective”**

**Dr Ian Clarkson**

**Macmillan GP Facilitator for Cancer  
and Palliative Care Practitioner**

# Expectations

- Support and security
- Responsiveness
- Clarity
- Timeliness
- Information
- Convenience
- Cooperation

# Experiences

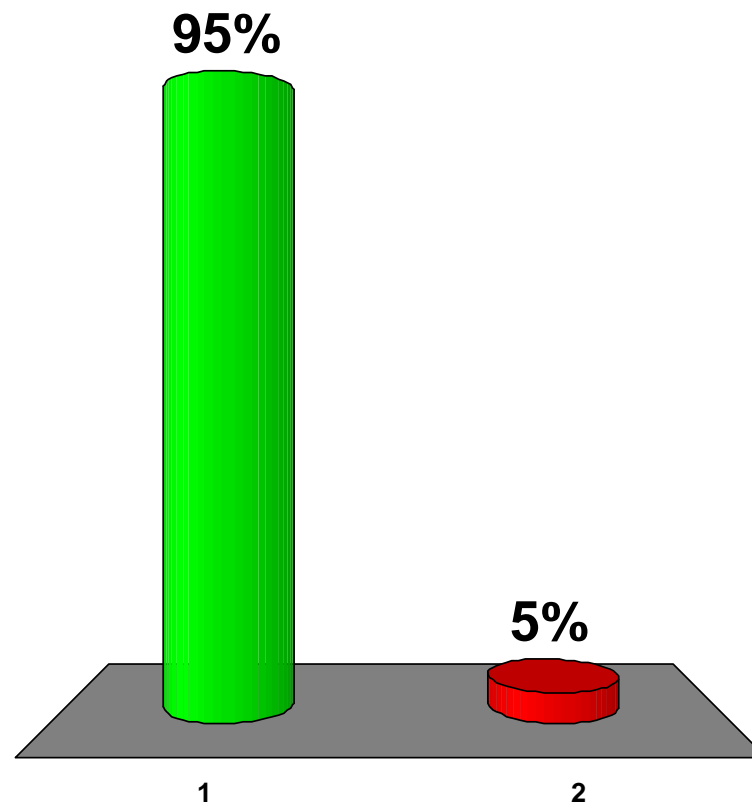
- Expectations and experience do meet!
- Duplication
- Confusion
- Delay
- Hurry
- Anxiety
- Anger

# Challenges

- Honest expectations of the process
- Flexibility and responsiveness in service provision
- Empowerment of patients
- Better conversations
- Clarifying/endorsing the role of primary care in follow-up

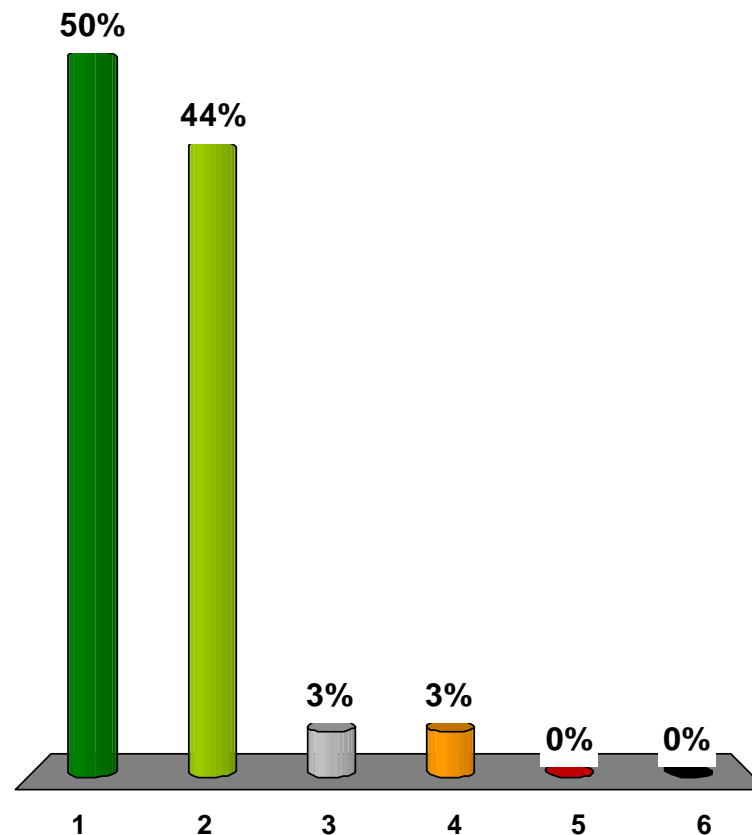
# Do current follow-up arrangements require 'root and branch' reform? Choose **ONE**

1. Yes
2. No



# Will future follow-up arrangements require new and enhanced primary care contribution? Choose **ONE**

1. Strongly agree
2. Agree
3. Neutral
4. Disagree
5. Strongly disagree
6. Don't know



**“Current Drivers for Change”**

**Jennifer Welsh**

**Director of Cancer and Specialist Services  
Belfast Health and Social Care Trust**

# Contextual factors & tensions

- Ageing population → increased incidence
- Ageing population → Multiple co morbidities
- Emerging technologies but limited resources
- Limited resources but increased expectations
- Resources: Prevention or Treatment or Care?
- Cure → Care: cancer as chronic illness
- Increasing Health Inequalities
- The age of biology & the rise of genomics

# Increasing demand & finite capacity

- More patients diagnosed
- Complex multimodality treatment pathways
- Multiple life extending treatment options
- End of life treatments
- Emergent therapies

72 % increase  
chemotherapy  
preparation in  
4 years

19 Business  
Cases through  
D&T

New  
generation  
drugs

# Efficient use of resources and complex cancer burden

- Time critical pathways
- Diverse disease trajectories
- Multiple Co morbidities
- Unscheduled admissions
- A&E attendances
- Complex health and social care needs
- Burdens on carers & families
- Pockets of ill health

Cancer accounts for 12% of all bed days\*

30 % of treatment beds occupied by non treatment related symptoms

65% attendances at A&E were general unwellness

# Ensuring productivity & increasing expectations

- Consultant led care
- Decision to treat
- Acute Oncology Services
- Multidisciplinary meetings
- Governance, Audit, Research
- Patient experience measures.
- Statutory obligations to children & carers

Competing Pressures for clinicians time

Review waiting lists accumulating

Duplication of review by surgery & oncology

Unmet need becomes unscheduled admission

# Clinical and Cost Effectiveness

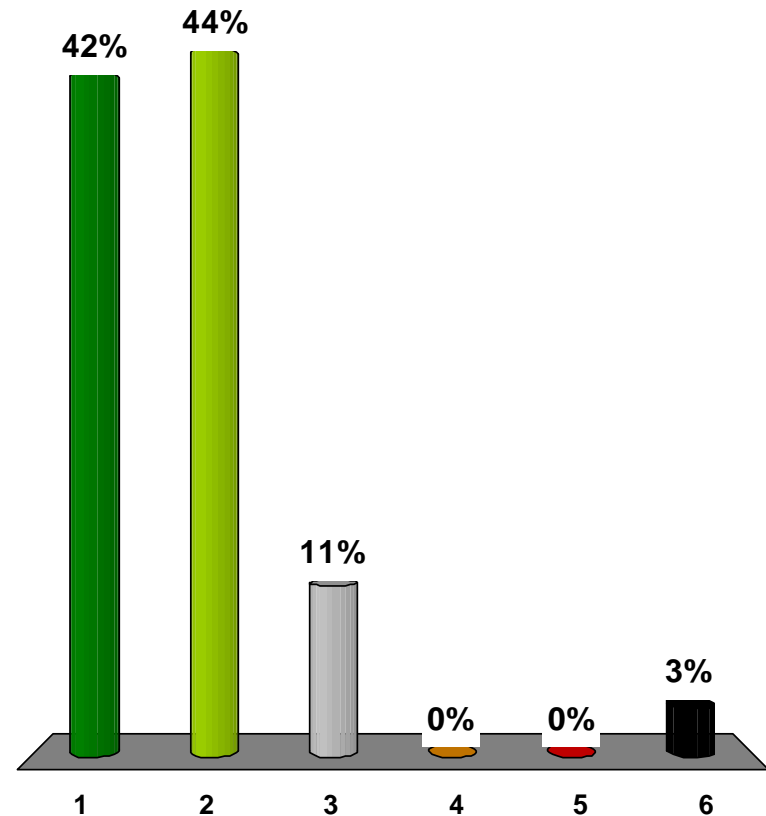
Clinical effectiveness: doing the right thing, at the right time, in the right way to the right person.

Cost Effectiveness: maximising utility by the judicious allocation of scarce resources

Other chronic illness such as COPD & cardiac failure utilise proactive health monitoring to avoid crisis and unscheduled admissions.

Could those on a chronic cancer trajectory benefit from proactive health surveillance? Choose **ONE**

1. Strongly agree
2. Agree
3. Neutral
4. Disagree
5. Strongly disagree
6. Don't know





## **Session 2**

**Looking Beyond:**

**Alternative Approaches to Cancer Follow-up**

# “National Cancer Survivorship Initiative”

Key Messages on Behalf of:

**Dr Adam Glaser**

**National Clinical Lead**

**&**

**Dr Jane Maher**

**Consultant Oncologist**

**MacMillan Cancer Support Medical Director**

# National Cancer Survivorship Initiative

Adam Glaser

Clinical Director, National Cancer Survivor Initiative

Please don't



# Cancer Reform Strategy

Dec 2007

- Chapter 5 is about “Living with and beyond cancer”
- “In partnership with cancer charities, clinicians and patients will consider a range of approaches to improving the services and support available for cancer survivors”
- National Cancer Survivor Initiative      Sept 2008  
NHS & 3<sup>rd</sup> sector partnership

# What is a cancer survivor?

Anyone living with or beyond a  
diagnosis of cancer

Macmillan Cancer Support

# This presentation considers

- If there is a need for change?
- Vision
  - 5 Key shifts

# Is there a need for change?

- 2 million living with and beyond cancer in UK
  - 1.6 m completed therapy
  - Prevalence increases by 3.2% p.a.
  - 4 million in 20 years
- Follow-up & support
  - Prevention, early detection and management
    - Recurrence
    - 2<sup>nd</sup> malignancy
    - Late complications
      - physical
      - psychological
      - social

# Does the health economy meet these requirements?

# National Cancer Survivorship Initiative

- The evidence suggests that current follow up arrangements are not meeting the medical, psychological, social, spiritual, financial and information needs that cancer survivors may have following their treatment.
- Routine follow up appointments are not effective in terms of detection of recurrence. In practice, the large majority of recurrences are detected either by patients themselves or on investigations which can be planned without a patient having to attend a clinic.

- Follow up strategies vary
  - Nationally, locally & within centres
- Is all follow-up necessary?
- Lack of capacity to continue model **4 million!**
- *Actually*

*Not always necessary*

*Not always convenient*

*Not personalised/risk stratified*

*empty episodes*

# Service Transformation

- Quality
  - Enhanced access to information
    - Diagnosis, treatments, complications, risks, surveillance
    - Survivor & all components of health economy
  - Rapid access to specialist support & advice
- Productivity
  - Reduce unnecessary “empty” episodes
  - Automated surveillance
  - Seamless information exchange
    - 1<sup>o</sup>, 2<sup>o</sup>, 3<sup>o</sup> care and service user
  - Risk stratification

- Is there a need for change?
- N.C.S.I. [Vision](http://www.ncsi.org.uk) [www.ncsi.org.uk](http://www.ncsi.org.uk)

## 5 Key shifts

# 1. Cultural shift in focus to recovery, health and well-being after treatment

- Shift towards assessment and personalised care planning based on individual risks, needs and preferences
- Shift towards support for self-management
  - Supported self management
- Shift from “one model fits all” clinical follow-up to a personalised information prescription and specialist support allowing early recognition of signs/symptoms secondary, recurrent or advanced disease
- Shift from emphasis on measuring clinical practice to measuring experience and outcomes for cancer survivors through PROMS in aftercare services

# 1. Continued

- Life following primary cancer treatment
- Can survive cancer
  - 5 year survival      78% children  
                                 >60% adults
- May not be cured but can live for long periods
  - metastatic prostate cancer
- Need to help ensure we maximise the quality of survival

## 5 Key Shifts

### 2. Shift towards holistic assessment and personalised care planning based on individual risks, needs and preferences

- Shift towards support for self-management
  - Supported self management
- Shift from “one model fits all” clinical follow-up to a personalised information prescription and specialist support allowing early recognition of signs/symptoms secondary, recurrent or advanced disease
- Shift from emphasis on measuring clinical practice to measuring experience and outcomes for cancer survivors through PROMS in aftercare services

## 2. Continued

>25% cancer patients have unmet needs a year after treatment

Armes et al, JCO, 2009.



Every patient will have an assessment, information, and a personalised care plan, so that their unique needs can be met

# Current situation

2009 Picker survey of over 2,000 survivors:

- 43% wanted more information and advice
- 75% did not have, or did not know if they had, a care plan
- 75% did not know who to contact for advice outside of office hours.

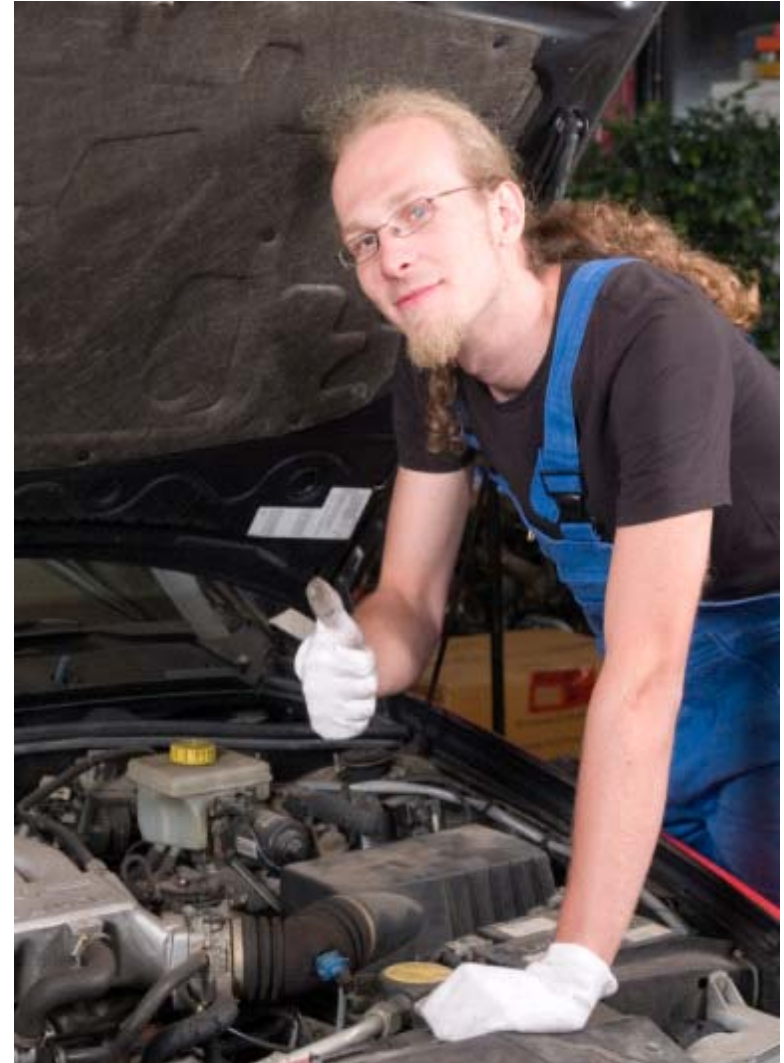
# Testing impact of:

- Consistent approach to assessment & care planning
- MDT communication to primary care (treatment summary record) at end of treatment
- Templates for improving quality of GP Cancer Care review
- Health and Well Being reviews



# Supporting patients return to work

- Testing model of vocational rehabilitation through pilots
- Work underway in providing support for employers
- Study into patient experience of DWP programmes
- Developing thinking about carers' issues



## 5 Key Shifts

### 3. Shift towards support for self-management - supported self management based on individual needs and preference with appropriate clinical assessment and support

- Shift from “one model fits all” clinical follow-up to a personalised information prescription and specialist support allowing early recognition of signs/symptoms secondary, recurrent or advanced disease
- Shift from emphasis on measuring clinical practice to measuring experience and outcomes for cancer survivors through PROMS in aftercare services

# Lifestyle change more important for cancer survivors than others



***Obesity***



***Dietary fat intake***



***Exercise***



***Smoking***

Health and well being clinics offer opportunities to learn more than how to manage their disease

## 5 Key Shifts

4. Shift from “one model fits all” clinical follow-up to a personalised information prescription and specialist support allowing early recognition of signs & symptoms secondary, recurrent or advanced disease

- Shift from emphasis on measuring clinical practice to measuring experience and outcomes for cancer survivors through PROMS in aftercare services

# Shift from "Follow-up" to "Aftercare"

<i>Level of need</i>	<i>Estimated % of patients ( vary according to cancer, individual &amp; treatment )</i>	<i>Currently</i>
<i>Level 1 – supported self-care with quick access back into the system if and when needed to improve early detection</i>	c75%	(<10%)
<i>Level 2 – level of requirement requiring regular primary or secondary care input</i>	c 20%	(90%)
<i>Level 3 – highly complex patients requiring case management by an assigned key worker (often a CNS) actively managing and "joining up" care for the patient</i>	c 5%	(<1%)

# 4. Tailored aftercare - consequences of treatment

- New illnesses may emerge months, years, decades after treatment.
  - >25 % adult survivors live with significant consequences of treatment
  - 60% childhood ca survivors experience 1 or more late effects 10y after Tx
- Reduce unnecessary follow-up

Increase support where needed

- Aim for
  - avoidable consequences to be avoided
  - unavoidable consequences to be recognised & managed to minimise their impact

## 4 (contd) Personalised support for those with advanced disease

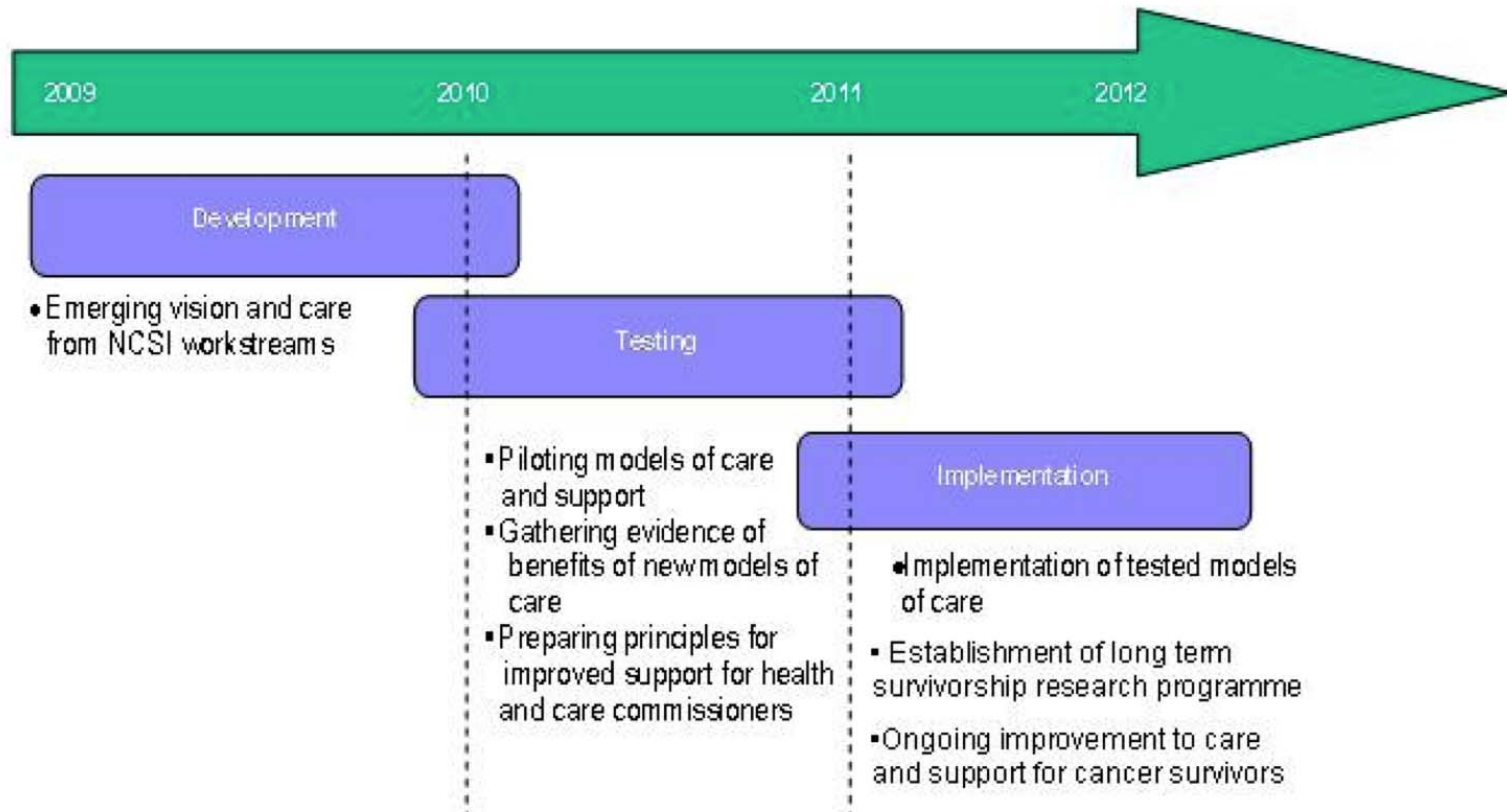
### Requires

- Pathways for rapid re-entry into the system
  - self-referral
  - from primary care
- Planning by MDT
  - therapeutic options
  - transition to End of Life Care
    - timely involvement of palliative care
- Specialist services

## 5. Shift from emphasis on measuring clinical practice to measuring experience and outcomes for cancer survivors through PROMS in aftercare services

- Promote more effective interactions with professionals
- Trigger “information prescriptions”
- Monitor change
- Measure outcomes
- Identify & target populations with needs

## Timeline for phases of the National Cancer Survivorship Initiative



# N.C.S.I.

- Clear vision and direction
  - 5 Key shifts
- 38 commissioned projects
  - extending to approximately 80 sites
- National support
  - Macmillan and other 3<sup>rd</sup> sector partners
  - NHS Improvement
- Significant investment (for at least 1 year more)
- *Exciting opportunity to transform the care and support delivered to the increasing numbers living with & beyond cancer*



# Consequences of treatment

Notes taken from telephone  
call with Dr Jane Maher

Please don't






# Size of the problem

- Currently 2 million in UK living with cancer
- Some cancers if get past 18 months to 1 year most likely go on to be a survivor (lung, unknown primary, upper GI, 50% colorectal)



# Changing cancer trajectory

- More than half of cancer patients live at least 5 years after diagnosis
- Upper GI, lung, cancer unknown origin - most die within 1 – 2 years
- Breast, prostate, colorectal : 20-30% develop chronic cancer or chronic treatment related illnesses
- All at higher risk of lifestyle related long term conditions



# Macmillan Health & Wellbeing Study

- Analysis of surviving population shows the same health profile as someone diagnosed with chronic illness
- If you are a cancer survivor *and* you have a chronic illness you have the same health profile as someone with 2 chronic illnesses
- Cancer patients higher risk of heart failure, diabetes and osteoporosis (GP data base)



# Benefits of Self Management

- People with cancer are more receptive to exercise and dietary self management programmes than others with chronic condition
- Currently missing this very important secondary prevention service
- If put in, these can save money

# How to pick up recurrence?

- 70% patients with cancer who recur could be picked up by
  - self assessment questionnaires
  - planned tests such as X-rays
- ..with no follow up appointment

# Working example

- Dr J Maher has run self supported follow up for people with breast cancer
- Need to stratify people in terms of risk associated with
  - Cancer
  - Treatment
  - Individual need (around 25% cant self manage)
- Generates 4 phone calls per day, needs CNS and administrative support

# Example contd

- 6 weeks after treatment have ‘stock take’ interview
  - Offer advise on risk of recurrence
  - Information and education on what to look out for
  - Give mammogram schedules (one per year x 5 years)
- Do not use “discharge” word rather they enter “self triggered follow up”, integrated service with GP
- Rapid access back through breast care nurse
- Positive patient feedback, no delays

# Assessment & Care Plan Milestones

- End of treatment
- One year later when acute side effects settle (most have physical or psychological impact, of which 75% settle)
  - If rehabilitation is right during first year people get back to work- this could save £ on disability benefits enable reinvestment to provide rehabilitation services within local community – (Manchester study)
- End of first year – assess risk of long term consequences
  - In case of pelvic cancers know there will be urine, bowel, sexual problems - need people to understand their illness, proper care planning for follow up.
  - Pay for CNS service by reduction in follow up appointments
- When peoples' health changes – either
  - Develop chronic cancer eg bone mets and need chronic illness management care plan
  - Develop long term consequences of treatment and need care plan
- Final re-assessment is the transition between chronic and end of life care

**“Back on Track – Fatigue Management”**

**Dr Jackie Gracey**

**Lecturer in Physiotherapy  
University of Ulster, Jordanstown**

**&**

**Ms Jane Rankin**

**Belfast Health & Social Care Trust**

## Back on track

- A rehabilitation service to deliver and develop research and supportive care for people living with and beyond cancer

# Outline

- Context
- **Breast cancer Rehab Initiative for Living Life** project
- Back on track
- Developments
- Question



## Context-Where has this concept arisen?

- Del funded Research studentships between UU and Physiotherapy in the Cancer Centre
- Research, surveys, focus groups, RCT Gynae Cancer patients- Home based walking programme. **F.A.T.I.G.U.E** study
- **Breast cancer Rehab Initiative for Living Life (Brill)** project
- Global evidence regarding exercise and lifestyle impacting on survivorship initiatives

**‘Brill’**



**‘Back on track’**

## The **B**reast cancer **R**ehab **I**nitiative for **L**iving **L**ife (**BRILL**)

A feasibility project, based on self-referral, and designed to address quality of life issues in the time period after breast cancer surgery

Patient-centred supportive care - encompassing patient's needs - for life either with cancer or after cancer

Partnership working with local leisure facilities and the Northern Trust to improve quality of life post breast cancer; funded by the Belfast Trust Health Improvement Team

## Brill Format:

- Project drivers, governance arrangements (including outcome measures), funding and protocols agreed
- 10 weeks of 1 hour varied exercise groups (for 10 people) at leisure centres
- Followed by informal health information provision e.g. lymphoedema prevention, accessing additional information and purchasing new modified underwear and swimwear
- Time to meet and chat with other patients who have had breast cancer

## Brill Outcomes:

### Subjective Outcomes:

One participant “***started the programme as a patient,***” however “***finished as a whole person again***” - ***the project had supported her through the lull of the “after treatment”*** phase and reduced her requirements for formal psychological input

### Objective:

Total FACT-B scores - a significant increase in QoL scores from baseline to post-intervention (highly significant on the paired t-test ( $p=0.009$ ))

# Back on track

- ‘Back on Track Service’ aims to translate research into a partnership interdisciplinary rehabilitation service with regional statutory and third sector agencies.
- The service aims to empower people to reduce the effects of fatigue and weight loss associated with cancer and create responsive user focused health services.



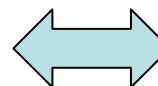
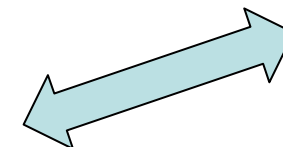
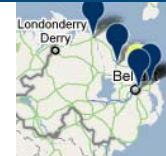
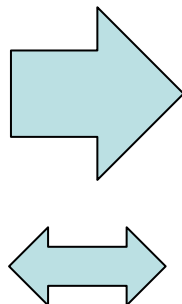
# Rationale

- To provide and evaluate individualised specialist interdisciplinary services for people with cancer who are experiencing fatigue and may present with anorexia/cachexia syndrome (ACS)
- To utilise the existing infrastructure of the Centre for Health and Rehabilitation Sciences as a venue for this public engagement service and ongoing research.

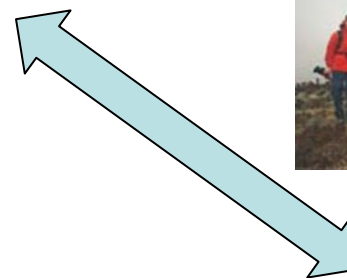
# Key Goals

- To provide and signpost to individualised and personalise exercise and lifestyle interventions.
- To continue to define and answer research questions and influence training and health decision making at regional, national and international levels.

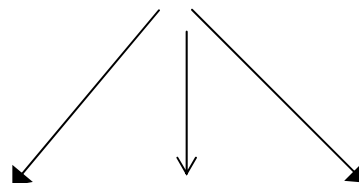




**Omagh Walking Club**



**Dungannon Leisure Centre**



## Progress to date

- January 6<sup>th</sup> 2010 initial concept meeting
- February 2010 engagement with the Macmillan survivorship initiative
- March 2010 University award 14K for research impact to pilot the project
- April 2010 NICAN event
- September Pilot
- Funding applications-R and D office translational research awards?
- Future potential commissioning?

## Back On Track Team

Jackie Gracey

Physiotherapist (research)

Cathy Payne

Dietetics UUU/Hospice

Lynn Dunwoody

Health Psychologist

Suzanne Martin

Occupational therapist (Academic enterprise)

Jane Rankin

Physiotherapist (clinical)

Max Watson

Palliative care consultant

## Current Partners

UU, Faculty of Life and Health Science

NICAN,

Macmillan,

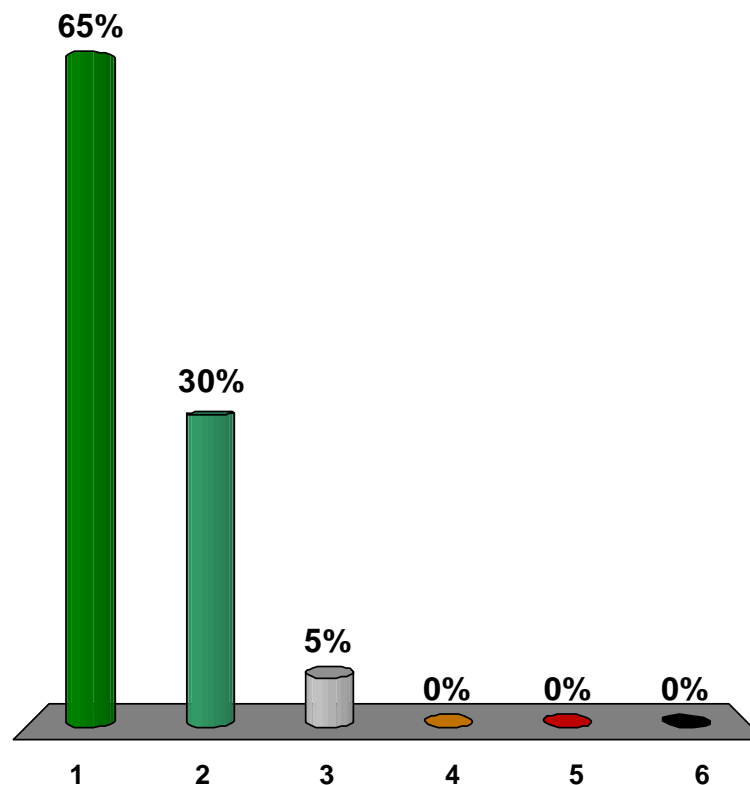
Belfast Trust,

Voluntary and community sectors



Do you feel there is a need for such a service in Northern Ireland? Choose **ONE**

1. Strongly agree
2. Agree
3. Neutral
4. Disagree
5. Strongly disagree
6. Don't know



**“Breast Reviews : Implementing Change”**

**Mr Stephen Kirk**

**Consultant Breast Surgeon**

# Routine Follow-up of Breast Cancer Patients – A Waste of Time?

SJ Kirk

Specialist Breast Unit, Department of Surgery  
Ulster Hospital Dundonald

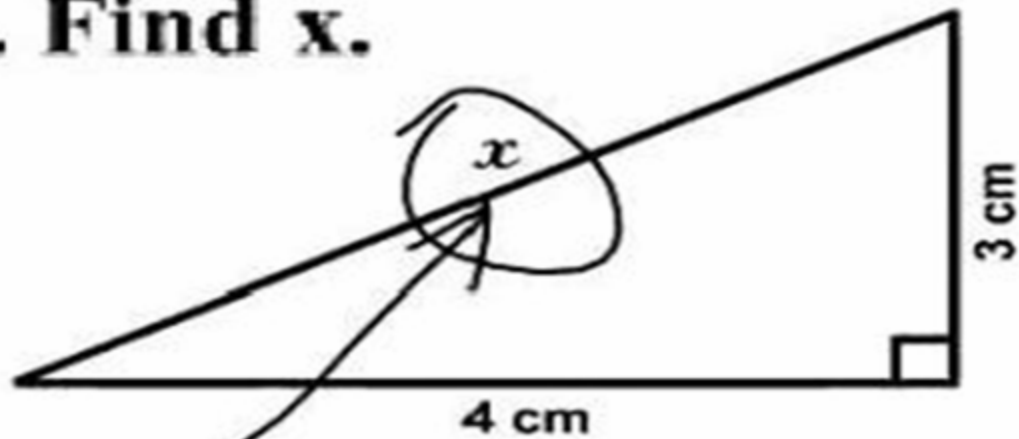
# The Value of Forward Planning

Where are we? Where did we come from?



Answer on a blonde's Geometry test

**3. Find  $x$ .**



*Here it is*

# WHY REVIEW ?

Was what we were doing best for patients

Was it best for the providers of the service

Was it best for those who resourced the service

Fundamentally what was the purpose of the review

To detect problems (Physical, Psychosocial) at a stage of development where intervention would be effective and potentially improve outcome

# Review

The Hospital

Doctor; Nurse, Imaging Department; The GP;  
The Telephone; The computer

Who Should Decide

The patient: The Doctor: The Commissioner:  
Politicians; Nice; The Americans

What Criteria should  
be met

Cost Effective: Treatment effective: Patient choice

# When should review take place

Never

Regularly – Traditional pattern, Risk based pattern

Random (open)

# When Should review Stop

Never

At end of treatment

Surgery/Chemo /Radio

Hormonal

At predefined time (Nice)

# The Aim of This Study

To determine if we could link follow up to patient risk

The Ultimate aim:

To “follow up” at the right time the right patient  
by the right person in the right place to allow us to do  
right by the patient

# Background

There is currently no conclusive evidence for follow-up of patients with Breast Cancer. Most units review patients according to regimes based on trial protocols, though NICE guidelines recommend less intense follow-up for a maximum of 3 years.

BASO have been unable to produce clear guidance, and there is no data on risk-directed follow-up.

# Aim of Study

Our objective in this study was to determine the effectiveness of a stratified follow-up programme in detecting recurrent disease in patients with Breast Cancer.

# Study design

All women treated for primary Breast Cancer in UHD between January 2000 and December 2004 were entered prospectively into the BASO database.

Patients stratified by Nottingham Prognostic Index (NPI) into high, moderate or low risk for disease recurrence (NPI <3.4 = Low, 3.5-5.4 = Mod, >5.5 = High.)

Follow-up schedules were assigned to each group, as in Figure 1. Data regarding relapse rate, site of recurrence, presentation and mechanism of detection was analysed.

Patients who had Stage 4 disease or did not undergo surgery were excluded from the study.

In addition to planned appointments, patients were able to access the clinic via Breast Care Nurses, their GP and the Oncology service.

Previous follow up had followed a “traditional” medical/nursing based model

Figure 1. Review schedule according to risk

	High	Mod	Low	Standard
Year 1	3	2	2	4
Year 2	3	2	1	4
Year 3	2	1	1	2
Year 4	1	1	1	2
Year 5	1	1	1	1
Total	10	7	6	13

# Results (1)

1303 women treated for primary breast cancer during the study period,

71 developed recurrent disease.

Median follow-up was 49 months.

Age range 25 –84, median age 56

Overall survival rate of 96%  
(88% High risk, 96% Mod, 99% Low.)

Disease-free survival was 93%, Mortality 3.1%

# Results

	NPI	Number in group (%)	Number of Rec	Rec. rate	% of total rec.
<b>Low</b>	<3.4	567 (43.5)	11	1.9%	14.3
<b>Mod</b>	3.5-5.4	485 (37.2)	26	5.3%	33.7
<b>High</b>	>5.5	251(19.3)	40	15.9%	52
<b>Total</b>	All	1303	77	5.9%	100

# Detection of Recurrence

	Numbers	Scheduled	Unscheduled
High	40	25%	75%
Moderate	26	31%	69%
Low	11	37%	63%
Total	77	28.6%	71.4%

# Results – pick-up rates

7753 routine follow-up appointments for 1303 patients over median 40 months

Yield - 22 recurrences

Only 1 in every 350 routine, scheduled follow-up appointments results in the detection of recurrent disease

**Pick-up rate 0.28%**

# Detection of Recurrence (Scheduled)

High risk group

2008 appointments

10 recurrences detected

200 appointments to detect 1 recurrence

Pick-up rate 0.5%

# Detection of Recurrence (Scheduled)

Moderate risk group

2910 appointments

8 recurrences detected

370 appointments to detect 1 recurrence

Pick-up rate 0.27%

# Detection of Recurrence (Scheduled)

Low risk group

2835 appointments

4 recurrences detected

700 appointments to detect 1 recurrence

Pick-up rate 0.14%

Figure 3. Recurrence by site and symptoms

	<b>Local</b>	<b>Regional</b>	<b>Distant</b>	<b>Total</b>
Symptomatic	13	6	27	46 (65%)
Asymptomatic	11	8	6	25 (35%)
Total	24	14	33	71

# Conclusions

- Over 70% of recurrences are detected outside the follow-up programme
- Low pick-up rates at scheduled appointments
- Importance of open access to breast clinic

# Conclusions

NPI can be used to estimate relative risk of recurrence.  
Most recurrences are detected outside scheduled review, even if review is stratified to risk.

The study suggests that routine review may not be beneficial in diagnosing recurrence.

However, this study has not addressed other aspects of a follow up program such as reassurance and discussion of treatment morbidity etc. Further work should be undertaken to address these issues..

# Final Key Questions ?

How  
What  
Why  
Where  
When

Some evidence that early intervention might be best?

# Teamwork Essential



What is Team Work ?

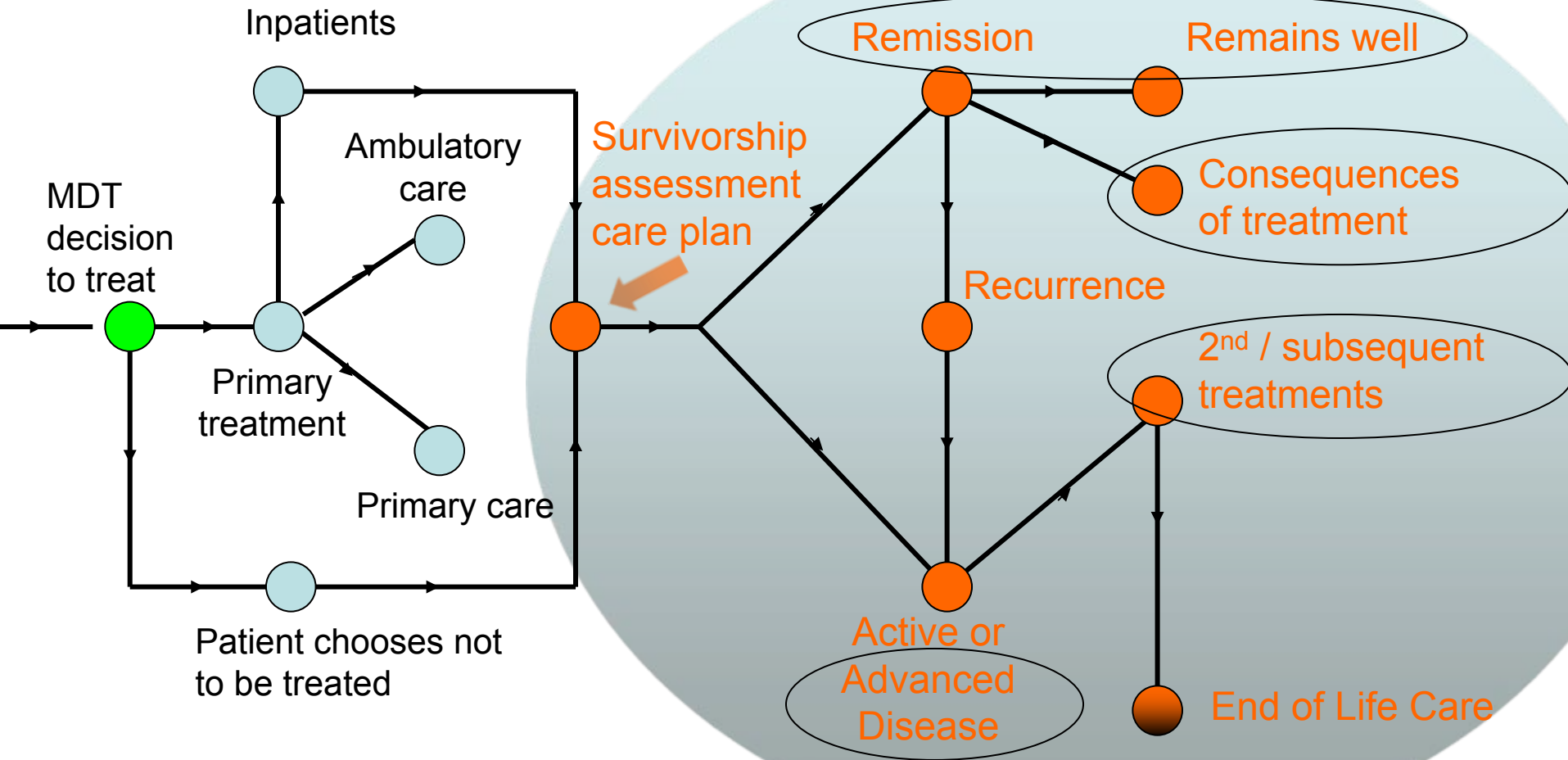


# Session 3

**Moving Beyond:**

**Exploring Changes to Cancer Follow-up**

# Care pathway for a patient with a diagnosis of cancer



# How do we tailor post-treatment services most effectively?

**1. Moving beyond cancer** - *Focusing on health and wellbeing*

**2. Cancer as a chronic illness**, *Needing proactive surveillance*

**3. Those with advanced disease**

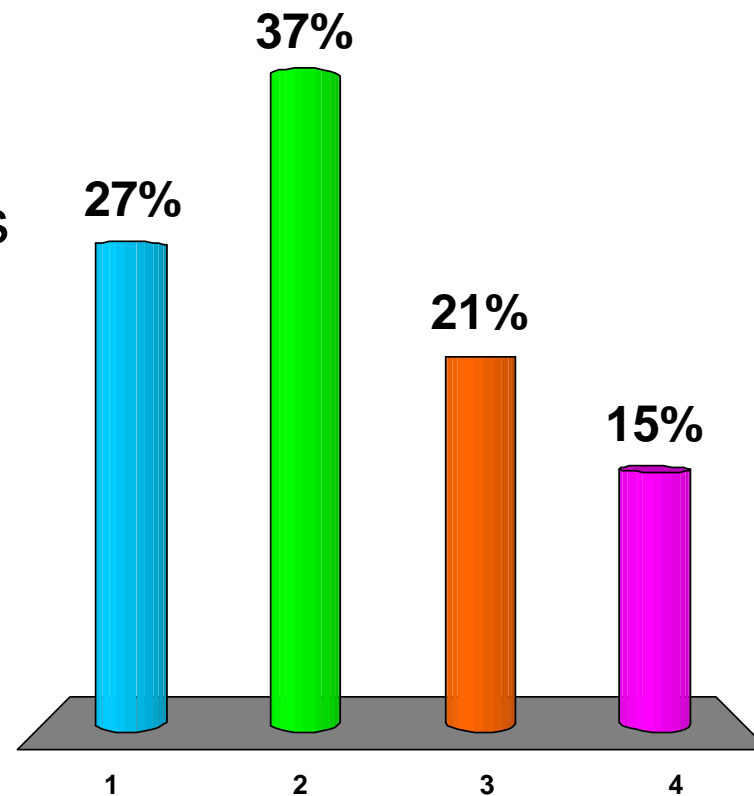
**4. Consequences of treatment**

# Changing Cancer Follow Up



# WORKSHOP – In which group could you contribute most? Choose **ONE**

1. Health and well-being
2. Cancer as chronic illness
3. Advanced cancer
4. Consequences of treatment



# Workshop Feedback



# Evaluation of Workshop...

**Your thoughts on today !**



# Your opportunity to **contribute** to the workshop generally...

1. Very Satisfied
2. Satisfied
3. Neutral
4. Dissatisfied
5. Very Dissatisfied



# Opportunity to **suggest solutions** to the issues identified

1. Very Satisfied
2. Satisfied
3. Neutral
4. Dissatisfied
5. Very Dissatisfied



# Opportunity to **identify further issues** to be resolved...

1. Very Satisfied
2. Satisfied
3. Neutral
4. Dissatisfied
5. Very Dissatisfied



# Opportunity to **learn** from others.....

1. Very Satisfied
2. Satisfied
3. Neutral
4. Dissatisfied
5. Very Dissatisfied



# How helpful or unhelpful did you find...

## Presentations

1. Very Helpful
2. Helpful
3. Neutral
4. Unhelpful
5. Very Unhelpful



How helpful or unhelpful did you find...

## Group Work Session

1. Very Helpful
2. Helpful
3. Neutral
4. Unhelpful
5. Very Unhelpful



# How helpful or unhelpful did you find...

## Digital Voting

1. Very Helpful
2. Helpful
3. Neutral
4. Unhelpful
5. Very Unhelpful



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CANCER SUPPORT**



**Thank you!**