Personalised Stratified Follow-Up:
Guidance to accelerate implementation in response to COVID-19

Purpose

This document is a COVID-19 recovery planning resource to assist MDTs and Trusts to support changes to follow-up for all patients with cancer, after initial treatment is completed. It outlines:

- guidance on accelerating implementation across all cancers
- the principles of Personalised Stratified Follow-Up (PSFU), which includes the delivery of personalised cancer care interventions for all patients
- a checklist to help mitigate the risk of patients being lost to follow-up during COVID-19 surges.
- a suite of resources to support implementation

This document should be read in conjunction with:

- NHS England/Improvement's Handbook for implementing Personalised Stratified Follow up in cancer (2020)
- NHS England/Improvement's guidance on Implementing Phase 3 of the NHS response to the COVID-19 pandemic (2020), specifically Section 4 on Patient Initiated Follow Up.

Acknowledgements

This document has been drawn together from experts in personalised cancer care across London, representing the following cancer alliances:

- North Central London
- North East London
- South East London
- RM Partners (South West and North West London)

It has been led and coordinated by Transforming Cancer Services Team (TCST) for London, part of the Healthy London Partnership through a COVID & PSFU working group.

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Background

What is personalised care?

Personalised care represents a new relationship between people, professionals and the system. It happens when we make the most of the expertise, capacity and potential of people, families and communities. Personalised care is based on 'what matters' to people and their individual strengths and needs. It also takes into account the people that they care for and those that may care for them.

Personalised care gives people the same choice and control over their mental and physical health that they have come to expect in every other aspect of their life. A one-size-fits-all health and care system simply cannot meet the increasing complexity of people's needs and expectations.

Personalised care in cancer includes a range of interventions that *all* cancer patients should have. These interventions are:

- Shared decision making about treatment and follow up options
- Personalised care and support planning (including holistic needs assessments) at the time of diagnosis, at the end of treatment, and at times in between where there are significant changes (physical, emotional/psychological and social) for the patient
- Treatment summaries provided to the patient and their primary care team at the end of a phase of treatment
- Health & wellbeing information and support
- Holistic cancer care reviews and long term management in primary care

What is personalised stratified follow up?

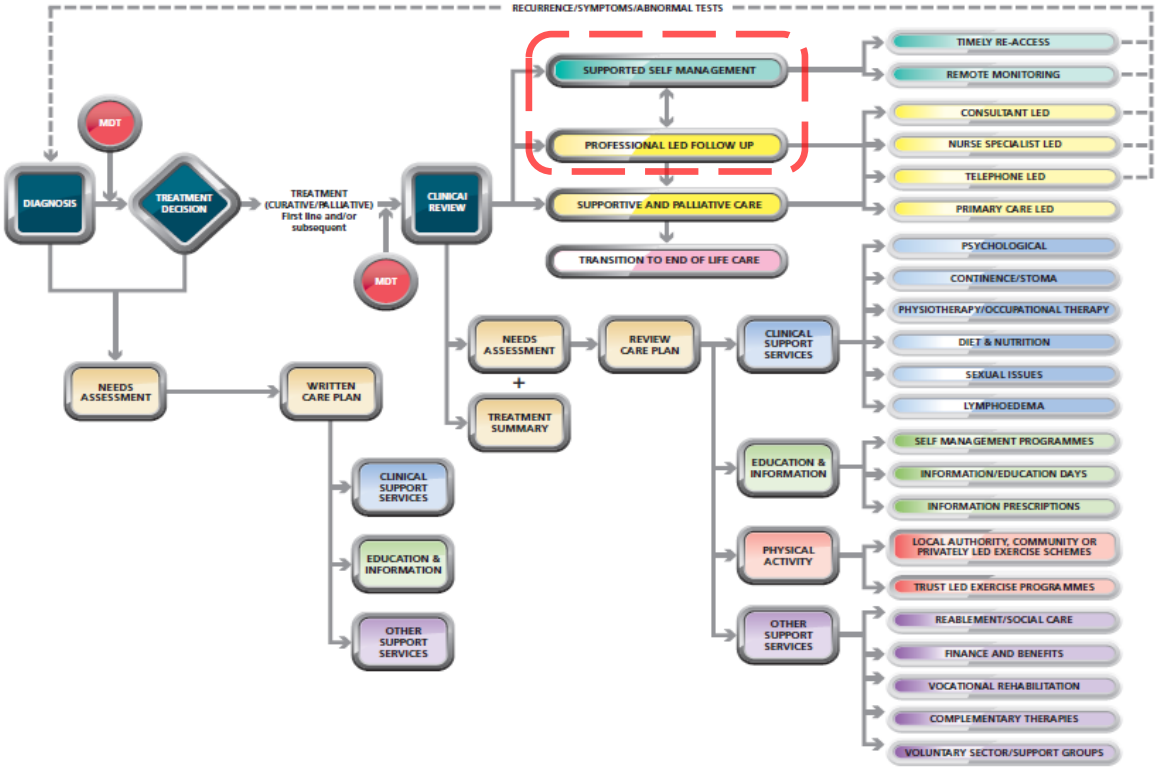
A model of follow-up in which the clinical team and the person living with cancer make a decision about the best form of aftercare based on the individual's clinical and personalised needs. Individuals enter either a professional led or a patient initiated follow up (PIFU) pathway.

- Professional Led Follow Up Pathway: The follow-up pathway in which individuals with cancer continue to have face to face, video, phone, or email contact with their clinical team as part of continuing follow up. Follow up may be led by doctors, nurses or specialist allied health professionals. Follow up may be delivered by the specialist team or by the primary care team.

- Patient Initiated Follow Up Pathway: The follow-up pathway in which patients are empowered with the knowledge and skills to self-manage their condition. They are given information about the symptoms to look out for and who to contact if they notice any of these alert symptoms, future scheduled tests, and how to contact the specialist team if they have any concerns. They do not receive any further outpatient appointments unless further investigations or support is required. PIFU may also be known as Open Access Follow Up (OAFU), Patient Triggered Remote Follow Up (PTFU) or Supported Self Management Follow Up (SSMFU).

As PSFU it is a core component of personalised care, PSFU should be introduced to the patient early in their cancer pathway. This is so that they are fully informed and understand the variety of ways in which they may be followed up after their initial treatment ends.

The diagram below from the National Cancer Survivorship Initiative (2013) shows the key interventions and support from services required on the PSFU pathway.



Guidance for implementing PSFU

Why do we need to accelerate implementation of PSFU?

In the current climate of COVID-19, personalising aftercare along the whole cancer pathway is more pertinent than ever. Whilst this has been mainly driven by capacity issues, individual risk assessment and patient choice to avoid clinical settings, the goal to provide personalised care is not new. When personalised care is provided sincerely, it is a fundamental way to prevent widening health inequalities and to reduce existing inequalities within our patient population.

NHS England/Improvement's guidance on Implementing Phase 3 of the NHS response to the COVID-19 pandemic outline many benefits of PIFU specifically:

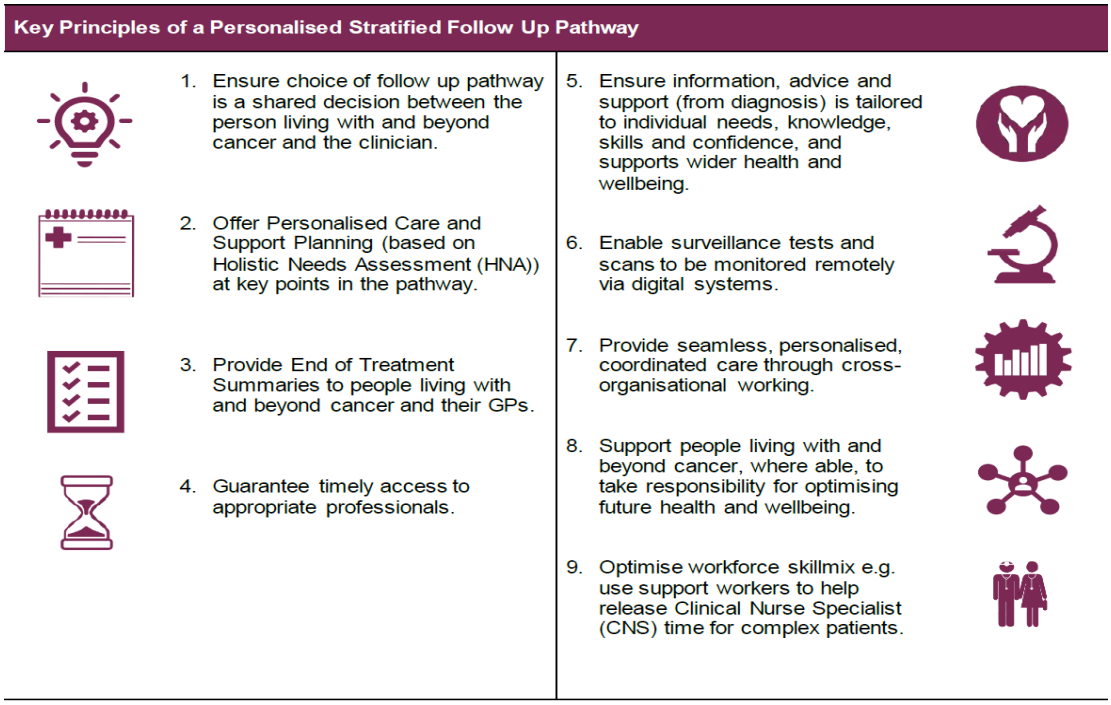
Benefits to patients	Benefits to clinicians	Benefits to organisations and systems
• Together with remote appointments, encourages patients to attend appointments, as they know they will not need to go to an NHS site unless clinically necessary • Improves patients' engagement with their health • Empowers patients by allowing them to book appointments when they most need them (eg during a flare-up) • Services are more responsive due to improved management of waiting lists • Time and cost savings due to not having to travel to appointments without clinical need[9,10] • Improved patient satisfaction[11] and reduction in anxiety	• Ensures clinicians know that they are seeing the patients who need it the most • Provides a mechanism for the clinician to jointly develop plans and 'what if' scenarios with patients, and share the clinical risk • Helps clinicians to manage their caseloads and waiting lists • Gives clinicians confidence that patients know how to contact services if they need to	• Reduction in waiting times and waiting lists due to net reduction in follow-up appointments[9,10,11] • Reduction in service costs[9] • Reduction in did not attends (DNAs) and improved use of clinical resources • Reduction in unmet need and clinical risk from patients being on waiting lists for follow-up appointments • Enabler to reducing outpatient appointments

What are the key features of PSFU?

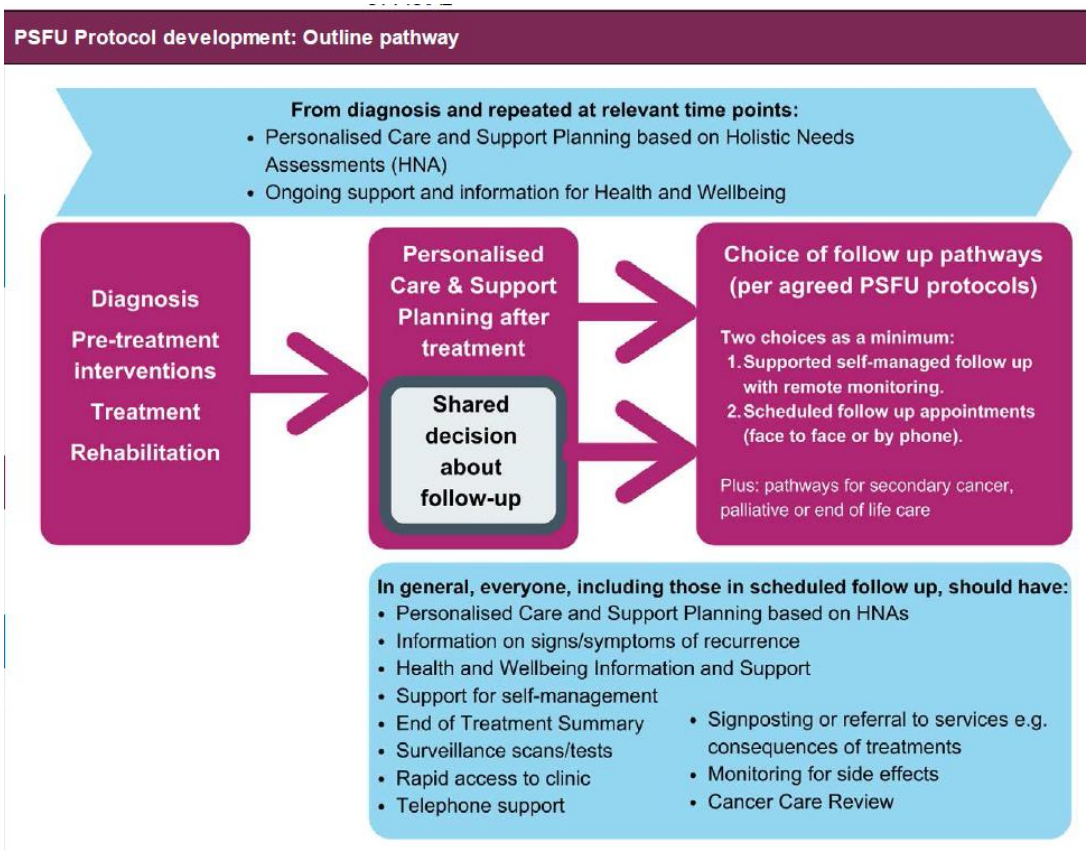
The National Cancer Survivorship Initiative (NCSI, 2013) advises that individuals are assessed early in the treatment pathway to determine which follow-up process would best meet their needs and identified the following key features:

- ✓ **Effective needs assessment at the point of diagnosis and end of treatment** that identifies and addresses any outstanding needs and ensures the patient has knowledge and confidence to self-manage.
- ✓ **Removal of routine follow-up appointments** from the pathway. The results will be reviewed by an appropriately qualified staff member and the patient is informed of the results (as per clinical judgement and local protocols).
- ✓ **Good communication** between specialist, community and primary care teams
- ✓ **A robust remote monitoring system** to manage on-going surveillance tests and ensure no one is lost to follow-up
- ✓ **A system that allows rapid re-entry** into the specialist cancer service as required. This reassures individuals that they are able to access appropriate, named support quickly should they need it, without having to go via their GP.

Key principles of Personalised Stratified Follow-up, outlined in NHS England/Improvement guidance (2020)



Overview of Personalised Stratified Follow-up Pathway, outlined in NHS England/Improvement guidance (2020)



General eligibility criteria for patient initiated follow up

In April 2020, the British Gynaecological Cancer Society published recommendations and guidance on PIFU. They outlined general eligibility criteria as shown in the box below.

General eligibility criteria for patient-initiated follow-up (PIFU)

- Completed primary treatment for a gynecological malignancy and are clinically well
- Patients should be willing and able to access healthcare if on PIFU
- They should be without significant treatment related side-effects that need ongoing management
- They should not have recurrent disease
- They should not be on active or maintenance treatment
- They should not be on a clinical trial where follow-up schemes are defined and limited to hospital-based follow-up
- They should not have a rare tumor with uncertain risk of recurrence and need for ongoing management
- They must be able to communicate their concerns without a significant language barrier or psychological co-morbidity and have competence to agree to PIFU

Principles to accelerate implementation of PSFU across all cancers

A great deal of work has already occurred across London to implement PSFU in breast, colorectal and prostate cancers**.** A self-assessment checklist has been developed for MDTs/Trusts to utilise as a resource to implement PSFU across additional cancer pathways and support safety netting processes for patient tracking list management (Appendix 1). This has been adapted from the East of England Cancer Alliance tool (2020). This document also includes a suite of resources relevant for London (Appendix 2). The content of this document, including the two appendices can be found on the HLP website.

Principle 1 – Clinical leadership and resource is required to implement PSFU

Executive buy-in for PSFU is needed at both Trusts' Cancer Board level and within Alliance recovery plans. At both levels, PSFU in cancer should be a shared objective between the Cancer Alliance's cancer recovery plan and the STPs' outpatient transformation programmes (and therefore embedded into STP/ICS Gold structures). By combining the governance with clinical leadership, it is expected this will lead to opportunities for resource and strategic focus.

An MDT clinical 'sponsor' should also be identified for implementing PSFU at tumour level. The sponsor will need to ensure the PSFU pathway is safe and pragmatic, including when it spans primary, secondary and tertiary services.

As governance and protocols will vary between tumour sites and between organisations, it is important that MDTs follow local clinical governance structure and protocols.

Principle 2 – Personalised care interventions are an integral part of cancer follow up

PSFU pathways must include all personalised cancer care interventions delivered by the hospital team – this includes shared decision making, Holistic Needs Assessment with a care plan; Treatment Summary; Health & Wellbeing information & support.

The personalised care principle of shared decision making should be used to determine which strata of follow up (ie professional led or PIFU) a patient is most likely to go on at the end of their initial treatment. This conversation should take place as early as possible in the patient's treatment pathway, recognising that it may change.

Health & Wellbeing Information & Support may be delivered jointly by NHS primary, community, acute teams, and with voluntary sector services. NHS England/Improvement has published a Health & Wellbeing Information & Support self-assessment checklist.

Patients should also be supported with a Cancer Care Review and long term management by their primary care team. London primary care leaders published a guidance on managing cancer as a long term condition for COVID recovery.

It is imperative for patients to receive all this information from the outset, in order to facilitate a clear understanding of the management of their condition. This ultimately promotes patient empowerment and reduces levels of anxiety and fear by knowing what to expect from their clinical teams, especially when this spans multiple services.

Principle 3 - Virtual appointments are a core element of PSFU

Decisions to stratify patients should be made as early as possible in the treatment pathway, and with the ethos of shared decision making. Follow up regimes, both during treatment and after treatment ends, will usually be structured as follows:

- Professional led, face to face appointments
- Professional led, virtual appointments
- Patient initiated (PIFU), virtual appointments

For many reasons, clinicians and patients may also decide that a change in follow up regime is appropriate. Therefore there should be a mechanism for reviewing the shared decision, for example (but not limited to) changes in surveillance test results or a change in social circumstances. Consideration of which pathway the patient is on should be reviewed at every OPA/contact – especially if they are on a professional led pathway and can be moved to patient initiated follow up.

In the COVID-19 Phase 3 guidance, the NHS England/Improvement National Cancer Team has stipulated that cancer alliances should implement at least two additional PSFU pathways over and above breast, colorectal and prostate cancer pathways by 2023/24. Pan London clinical protocols with eligibility criteria will be developed for some tumour types through the pan London tumour working groups and STP Cancer GP Leads group, which in turn will be approved via NHS England's cancer hub and Clinical Advisory Group. Trusts are advised to liaise with their Cancer Alliance regularly in order to confirm whether there are new clinical

protocols in place. Trusts are also encouraged to utilise the PSFU principles and guidance to progress implementation where there is appetite to do so locally.

Principle 4 – Robust patient tracking and remote monitoring systems are integral to patient safety

All trusts need to ensure their remote monitoring system has the most up to date version and that any technical issues are regularly feedback to the IT provider.

London cancer alliances have an agreed specification for remote monitoring systems to facilitate robust tracking and safety netting of patients. Please see the resources for an example Project Initiation Document that includes essential and desirable criteria for remote monitoring systems.

Principle 5 – Clear and timely communication between primary and secondary care teams is required for safety and good outcomes

It is imperative that acute teams communicate in a timely way with their primary care colleagues and vice versa.

The level of information provided to primary care should also be appropriate for primary care teams and patients. Treatment summaries are the preferred method of communicating the end of a patient's phase of treatment.

Principle 6 – MDTs must provide end of treatment clinic appointments for all patients, to transfer patients to PSFU safely.

An end of treatment appointment must include the following as a minimum:

- a post-treatment holistic needs assessment and refreshed care plan
- signposting to health & wellbeing information and support
- referrals to any health or social care services as required
- a treatment summary provided to the patient and their primary care team.

Treatment summaries should include the SNOMED codes that primary care teams will record on their clinical systems. This will facilitate primary care to safety netting for long term condition management. A summary list of codes is included in the resources section.

To further support safe transfer to PSFU, discussions on follow up regimes should be held with the patient as early as possible in the patient's pathway. Other personalised care interventions, such as cancer care reviews and long term management in primary care, will also provide structure for the patient to support safe transfer to PSFU.

Principle 7 – Re-access to specialist teams should be clearly defined for people with suspicion of a subsequent cancer.

Patients and their carers need to be educated through health and wellbeing interventions to understand the red flags for referrals and referral routes, as addressed by previous patient education pathways.

Rapid access to secondary care advice and guidance should be easily available to primary care teams and other senior healthcare professionals. Primary care should safety net their patients when re-accessing oncology services for suspicion of subsequent cancers. MDT discussions should access the patient's surveillance test results and these should be communicated to primary care in a timely way.

Hospital teams should consider that their re-access routes include:

- self-referral (PIFU)
- from primary care professionals (including GPs, senior General Practice Nurses, Pharmacists, Dentists)
- from allied health professionals (e.g. consultant physiotherapists, dieticians, occupational therapists and speech & language therapists).

Principle 8 – there should be clear routes to access services when symptoms/ conditions develop, related to the physical and psychosocial consequences of treatment

Rapid access to generalist and specialist advice and guidance on consequences of cancer and its treatment should be easily available to those clinically responsible for patients on PSFU pathways.

When patients present to primary care with signs or symptoms, they should also safety net their patients when requiring access to services for consequences of cancer and its treatments.

Primary care professionals are ideally placed to identify and initially respond to patient concerns with potential consequences of cancer treatment. When appropriately trained, primary care professionals will facilitate access to early diagnosis of the consequences of cancer and its treatment. Training needs assessments may be required to identify training gaps in primary care in terms of knowledge of cancer consequences of treatment.

Principle 9 – MDTs should use the self assessment checklist and audit to support implementation and embedding all aspects of PSFU pathways safely.

In addition to the checklist, MDTs will want to conduct clinical audits of patient cohorts on PSFU, for both safety and research purposes. If resourcing permits, begin auditing as soon as possible or alternatively undertake a short scoping exercise to complement any future audits. Audits should examine changes to Personalised Care interventions throughout the treatment and follow up pathway, evaluating what changes can be modified to bring in line with models of Personalised Care Interventions, including PSFU.

An inequalities impact assessment should also be completed to ensure changes reduce existing inequalities in access and outcomes, and that they do not contribute to widening inequalities in these areas.

Principle 10 – MDTs should proactively assess patient experience and provide clarity on what is expected of patients and of the service.

Local guidelines and standardised operating procedures (SOPs) should be developed and followed, clearly outlining the patient information provided regarding:

- What patients and carers can expect throughout the PSFU pathway.
- What is expected of patients and carers throughout the PSFU pathway, for example going for tests, cancelling appointments etc

MDTs should routinely evaluate patient experience on the PSFU pathways. Data should be analysed to highlight any inequalities, support service improvements and contribute to research on patient outcomes.

Appendix 1 – Implementation and Safety Netting checklist

Cancer Service Level PSFU implementation checklist:	In place?		
	Yes	In progress	No
1. CLINICAL GOVERNANCE AND RESOURCE			
1a) Clinical Lead has been identified and governance process agreed at Trust Cancer Board and ICS level			
1b) PSFU cancer site clinical management standard operating protocol has been agreed			
1c) MDT clinical sponsor has been identified to champion PSFU/Personalised cancer care and embed changes on the patient pathway.			
2. PERSONALISED CARE INTERVENTIONS			
2a) There is an agreed, shared decision making process to stratify patients and a mechanism for reviewing the follow up regime with the patient.			
2b) Holistic Needs Assessments (with a personalised care and support plan) are embedded within the pathway			
2c) Process is in place for *all* patients and their primary care team to be provided with a Treatment Summary with on-going treatment information, signs and symptoms to watch out for re subsequent cancers and consequences of treatment, details for rapid access to advice & guidance.			
2d) Provision of health & wellbeing information and support is provided to all patients to support them to self manage			
2e) Patient information includes signposting to Cancer Care Map and London Cancer Wellbeing website.			
2f) Mechanisms are in place to record evidence that all patients are receiving these			
3. VIRTUAL FOLLOW UP APPOINTMENTS			
3a) Telephone or video-based functionality in place to deliver virtual follow-up appointments			
3b) PSFU Telephone or Video Consultation Review treatment – all individuals receive personalised information and be stratified onto the pathway which best meets their needs			
3c) Competencies are in place for staff providing care, support or signposting for patients via virtual methods			
3d) Trusts have considered health inequalities in access to virtual consultations and have a system in place for patients to access follow up where virtual consultation is not possible			
4. SAFE PATIENT TRACKING AND REMOTE MONITORING			
4a) The Trust's remote monitoring system complies with the Cancer Alliance's IT specification.			

4b) *During treatment*, robust patient tracking systems are in place for follow up appointments and surveillance tests			
4c) *After treatment*, robust patient tracking systems are in place for follow up appointments and surveillance tests			
5. COMMUNICATION BETWEEN HOSPITAL AND PRIMARY CARE			
5a) *During treatment* and *during personalised stratified follow up*, core documentation is shared with primary care teams for all cancer patients: • Care Plan documentation from HNA • Treatment Summary • Letters or notification of referrals to any supportive services.			
6. SAFE TRANSFER TO PSFU			
6a) All patients are invited to an end of treatment clinic appointment that includes: • a post-treatment holistic needs assessment and refreshed care plan • signposting to health & wellbeing information and support • referrals to any health or social care services as required • a treatment summary provided to the patient and their primary care team, shared electronically where possible.			
6b) Treatment summaries include appropriate SNOMED codes so that primary care teams can safety net their patients for requesting surveillance tests, proactively manage risks of recurrence and/or consequences of treatment.			
7. ACCESSING SPECIALIST SERVICES - ?subsequent cancer			
7a) There is a clear and agreed process for rapid re-access to specialist services, by patients and/or their primary care teams.			
7b) MDTs have a standard operating procedure that specifies their arrangements for continuity of care, for example management of a generic inbox, voicemail etc.			
8. ACCESSING SPECIALIST SERVICES - ?consequences of treatment			
8a) There are clear referral pathways to specialist psychology services			
8b) There are clear referral pathways to specialist cancer rehabilitation services			
8c) There are clear referral pathways to lymphoedema services			
9. POST-COVID-19 PSFU AUDIT			
9a) Annual audit of PSFU pathways – data collection and date for report to be presented to Trust Cancer Board identified. Should include inequalities impact assessment.			
10. PATIENT EXPERIENCE & EXPECTATIONS			

10a) The MDT has a patient information sheet summarising what patients can expect of the service and vice versa.			
10b) The MDT routinely collects and analyses patient experience and outcome data for PSFU pathways.			

Name(s), Role(s):

Cancer Site(s): **Last updated:**

Appendix 2 – Suite of resources to support implementation of PSFU

This document provides a summary of the principles and highlight the resources available to support service level professionals to implement Cancer PSFU. We hope this comprehensive 'one stop shop' resource information pack will provide you with practical information to deliver cancer PSFU locally during Covid-19.

If resourcing permits, begin audit as soon as possible or alternatively undertake a short scoping exercise to complement future audit, in order to determine changes to Personalised Care interventions throughout tumour pathway, as well as follow-up pathways due to Covid-19, evaluating what changes can be modified to bring in line with models of Personalised Care Interventions, including PSFU. An inequalities impact assessment should be completed.

Principles/Resources	Links
1. Clinical Leadership and resource is required to implement PSFU	
East of England Cancer Alliance: PSFU Failsafe framework slide pack	https://www.canceralliance.co.uk/our-work/personalised-care-package/person-centred-follow-up/psfu-failsafe-framework.aspx
NHS England/Improvement Cancer Programme: Personalised Stratified Follow up Handbook	https://www.england.nhs.uk/wp-content/uploads/2020/04/cancer-stratified-follow-up-handbook-v1-march-2020.pdf
South East London Cancer Alliance: Breast PSFU protocol (December 2018)	SEL Breast SFU Protocol_December
RM Partners (West London Cancer Alliance): Breast PSFU protocol	FINAL LCA_BreastGuidelin
RM Partners (West London Cancer Alliance): LCA Colorectal Cancer Clinical Guidelines (September 2014)	https://rmpartners.nhs.uk/wp-content/uploads/2017/03/lca_colorectalclinicalguidelines2014.pdf
RM Partners: Colon and Rectal cancer Surveillance Guidelines for Personalised Stratified Follow-up 2019	revised Colorectal Surveillance protocc

North Central and East London Cancer Alliances: London Cancer Early Breast Cancer Stratified Follow–Up Implementation Resource Pack (December 2014)	http://www.londoncancer.org/media/88541/Guidelines-Early-Breast-Cancer-Stratified-Follow-up-Pathway-Dec-2014-Final-Version-1.0.pdf
North Central and East London Cancer Alliances: UCLH Cancer Collaborative Colorectal Stratified Follow up Implementation Resource Pack (June 2018)	https://www.uclh.nhs.uk/OurServices/ServiceA-Z/Cancer/NCV/LC/Colorectal%20pathway%20board%20documents/Colorectal%20Stratified%20Follow-up%20Pathway%20Resource%20Pack%20-%20June%202018.pdf
North Central and East London Cancer Alliances: London Cancer Prostate Cancer Stratified Follow up Implementation Resource Pack (March 2016)	http://www.londoncancer.org/media/143816/Prostate-Implementation-Resource-Pack_March-2016_FINAL.pdf
West Middlesex Hospital Trust: Breast Cancer Personalised Stratified Follow Up (PSFU): Standard Operating Policy 2019	 SOP WMH draft 4 12.19.docx
Healthy London Partnership: pan London personalised cancer care key performance indicators (March 2020)	https://www.healthylondon.org/resource/london-personalised-care-for-cancer-kpis/
University of Southampton and Healthy London Partnership: Business planning and commissioning of PSFU	 UoS TCST Business planning and commis:
2. Personalised care interventions are an integral part of cancer follow up	
NHS England/Improvement: Health and Wellbeing Information & Support checklist	https://future.nhs.uk/connect.ti/canc/view?objectID=15779056
Macmillan: Electronic Holistic Needs Assessment	https://www.macmillan.org.uk/about-us/health-professionals/programmes-and-services/recovery-package/ehna.html
Macmillan: Treatment summaries How To guide	https://be.macmillan.org.uk/Downloads/CancerInformation/ResourcesForHSCP/MAC16788Treatment-SummaryGuideWEB.pdf
Macmillan: Health and Wellbeing: How to Guide	http://be.macmillan.org.uk/Downloads/ResourcesForHSCPs/MAC16500HWBEGuideWeb.pdf

Macmillan: Macmillan information & support centre's YouTube channel - Providing wellbeing activities during COVID-19 outbreak confinement period.	 MISC Youtube channel Policy Marc https://www.youtube.com/channel/UC2hmgAlGy4tjAK2QEZ9vQDQ/about?view_as=subscriber
Macmillan social prescribing guide for Primary Care Networks	https://www.macmillan.org.uk/_images/social-prescribing-network-guide_tcm9-355360.pdf
Macmillan: Providing personalised care for people living with Cancer (October 2019)	https://www.macmillan.org.uk/_images/providing-personalised-care-for-people-living-with-cancer_tcm9-355674.pdf
Healthy London Partnership and Macmillan: Principles and tools for Cancer Care Reviews and managing cancer as a long term condition (2020)	https://www.healthylondon.org/our-work/cancer/cancer-covid/covid-19-personalised-cancer-care-in-primary-care-a-framework-for-improvement-in-primary-care-for-people-affected-by-cancer/
NHS England/Improvement: comprehensive model of personalised care	https://www.england.nhs.uk/personalisedcare/
3. Virtual appointments are a core element of PSFU	
NHS England/Improvement: Video consultations for secondary care (April 2020)	https://www.england.nhs.uk/coronavirus/publication/video-consultations-for-secondary-care/
Chartered Society of Physiotherapy: COVID-19: guide for rapid implementation of remote consultations (May 2020)	https://www.csp.org.uk/publications/covid-19-guide-rapid-implementation-remote-consultations
NHS England/Improvement: Principles of safe video consulting in general practice	https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/03/C0479-principles-of-safe-video-consulting-in-general-practice-updated-29-may.pdf
BMJ Journal: Guidance on the introduction and use of video consultations during COVID-19: important lessons from qualitative research	https://bmjleader.bmj.com/content/early/2020/05/17/leader-2020-000262

NHS England/Improvement: Equality impact assessment of the NHS Long Term Plan (2019) specifies legal duties and requirements of the NHS to give due regard or regard to addressing health inequalities and advancing equality of opportunity.	https://www.england.nhs.uk/wp-content/uploads/2019/01/ehia-long-term-plan.pdf
4. Robust patient tracking and remote monitoring systems are integral to patient safety	
North Central East London Cancer Alliance: Stratified Follow Up Remote Monitoring IT System Enhancement PID	 Trustlevel PID for Remote Monitoring
SOMERSET • The guide outlines the advised tracking method within SCR for cancer patients with COVID. • They have issued a customer newsletter to update everyone on Spring Release, Phase 2 of RMS.	https://somersetft.nhs.uk/somerset-cancer-register/wp-content/uploads/sites/37/2020/03/Remote-Monitoring-Templates-and-Resources-Guide-19.2.pdf https://www.somersetscr.nhs.uk/ Email: CancerReg@tst.nhs.uk
INFOFLEX They have offered their services to all their customers using InfoFlex for cancer tracking, and other clinical areas such as IBD. Infoflex can help customers configure the reports and worklists needed as well as any other data collection requirements to support the current COVID-19 crisis. There is no charge for any of this work. They are able to rapidly implement: • **COVID-19 Alerting:** At **Sherwood Forest Hospitals NHS Foundation Trust** InfoFlex has been configured to alert clinicians that a patient has been tested for COVID-19 and provide them with the results of that test. This allows the clinician to take this into account when determining the patient's treatment. This alerting has been applied to monitor COVID-19 in cancer patients but it can also be applied to all patients across all clinical specialties. • **COVID-19 Tracking For Cancer Patients:** At **Gloucester Hospitals NHS Foundation Trust** InfoFlex has been configured to indicate that a patient has been tested for COVID-19 with the results of the test. This will allow clinicians to include the patient's COVID-19 status when considering their treatment. This process is specifically designed to further	For trusts who have procured their RMS from Infoflex, they have been allocated a Project Manager who will be happy to discuss how this may be accelerated. https://infoflex.co.uk/ Infoflex Contact Form here

support the management of cancer patients in light of COVID-19 • **COVID-19 Global Data Collection and Covid-19 Virtual Hospital:** InfoFlex has been configured at **West Hertfordshire Hospitals** NHS Trust to collect essential COVID-19 data on all patients within the hospital. It is a comprehensive set of data items that can be recorded for a patient in relation to test results, co-morbidity, admissions and treatment. ○ The trust has created two specific datasets to record COVID-19 and co-morbidity data which are linked to their normal admission process 'Admission Summary Data View' that they currently use in InfoFlex for all admissions. A COVID Virtual Hospital has also been created to manage patients that are not admitted to the hospital in the normal manner but could be being seen through home visits or temporary accommodation set up by the health care community.	
Macmillan: Guidance for professionals on managing virtual consultations, includes resources on the following areas: • Leading difficult conversations • The Five Steps to delivering bad news • The key principles of leading difficult conversations • Talking about death and dying • Examples of difficult conversations • Using technology to communicate • Communicating through PPE • Communicating with people who are recently bereaved • How we can help	https://www.macmillan.org.uk/coronavirus/healthcare-professionals
North Central & East London Cancer Alliances: Prostate Pathway Standard Operating Procedure	 Prostate Pathway diagram for Lonon F
5. Clear and timely communication between primary and secondary care teams is required for safety and good outcomes	
North Central London Cancer Alliance Information for GPs: Supported self-management follow-up for prostate cancer	 GP information leaflet on supportec
Macmillan: suite of top 10 tips for primary care professionals	https://www.macmillan.org.uk/about-us/health-

	professionals/resources/primary-care-top-ten-tips.html
6. MDTs must provide end of treatment clinic appointments for all patients, to transfer patients to PSFU safely	
National Cancer Survivorship Initiative: Treatment summary template (2013)	Trust Cancer Treatment Summary.
North Central and East London Cancer Alliances: UCLH Cancer Collaborative Electronic Safety Netting Toolkit for Cancer: The EMIS Web user guide	UCLH ESafety toolkit 4.pdf
West Middlesex Hospital Trust: Breast Cancer Personalised Stratified Follow Up (PSFU): Standard Operating Policy 2019	SOP WMH draft 4 12.19.docx
7. Re-access to specialist teams should be clearly defined for people with suspicion of a subsequent cancer	
West Middlesex Hospital Trust: Breast Cancer Personalised Stratified Follow Up (PSFU): Standard Operating Policy 2019	See above
8. there should be clear routes to access services when symptoms/ conditions develop, related to the physical and psychosocial consequences of treatment	
Macmillan – SafeFit trial information (2020)	https://www.macmillan.org.uk/cancer-information-and-support/get-help/physical-help/safefit
Royal College of GPs: Consequences of Cancer Toolkit	https://www.rcgp.org.uk/clinical-and-research/toolkits/~/link.aspx?_id=F4B55E16E8E84836B5FF37D2032D94DA&_z=z
Healthy London Partnership: TCST Commissioning Guidance for Lymphoedema Services for Adults Living with and Beyond Cancer (March 2020)	https://www.healthylondon.org/resource/commissioning-guidance-lymphoedema/
Healthy London Partnership: TCST Improving psychologically informed cancer care: implementing the London Integrated Cancer Psychosocial Care Pathway and the development of psycho-oncology services (February 2020)	https://www.healthylondon.org/resource/psychosocial-support/business-case-for-integrated-cancer-psychosocial-support/
Healthy London Partnership: TCST Integrated Care System Guidance for Cancer Rehabilitation: A guide to reducing variation and improving outcomes in cancer rehabilitation in London (October 2019)	https://www.healthylondon.org/wp-content/uploads/2019/07/A-guide-to-reducing-variation-and-improving-

	outcomes-in-cancer-rehabilitation-in-London.pdf
NHS England/Improvement: Allied health professionals' role in rehabilitation during and after COVID-19 (May 2020)	https://www.england.nhs.uk/coronavirus/publication/allied-health-professionals-role-in-rehabilitation-during-and-after-covid-19/
9. Audit	
North Central London Cancer Alliance: Suggested audit tool to track PSFU	 Suggested Audit tool to track PSFU d
NHS England/Improvement: PSFU Audit Support tool	 PSFU Audit Support Tool 19-20.docx
North Central and East London Cancer Alliances: PSFU patient evaluation – Prostate Cancer	 Prostate PSFU Patient evaluation.d
Macmillan: Coronavirus hub	https://www.macmillan.org.uk/coronavirus
West Middlesex Hospital: Patient leaflet – Breast Cancer	 West Middlesex patient leaflet for br
North Central London Cancer Alliance: Sample patient information leaflet	 Patient information sample.docx
Kent and Medway CCG: Patient information films about accessing primary care and cancer care in general during COVID19	https://www.kentandmedwayccg.nhs.uk/news-and-events/news/gps-remind-public-we-are-hereforyou https://www.youtube.com/watch?v=VkZauEXN1SQ&utm_campaign=348814_Connect%20-%20Issue%2019&utm_medium=email&utm_source=NHS%20Mid%20Essex%20CCG
Cancer Care Map: an online directory that helps people find cancer care and support services in their	https://www.cancercaremap.org/

local area. People with cancer, their friends and family can either search for a service or can browse the types of services available. It uses stories and videos to show how the services have benefited other people living with cancer and sign-posts services across the country whether they are charity funded, community based or NHS led.	
London's cancer alliances: London Cancer Wellbeing website provides information on health and wellbeing support for people affected by cancer.	https://cancerwellbeinglondon.nhs.uk/
10. Patient experience and expectations	
Macmillan: Coronavirus hub	https://www.macmillan.org.uk/coronavirus
West Middlesex Hospital: Patient leaflet – Breast Cancer	 West Middlesex patient leaflet for br
North Central London Cancer Alliance: Sample patient information leaflet	 Patient information sample.docx
Kent and Medway CCG: Patient information films about accessing primary care and cancer care in general during COVID19	https://www.kentandmedwayccg.nhs.uk/news-and-events/news/gps-remind-public-we-are-hereforyou https://www.youtube.com/watch?v=VkZauEXN1SQ&utm_campaign=348814_Connect%20-%20Issue%2019&utm_medium=email&utm_source=NHS%20Mid%20Essex%20CCG
Cancer Care Map: an online directory that helps people find cancer care and support services in their local area. People with cancer, their friends and family can either search for a service or can browse the types of services available. It uses stories and videos to show how the services have benefited other people living with cancer and sign-posts services across the country whether they are charity funded, community based or NHS led.	https://www.cancercaremap.org/

London's cancer alliances: London Cancer Wellbeing website provides information on health and wellbeing support for people affected by cancer.	https://cancerwellbeinglondon.nhs.uk/