Endometrial Cancer Follow up and Self Supported Management Full Clinical Guideline

Reference No.: UHDB/GynaeOnc/10:22/E6

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1. Introduction

This standard operating procedure aims to outline the pathway for endometrial cancer patients, in regards to their follow up journey once treatment is completed. This will set out the pathway for low, intermediate, high-intermediate and high risk patients. This will include the initiation of Self-Supported Management and the use of treatment summaries.

2. Abbreviations

CNS	-	Clinical Nurse Specialist
EMCA	-	East Midlands Cancer Alliance
HNA	-	eHolistic Needs Assessment
MDT	-	Multidisciplinary Team
PIFU	-	Patient Initiated Follow Up
SSM	-	Self Supported Management

3. What is Self-Supported Management?

Self-Supported Management can also be referred to as Patient Initiated Follow Up (PIFU) or Patient Stratified Follow Up. This is redesigning follow up pathways and links in with the survivorship agenda. This is supported by the British Gynaecology Cancer Society (BGCS) and the East Midlands Cancer Alliance. (EMCA).

Self-Supported Management- provides the patient with a personalised care package in which they will be offered:

- A eHolistic Needs Assessment (HNA) including a personalised care and support plan.
- Health and wellbeing support information
- Treatment Summary
- Cancer Care Review

4. What is a eHNA?

An HNA is a simple assessment completed by the person affected by cancer that assesses the physical, practical, emotional, spiritual, social needs of the individual and ensures these needs are met in a timely and appropriate manner.

The completed HNA assessment informs the development of a personalised patient care and support plan following discussion with the Clinical Nurse Specialist or Navigator, high lighting the most important issue to the patient at that time. The personalised care plan is agreed with the patient and they will be provided with a copy, they can reflect on.

5. What is health and wellbeing support information?

All individuals will have access to health and wellbeing support and information. There are several ways this will be made available, these may include but are not limited to:

- Information provided by the CNS or Navigator.
- Information and support from the Macmillan Information Centre.
- The UHDB Cancer App.

6. What is a Treatment Summary?

A treatment summary is a document produced by a health professional after an individual's phase of treatment. It is designed to be shared with the person living with cancer and their primary care team. This is to enable them to manage their health and wellbeing. The treatment summary and HNA will inform and support an effective cancer care review in primary care.

7. What is a cancer care review?

The patients GP practice offers a cancer care review, six months after diagnosis. The cancer care review is a holistic conversation between the individual and a healthcare professional in their GP practice. It allows an opportunity for the individual to raise any concerns that may be affecting their quality of life, taking into account their existing conditions and medication. This enables the individuals to discuss their cancer experience and supports them to manage their own health and wellbeing. The GP can support individuals expressing concerns and signpost them to appropriate services.

Endometrial Pathway

Low Risk: Surgery Only (see flow chart Appendix 1)

Steps	Actions	Persons responsible
1	Patient referral to Gynaecology MDT at time of surgery for histology results	Consultants / Doctors
2	MDT outcome recorded on infoflex and Gynaecology database system.	MDT Co-Ordinator / Gynaecology Navigator
3	Post-Operative consultant appointment arranged on Lorenzo by 1week post MDT discussion	Gynaecology Oncology CNS team/ Gynaecology Navigator
4	Appointment arranged on Lorenzo in SABSN in six months	Gynaecology appointments team
5	eHNA posted to patient 2weeks prior to appointment	Gynaecology Navigator
6	Patient seen in SABSN, speculum examination preformed. eHNA completed. End of Treatment Summary completed	Gynaecology Oncology CNS
7	Treatment Summary automatically sent to GP Copy sent to patient.	Gynaecology Oncology CNS

Intermediate Risk: Surgery with Brachytherapy (see flow chart Appendix 1)

Steps	Actions	Persons responsible
1	Patient referral to Gynaecology MDT at time of surgery for histology results	Consultants / Doctors
2	MDT outcome recorded on infoflex and Gynaecology database system.	MDT Co-Ordinator / Gynaecology Navigator
3	Post-Operative consultant appointment arranged on Lorenzo for 1week post MDT discussion	Gynaecology Oncology CNS team/ Gynaecology Navigator
4	Patient reviewed in consultant clinic. End of treatment letter completed. Referred to Medical Oncology for further treatment.	Gynaecology Consultant
5	Appointment arranged with Medical Oncology Team for treatment discussion and plan.	Gynae CNS +Navigator / Oncology Secretaries team.
6	Completion of treatment: Appointment arranged with Medical Oncology consultant at 6weeks. End of treatment summary completed. Consultant to discuss SSM v's Standard following up, consultant and patient to agree and document outcome.	Medical Oncology Consultant Team
7	Patient registered into Self-Supported Management for 3 years- Open appointment.	Gynaecology Navigator/ Gynae appointments team / SOP team and Oncology Secretaries.
8	Appointment arranged on Lorenzo in CNS clinic GSN01 / GSNO3 within 2 weeks	Gynae Appointments / Gynaecology Navigator
9	Patient seen in CNS clinic. eHNA completed. End of Treatment Summary completed.	Gynaecology Oncology CNS
10	Treatment Summary automatically sent to GP Copy sent to patient. Information leaflet sent to GP and Patient	Gynaecology Oncology CNS

High-Intermediate and High Risk:

Surgery with External Beam Radiotherapy / Chemotherapy (See flow chart Appendix 1).

Steps	Actions	Persons responsible
1	Patient referral to Gynaecology MDT at time of surgery for histology results. Identify patient suitability for SSM.	Consultants / Doctors team
2	MDT outcome recorded on infoflex and Gynaecology database system.	MDT Co-Ordinator / Gynaecology Navigator
3	Post-Operative consultant appointment arranged on Lorenzo for 1week post MDT discussion	Gynaecology Oncology CNS team/ Gynaecology Navigator
4	Patient reviewed in consultant clinic. End of treatment letter completed. Referred to Medical Oncology for further treatment.	Gynaecology Oncology Consultant
5	Appointment arranged with Medical Oncology Team for treatment discussion and plan.	Gynae CNS +Navigator / Oncology Secretaries team.
6	Appointment arranged for Medical Oncology consultant review on completion of treatment. End of treatment summary completed. Patient allocated to appropriate joint clinic.	Medical Oncology Consultant Team
7	Patient allocated to appropriate joint clinic SAB30 / ABP2P 4mthly appointment.	Gynae Navigator / SOP appointment team / Gynae appointment team,
8	2 year appointment with consultant made.	Gynae Navigator /Oncology Secretaries /SOP Appointment teams.
9	Consultant to discuss SSM v's Standard following up, consultant and patient to agree. Document outcome.	Gynaecology Oncology / Medical Oncology Consultant.
10	Patient registered into Self-Supported Management for 3 years- Open appointment.	Gynaecology Navigator/ Gynae appointments team / SOP team and Oncology Secretaries.
11	eHNA posted to patient within 72hrs of consultant clinic appointment.	Gynaecology Navigator / Gynaecology CNS team
12	Appointment arranged on Lorenzo in CNS clinic GSN01 / GSNO3 within 2 weeks	Gynae Appointments / Gynaecology Navigator
13	Patient seen in CNS clinic. eHNA completed. End of Treatment Summary completed.	Gynaecology Oncology CNS
14	Treatment Summary automatically sent to GP Copy sent to patient. Information leaflet sent to GP and Patient	Gynaecology Oncology CNS

Pathway for patients not suitable for Self Supported Management.

The Consultant along with the patient will make a decision on whether a patient is appropriate / suitable for Self Support Management. This is a multi-factual clinical decision made by a consultant and documented. These patients will remain on the standard pathway with actions as follows:

Intermediate Risk: Surgery with Brachytherapy (See Appendix 2: Patient not suitable for Self Supported Management.)

Steps	Actions	Persons responsible
1	Patient referral to Gynaecology MDT at time of surgery for histology results	Consultants / Doctors
2	MDT outcome recorded on infoflex and Gynaecology database system.	MDT Co-Ordinator / Gynaecology Navigator
3	Post-Operative consultant appointment arranged on Lorenzo for 1 week post MDT discussion	Gynaecology Oncology CNS team/ Gynaecology Navigator
4	Patient reviewed in consultant clinic. End of treatment letter completed. Referred to Medical Oncology for further treatment.	Gynaecology Consultant
5	Appointment arranged with Medical Oncology Team for treatment discussion and plan.	Gynae CNS +Navigator / Oncology Secretaries team.
6	Completion of treatment: Appointment arranged with Medical Oncology consultant at 6weeks. End of treatment summary completed. Consultant to discuss SSM v's Standard following up, consultant and patient to agree and document outcome.	Medical Oncology Consultant Team
7	Patient Not Appropriate for SSM: allocated to appropriate joint clinic SAB30 / ABP2P 4mthly appointment for years1-2, 6mthly appointment for year 3.	Gynae Navigator / SOP appointment team / Gynae appointment team,
8	Infoflex updated not suitable for SSM for standard follow up.	Gynae Navigator
9	eHNA posted to patient within 72hrs of consultant clinic appointment.	Gynaecology Navigator / Gynaecology CNS team
10	Patient seen in CNS clinic. eHNA completed.	Gynaecology Oncology CNS
11	Patient follow up clinic appointment confirmed 4mthly appointment for years 1-2, 6mthly appointment for year 3.	Gynae Navigator / Gynae appointments / Oncology Secretaries /SOP appointments

Surgery with External Beam Radiotherapy / Chemotherapy (See flow chart Appendix 2 Patient not suitable for Self Supported Management).

Steps	Actions	Persons responsible
1	Patient referral to Gynaecology MDT at time of surgery for histology results. Identify patient suitability for SSM.	Consultants / Doctors team
2	MDT outcome recorded on infoflex and Gynaecology database system.	MDT Co-Ordinator / Gynaecology Navigator
3	Post-Operative consultant appointment arranged on Lorenzo for 1week post MDT discussion	Gynaecology Oncology CNS team/ Gynaecology Navigator
4	Patient reviewed in consultant clinic. End of treatment letter completed. Referred to Medical Oncology for further treatment.	Gynaecology Oncology Consultant
5	Appointment arranged with Medical Oncology Team for treatment discussion and plan.	Gynae CNS +Navigator / Oncology Secretaries team.
6	Appointment arranged for Medical Oncology consultant review on completion of treatment. End of treatment summary completed. Patient allocated to appropriate joint clinic.	Medical Oncology Consultant Team
7	Patient allocated to appropriate joint clinic SAB30 / ABP2P 4mthly appointment.	Gynae Navigator / SOP appointment team / Gynae appointment team,
8	2 year appointment with consultant made.	Gynae Navigator /Oncology Secretaries /SOP Appointment teams.
9	Consultant to discuss SSM v's Standard following up, consultant and patient to agree. Document outcome.	Gynaecology Oncology / Medical Oncology Consultant.
10	Patient Not Appropriate for SSM: allocated to appropriate joint clinic SAB30 / ABP2P 6mthly appointment for years 3, 4 and 5.	Gynae Navigator / SOP appointment team / Gynae appointment team,
8	Infoflex updated not suitable for SSM for standard follow up.	Gynae Navigator
9	eHNA posted to patient within 72hrs of consultant clinic appointment.	Gynaecology Navigator / Gynaecology CNS team
10	Patient seen in CNS clinic. eHNA completed.	Gynaecology Oncology CNS
11	Patient follow up clinic appointment confirmed 6mthly appointment, till year 5.	Gynae Navigator / Gynae appointments / Oncology Secretaries /SOP appointments

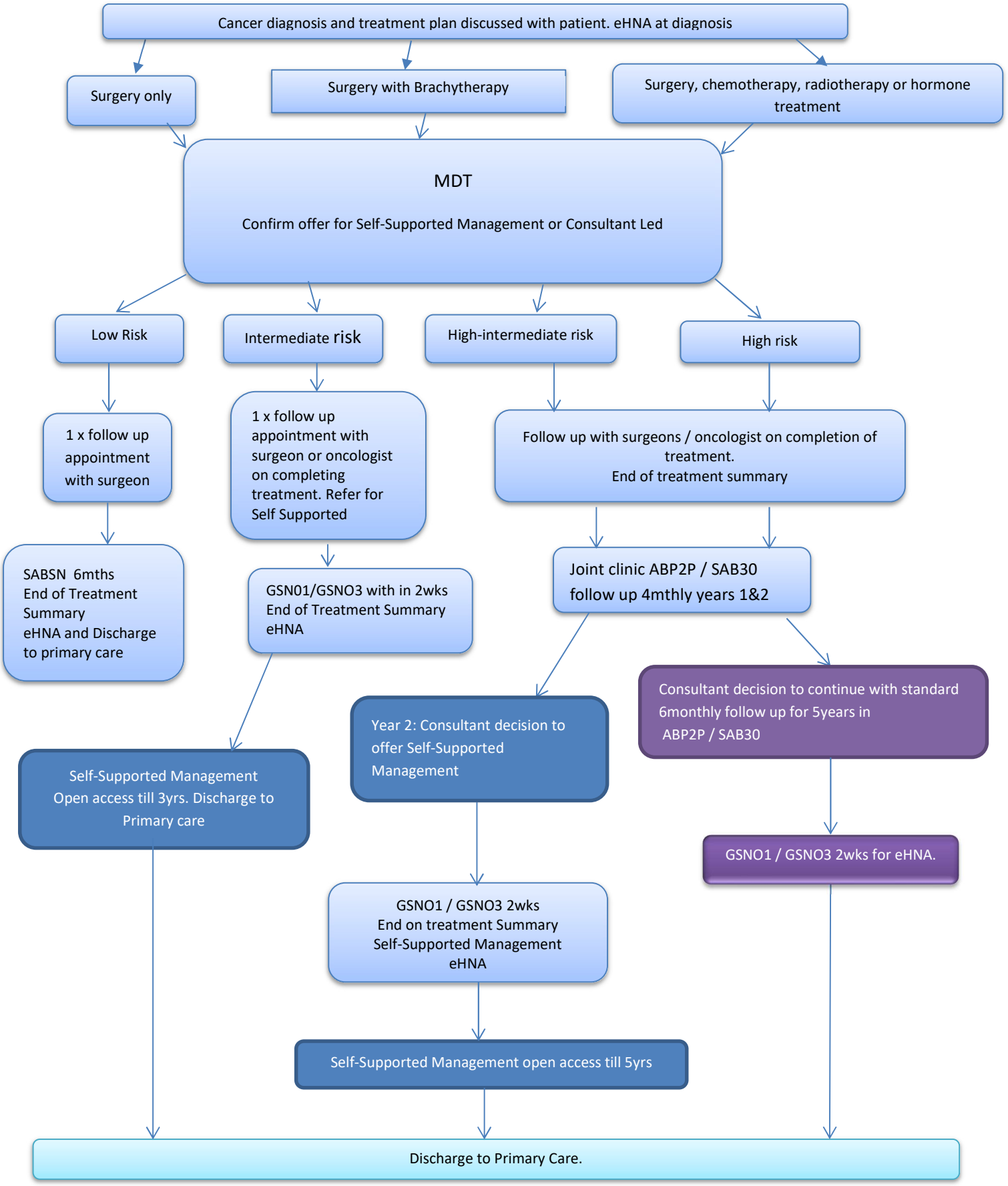
Rapid re-access and Patient Triage:(See Appendix 3)

There are many ways patients can re-access a clinical review if required. These include direct access by ringing the CNS themselves or a family member ringing on the patient's behalf. The patient's GP contacting the team on the patient's behalf. Alternatively, via The Gynaecology Assessment Unit or hospital assessment units and the Gynaecology ward.

The Gynaecology Clinical Nurse Specialist Team are available Mon – Fri between 8-4pm. If a patient, relative or other professional contacts the team directly with in the working day; they will receive a triage call back that day by a member of the Clinical Nurse Specialist Team. This will be inputted on to the telephone log system and if appropriate logged on to infoflex with any further appointment information given. Outside of the normal working hours the patient or referrer will be contacted on the next working day.

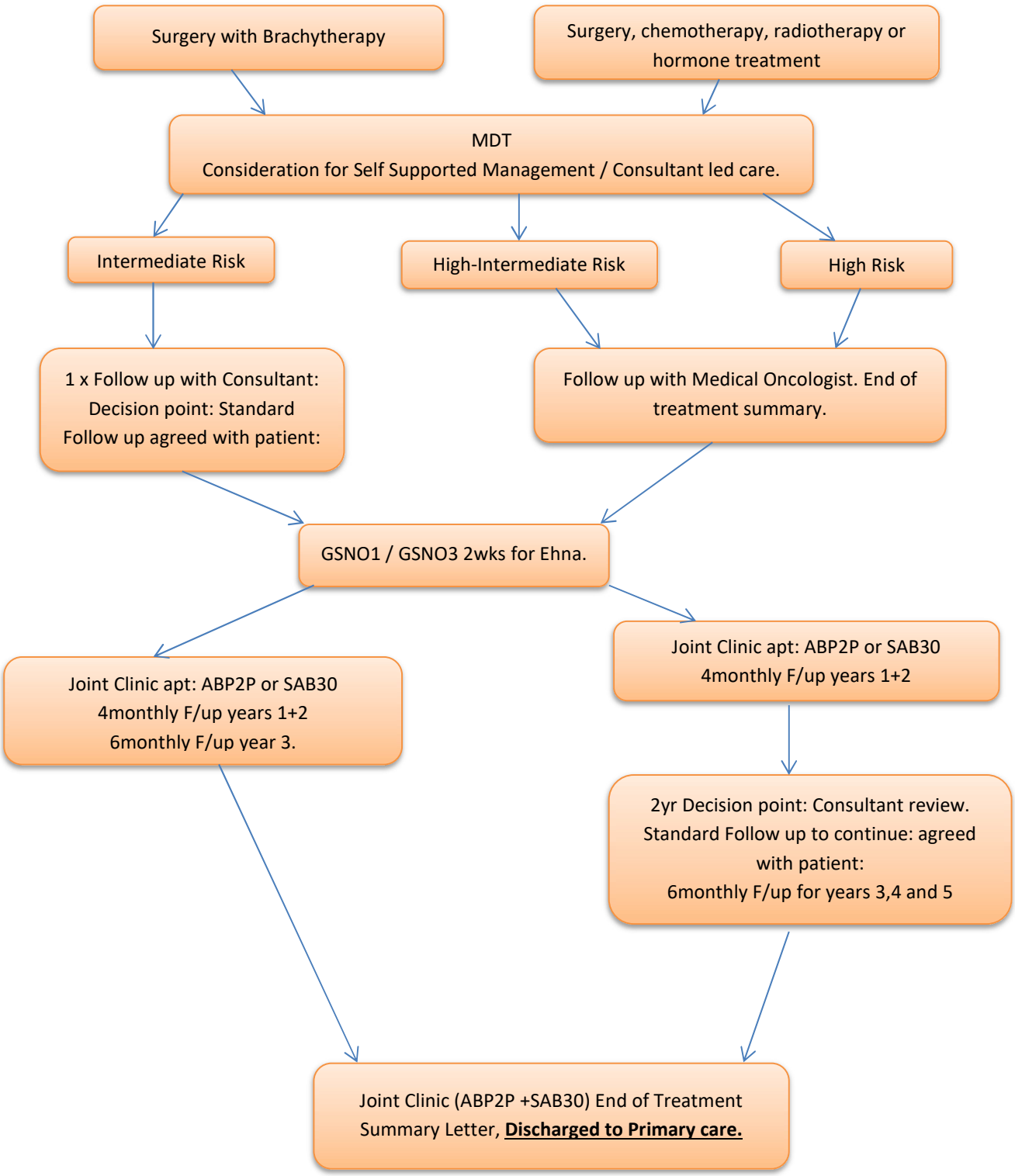
Point	Action	By whom.
1	Triage call back to patient and other professional completed and documented on Lorenzo Gynaecology call log. Call to be logged on infoflex	CNS Team
2	Request for re-access sent to Navigator	CNS Team
3	Complete re-access event on infoflex. Including referral date clinic code and appointment details	Navigator / CNS
4	Patient's appointment details to show on Navigators work list with appointment details and reason for appointment.	Navigator
5	Check / investigate outcome from clinic appointment, review outcomes on Lorenzo and actions.	Navigator
6	Amendment to pathway as required. Check patient is suitable to remain on the SSM or revert to consultant led care.	Navigator
7	Check outcome recorded on infoflex and completed. Patient should automatically be removed from work list at this time.	Navigator

Appendix 1: Endometrial Cancer Self Support Management Follow Chart.

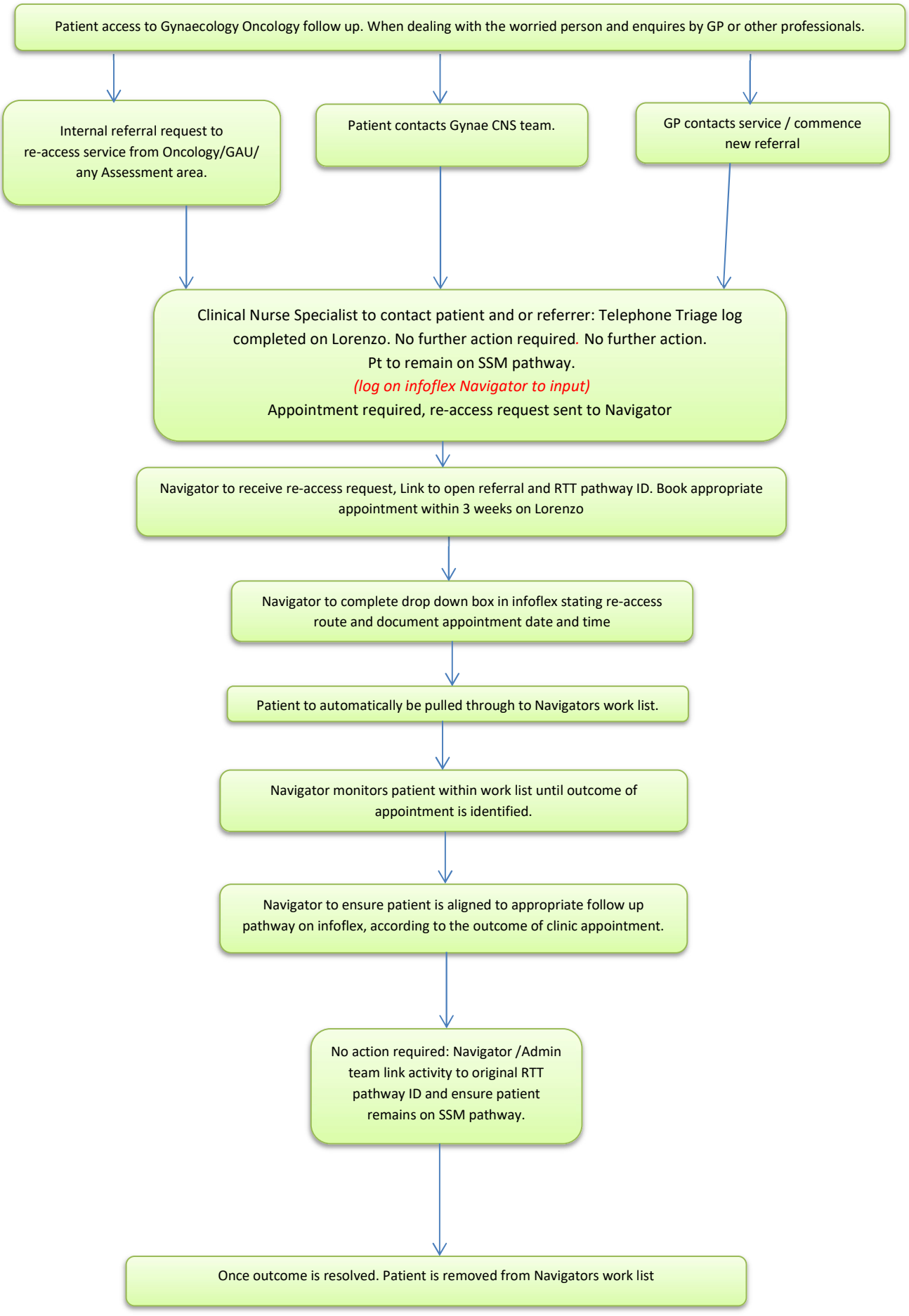


Pt to contact CNS Team with any concerns.
Navigator will log call - CNS toTriage.
CNS to reassure or book into appropriate clinic for Doctor review.

Appendix 2: Pathway for patients not suitable for Self Supported Management:



Appendix 3: Rapid Re-access



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<tr><td>Key Contact:</td><td colspan="4">Cindy Meijer</td></tr>
</table>