



TITLE: Personalised Stratified Follow Up Guidelines for people with a Breast Cancer Diagnosis

Document Category:	CLINICAL		
Document Type:	GUIDELINE		
Keywords:	Personalised care, Risk stratified pathway, Open Access follow up, PSFU, OAFU		
Version:	Issue Date:	Review Date:	
1.0	02/11/2022	02/11/2024	
Supersedes:	N/A		
Approved by (committee/group):	Breast Governance	Date Approved:	02/11/2022
Scope/ Target Audience: (delete as applicable / describe)	Trustwide		
Evidence Base/ References:	East Midlands Cancer Alliance Guidelines East Midlands Breast Expert Clinical Advisory Group Guidelines Macmillan Recovery Package The National Cancer Survivorship Initiative		
Lead Division:	Planned Care and Surgery		
Lead Specialty:	Breast		
Lead Author:	Lisa Rahn, Breast Clinical Nurse Specialist		
Sponsor:	Mr A Jahan		
<i>Name the documents here or record not applicable</i>			
Associated Policy	N/A		
Associated Procedure(s)	N/A		
Associated Pathway(s)	N/A		
Associated Standard Operating Procedure(s)	N/A		
Other associated documents e.g. documentation/ forms	End of Treatment Summaries Triage Form		
Consultation Undertaken:	<ul style="list-style-type: none"> • SFH Breast MDT 		
Template control:	v1.4 November 2019		

Table of Contents

SECTION 1: INTRODUCTION/ BACKGROUND	3
SECTION 2: AIMS/ OBJECTIVES/ PURPOSE	3
SECTION 3: ROLES AND RESPONSIBILITIES	5
3.1 Diagnosis and Treatment	5
3.2 End of Treatment and Follow-Up	5
Diagram 1 – Supported Self-Management (SSM) Pathway	6
Diagram 2 – Professional Led (PL) Pathway	6
3.3 Triaging of OAFU patients	8
3.4 Surveillance Investigations	8
3.5 Discharge to Primary Care	9
3.6 Outcomes on Careflow and Reconciliation slip	9
SECTION 4: GUIDELINE DETAILS (including Flowcharts)	11
4.1 Eligibility for Entry to Personalised Supported Self-Management (SSM) Pathway	11
4.2 Eligibility for Entry to Personalised Professional Led (PL) Pathway	11
4.3 Follow up timeframes	11
4.4 Personalised Stratified Follow-up Pathway	12
4.5 Surveillance Investigations	12
Flowchart 1 – Detailed Pathway Flow Chart	13
Flowchart 2 – Simplified Pathway	14
Flowchart 3 – Triage process	15
SECTION 5: EDUCATION AND TRAINING	15
SECTION 6: MONITORING COMPLIANCE AND EFFECTIVENESS	15
SECTION 7: EQUALITY IMPACT ASSESSMENT	16
SECTION 8: APPENDICES	18

SECTION 1: INTRODUCTION/ BACKGROUND

This personalised stratified follow up (PSFU) guideline for people with a breast cancer diagnosis, covers the care of the individual who has completed their treatment for breast cancer. This has been established and adapted utilising the East Midlands Cancer Alliance Guideline (Appendix A).

The guideline is to assist all members of the breast multidisciplinary team to understand the process and ensure optimum follow-up care is provided to all breast cancer patients completing treatment.

Stratified follow-up is an approach to steering individuals onto the best follow up pathway to address their specific needs. It has a focus on promoting wellbeing, recovery, and empowerment to provide individuals with the information and confidence to have an active role in their care.

There is no evidence that traditional follow-up; consisting of regular appointments in secondary care, provides the most effective care or best means to detect disease recurrence, thus providing rationale for a stratified model. In addition, longer life expectancy combined with more intensive treatments are resulting in increasing numbers of individuals living with consequences of treatment which may manifest years after treatment ends (Macmillan, 2013).

The National Cancer Survivorship Initiative advises that individuals are assessed to determine which tier of follow-up would best meet their needs. Individuals deemed at low risk of recurrence and late effects (physical and psychosocial) are encouraged towards supported self-management (SSM) and those at moderate/high risk receive planned and co-ordinated care from specialist services (Professional Led – PL).

Throughout all documentation, the terms Personalised Stratified Follow Up (PSFU) Pathway and Open Access Follow Up (OAFU) Pathway are used interchangeably, the latter being more patient friendly and thus used in any patient facing documentation.

SECTION 2: AIMS/ OBJECTIVES/ PURPOSE

The aim of this follow-up guideline is to provide breast cancer patients who have completed their treatment with personalised follow-up plans based upon their individual needs.

From diagnosis, PSFU will be mentioned so patients are prepared for the discussion of Open Access to the Breast Unit, rather than annual clinical visits following their surgery. Patients will have continual access to personalised care interventions throughout their pathway from diagnosis, e.g., personalised care and support planning based on holistic needs assessments (HNA) care plans, including health and wellbeing information and support where applicable.

Following surgery, patients will be discussed at a multidisciplinary team (MDT) meeting to enable the most appropriate follow-up plan to be identified (supported self-management – SSM or professional led - PL) depending on their risk stratification and personal needs.

At the post-operative results appointment with a Surgeon and Breast Clinical Nurse Specialist (CNS), a review of the MDT treatment plan (proposed Chemotherapy, Radiotherapy, Endocrine

Therapy, Bisphosphonate Therapy, targeted therapy, immunotherapy and the identified risk stratified pathway) is discussed, with explanation of the proposed follow-up plan of either SSM or PL and how the Open Access Service works.

Holistic Needs Assessment (HNA) concerns checklist (Appendix B) will be given for the patient to return within 4 weeks (to ensure the patient has no current issues or informational needs), the “invitation to Open Access Workshop” leaflet (Appendix C) is given, and the Open Access workshop appointment will be organised (the timing of which will depend on their risk as per flowchart 1).

The overall aim of the approach is to improve patient experience, outcomes and quality of care by tailoring aftercare, and embedding supported self-management (SSM) within the cancer pathway.

Key features:

- Enables people who are willing and able to undertake self-management to do so in a safe and supported manner.
- Incorporates National Cancer Survivorship Initiative (NCSI) Personalised Care Package interventions (Holistic Needs Assessment and Care Plan, Treatment Summary, Health and Wellbeing Event) to improve outcomes and co-ordination of care.
- Improves patient experience by eliminating anxiety and stress induced by attending unnecessary appointments.
- Rapid re-entry into the specialist cancer service as required within the 5 years follow up period. This reassures individuals that they can access appropriate, named support quickly should they need it, without having to go via their GP. The ability to re-access services quickly and easily has been shown to be crucial to the confidence of people undertaking supported self-management (SSM), and consequently to the long-term success of a supported self-management (SSM) programme.
- Removal of routine follow-up appointments. Routine surveillance mammography is still completed where applicable. The individual is sent an appointment for the mammography, the results are reviewed by an appropriate qualified member of staff, and the patient informed of the results by letter, phone or clinical recall.

Related Trust Documents

Breast Unit Multidisciplinary Team (MDT) guidelines

SECTION 3: ROLES AND RESPONSIBILITIES

The following section outlines the components required in the delivery of personalised stratified follow-up (PSFU), and the respective responsible MDT members.

3.1 Diagnosis and Treatment

- **The Breast Multidisciplinary team** will discuss each patient's diagnosis and treatment pathway.
- At the diagnosis results appointment, patients are given an information leaflet: "Support Services for Patients with Breast Cancer" within their information pack by their **Clinical Nurse Specialist (CNS) or Breast Cancer Support Worker (BCSW)**; this will include a brief description of the Open Access PSFU pathway, holistic needs assessment (HNA), possible treatments, contact numbers and health and wellbeing opportunities. A copy of this is provided at Appendix D.

3.2 End of Treatment and Follow-Up

- Patient's post-operative histology and risk category is discussed at the MDT meeting. Eligibility for supported self-management (SSM) or professional led (PL) follow up decided and documented on Infoflex and the MDT outcome proforma. This is filed in the medical notes by the MDT co-ordinator.
 - Patients who are eligible for supported self-management (SSM) will be informed at their post-operative results appointment and agreement documented in medical notes.
 - Patients, who are ineligible (section 4), will be recorded as not appropriate for self-managed follow up and continue the professional led (PL) follow up pathway.
 - All patients can utilise the open access service and personalised packages of care.
 - At the post-operative results appointment, all patients are given the "Invitation to Open Access Workshop" A3 leaflet by their **CNS/BCSW** which briefly outlines what to expect from the session. A copy of this is provided at Appendix C.
 - Patients are also given HNA concerns checklist to return within four weeks which will generate an appointment with **CNS/BCSW** to complete a personalised care plan and address any informational or support needs. Concern checklists that are not returned are captured as declined on Infoflex and Macmillan website, following a phone call to check patient has no concerns.
 - The **CNS/BCSW** will add the patient to stratified follow-up remote monitoring system on Infoflex and ensure that patients are tracked within the system to receive the necessary investigation/reviews/follow-up in line with their clinical care, up until the point of discharge.

Diagram 1 – Supported Self-Management (SSM) Pathway

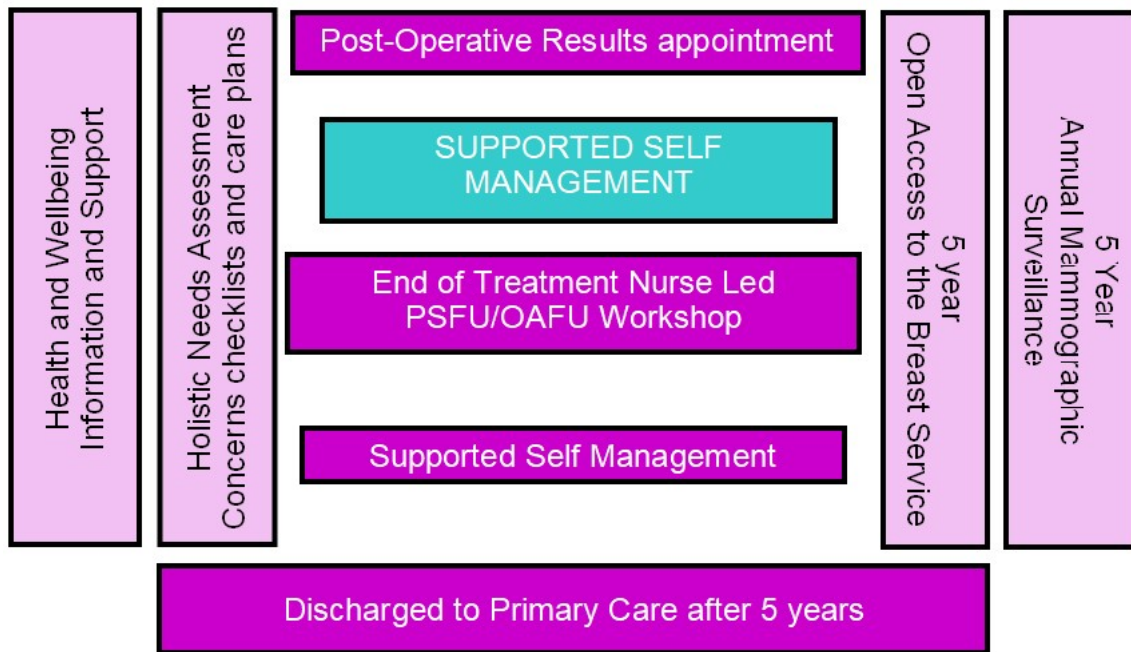


Diagram 2 – Professional Led (PL) Pathway



Diagrams 1 and 2 (Pathways) Explained:

- Following surgery, patients attend a Surgeon led results appointment at the Breast Unit (Clinic 14). They are informed of MDT recommendations for adjuvant treatments (if applicable), their risk category and a proposed follow up plan (SSM or PL).
- The End of Treatment (EOT) summary is generated during this appointment by the **Surgeon dictating, as part of the post-operative appointment** and then populated by the **typists** using the templates on Dragon Medical/Winscribe (templates included at Appendices E-G).

- The EOT summary will be sent to the patient along with their post-operative results letter.
- Treatment summary also sent to GP, in patient's case notes and on electronic records.
- The reconciliation slip from the results appointment (Appendix H) will be completed with the clinic code "BREWL" (Breast Nurse End of Treatment Workshop Low Risk) or "BREWH" (Breast Nurse End of Treatment Workshop High Risk) by the **Clinician or CNS/BCSW** and for either 4 months if patient falls into the Low Risk (SSM) category, or 8 months if patient is in the High/Moderate Risk (PL) category (Section 4; Flowchart 1), as these timescales are in line with when the patient should have finished adjuvant treatment. This is an End of Treatment (EOT) appointment for the **CNS led** workshop presentation. The workshop educates patients about open access to the Breast Unit, health and wellbeing events, common concerns, and self-management.
 - Should a patient who comes under Low Risk not be suitable for Supported Self-Management, or the patient wishes to remain on the Professional Led pathway, the patient would still be required to attend the Low Risk End of Treatment Workshop.
- At the end of treatment, the patient attends a **CNS led** group presentation suitable to their level of risk (DCIS/Low: clinic code BREWL or moderate/high: clinic code BREWH). This will describe possible late effects from adjuvant treatments, what to look for as signs of recurrence, breast awareness, surveillance mammography/recall, lifestyle, health and wellbeing support, peer support, self-management, psychological support, lymphoedema and menopausal symptoms.
- If a patient does not attend (DNA) the End of Treatment Workshop, the **CNS** will document on the reconciliation slip (Appendix H) for another workshop to be offered. The **PPC/Receptionist** will then action this. Should the patient DNA a second workshop, the **CNS** will complete the reconciliation slip with DNA and for PL patients also tick 12 month follow up. **PPC/Receptionist** to ensure that PL patients already have a 12 month follow up on Careflow. **CNS** to dictate the letter template "DNA Workshop" (Appendix L) and **PPC/Typist** to include the patient information handbook titled "Open Access Follow up after Treatment for Breast Cancer" (Appendix K) when posting out the letter.
- Patient information handbook titled "Open Access Follow up after Treatment for Breast Cancer" (Appendix K) is given to patients at the workshop. Optional leaflets on health and wellbeing located within the room for patients to take. Leaflet stock should be maintained by **BCSW**. Orders should be placed via the Macmillan Information and Support Centre and Breast Cancer Care website.
- The workshop will be manned by 2 members of the nursing team.
- The **CNS Led** workshop will be held in the Conference Centre on a Thursday Morning, however this may be subject to change in the future due to team requirements. **CNS/BCSW** need to ensure rooms are booked for the workshops up to 6 months in advance. To make a room booking, contact sfh-tr.kingsmillconference.centre@nhs.net. Rooms need to be booked on level 0 to make signposting easier for patients and needs to accommodate 10 patients.
- Patients on the moderate/high risk pathway (PL) will have their 12 month follow up requested via the reconciliation slip using the code BRE5P as above and should have already been generated from post-operative results appointment.
 - The **CNS/BCSW** will be responsible for ensuring the reconciliation slip is completed to request the 12 month Consultant follow-up, whether or not the patient attends the End of Treatment Workshop.

- DCIS / Low Risk patients do not have any further routine appointments with a professional and follow the supported self-management (SSM) pathway with Open Access to the Breast Unit as required unless they are ineligible and follow the Professional Led (PL) Pathway.
 - SSM cases are reviewed at MDT at year 5 and if indicated, discharged from the service via a generic letter (appendix O) typed by the **Typists/PPC** as part of MDT outcome.
- Moderate / High Risk / ineligible for Supported Self-Management (SSM) patients follow the Professional Led (PL) Pathway.
 - They are reviewed clinically at 12 months in clinic 14 by a **Surgeon**.
 - Final clinical review by a **Surgeon** and discharge to GP care at year 5 utilising letter template (Appendix P).
- **All patients have Open Access to the Breast Team and to Personalised Health and Wellbeing Support for the duration of their 5 years follow up.**

3.3 Triaging of OAFU patients

- The **BCSW** and designated triaging **CNS** will co-ordinate Open Access Follow Up (OAFU) each working day by answering the dedicated OAFU phone line.
- Any concerns raised by patients will be triaged into the appropriate clinic by the **CNS** who will initiate discussion with the **MDT** if required. Outcomes of triage can be triple assessment, surgeon review, oncology review, CNS review, HNA or late effects clinic (see flowchart 3). The triage outcome will be documented on Infoflex.
- Triage sheet (Appendix M) completed with patient concerns and history by **CNS/BCSW** and given to **Surgical or Oncology PPC** to allocate appointment and inform patient.
- If health and wellbeing, psychological and socioeconomic concerns are discussed, HNA/care plan will be completed by **CNS/BCSW**, and referrals made to the appropriate services. This may require booking onto a dedicated HNA clinic appointment to allow appropriate time for discussions. Any actions undertaken will be recorded on Infoflex.
- If general advice or signposting is provided, this will be documented on Infoflex.
- Completed triage sheets to be kept in patients' medical notes.
- Logging of triage telephone calls in Careflow under the clinic BRETR to be actioned by triaging **CNS/BCSW**.

3.4 Surveillance Investigations

- Routine mammography will be monitored and organised by **Radiographers** for the 5-year annual follow up following surgery, or until patient reaches the age for the national screening programme.
 - The due date (month/year) will be checked on Infoflex by the mammogram surveillance lead.
- DEXA bone mineral density scans for post-menopausal women on Aromatase Inhibitors will be organised by:
 - The prescribing clinician at either surgical or oncology clinic at the start of treatment.
 - As per the adjuvant endocrine and bisphosphonate guidelines (Appendix N).

- If a patient stopped bisphosphonates early prior to completing 3 years of treatment, they will need a baseline and further scan in 3 years time.

5 years of Treatment	5 years of treatment and bisphosphonates	10 years of treatment and bisphosphonates	10 years of AI
Baseline and 3 years	At 5 years	At 5 years and 8 years	Baseline and 3 years. If stable, no others required.

- Interval scans (MRI/CT) will be organised and monitored by requesting **medical staff** and documented on Infoflex by **CNS/BCSW**.
- Each treatment pathway has an associated protocol which is applied for the management of surveillance tests. These have been embedded into Infoflex. The **CNS team** will ensure that surveillance tests/follow-ups are managed in accordance with the protocols through accessing worklists within the Infoflex system.

3.5 Discharge to Primary Care

- MDT meeting carried out at 5 years post-surgery (list generated on Infoflex by **CNS/BCSW**, emailed to MDT co-ordinator and patients added to existing Friday MDT) to review and discharge as appropriate.
- Histopathology, administered treatments, previous MDT outcomes and any new developments in treatment pathways reviewed with appropriate key members of the MDT.
 - DCIS/Low Risk: Letter generated by the **PPC/Typists** informing patient of discharge from PSFU under the breast team and to be re-referred into the service via GP if any concerns in the future. Generic letter created on Dragon flow/Winscribe (Low Risk Discharge Letter Appendix O).
 - Moderate/High Risk: Attend final 5-year appointment with **surgeon** and letter generated by the **Typists** following dictating by the surgeon confirming discharge from PSFU and to be re-referred into the service via GP if any concerns in the future (Moderate/High Risk No Concerns Letter Appendix P).
 - If a patient at their Moderate/High Risk final 5-year discharge appointment has any clinical concerns that require further investigation or discussion, these will be decided by the **medical professional** and documented in medical notes/dictated in the patient letter. Further appointment or outcome to be decided by the medical professional.

3.6 Outcomes on Careflow and Reconciliation slip

- At post-operative results appointment, Low Risk / DCIS patients (SSM) will have their reconciliation slip completed (**By Surgeon/CNS/BCSW**) as below and **PPC/Receptionist to outcome on Careflow**:
 - BREWL 4 months (Nurse workshop).
 - Refer to Another Provider Treatment (if having oncology treatment).

- After the patient attends the Breast CNS led EOT Workshop at 4 months, their reconciliation slip can be completed (**By CNS/BCSW**) as below and **PPC/Receptionist to outcome on Careflow**:
 - Add to SSM Review List: 4 years, 8 months (this allows any triage bookings as part of SSM),
- At post-operative results appointment, Moderate / High Risk patients (PL) will have their reconciliation slip completed (**By Surgeon/CNS/BCSW**) as below and **PPC/Receptionist to outcome on Careflow**:
 - BREWH 8 months,
 - BRE5P 12 months (Surgeon follow up),
 - Refer to Another Provider Treatment (if having oncology treatment).
- After the patient attends the Breast CNS led EOT workshop at 8 months, their reconciliation slip can be completed (**By CNS/BCSW**) as below and **PPC/Receptionist to outcome on Careflow**:
 - BRE5P 4 months (**PPC/Receptionist** to ensure patient has their 12 month PL follow up on the Careflow system previously generated).
E.g. If the patient was seen on time in the 8 months workshop, this would be 4 months to enable a 12 month review.
- At the 12 months follow up on BRE5P, the reconciliation slip should be completed (**By Surgeon**) as below and **PPC/Receptionist to outcome on Careflow**:
 - Add to Breast PSFU Hold unless a further appointment is required which is not yet scheduled. If a further appointment requires scheduling, this should be booked as required.
 - At the time of generating the list of patients to be discussed at MDT for their 5 year review (from infoflex), the list should be given of the **PL** patients to **PPC** who will add to the BRE5P clinic for their 5 year review.
E.g., If the patient was seen on time in the 12 month Consultant review, this would be 4 years to enable a review at 5 years.
- If a patient contacts the service via the open access phone line, this contact will be recorded retrospectively in the BRETR clinic by **CNS/BCSW**. When booking this appointment, teams must ensure that they select to **not** remove the patient from any existing partial booking lists.
 - Add to Breast PSFU Hold unless a further appointment is required which is not yet scheduled. If a further appointment requires scheduling, this should be booked as required.
 - Any patients who do not have further appointments in the breast unit, primarily SSM patients **need to have Add to Breast PSFU Hold** selected (this keeps the ability to book appointments open).
- At the 5th year follow up, patients can be discharged to their GP if agreed by the MDT.

N.B Failsafe for Careflow: Data quality have had a report developed around the SSM review list. This will flag any patients that have been removed from the SSM review list ahead of the date they were planned to be on the list for. E.g., If patient is added to SSM Review list for 5 years, and was taken off after 3, the patient would appear on the report below so it could be investigated. Please note, the report is for multiple tumour sites, but the code will highlight which are for breast. In other tumour sites this has been handed over to the business unit.

<http://sfh-ssrs.nhis.local/Reports/report/Cancer%20Services/SFU%20Removed%20From%20Partial%20Booking%20List>

SECTION 4: GUIDELINE DETAILS (including Flowcharts)

4.1 Eligibility for Entry to Personalised Supported Self-Management (SSM) Pathway

- All early breast cancer patients who have been diagnosed with DCIS or risk stratified under the “Low” category and have completed treatment will be considered for entry.

4.2 Eligibility for Entry to Personalised Professional Led (PL) Pathway

- All early breast cancer patients who have been risk stratified under the “Moderate/High” category and have completed treatment will be considered for entry.

Some patients may not be appropriate for supported self-managed care and will join the professional led (PL) pathway. These can include:

- The individual who is unable to self-manage due to physical, cognitive, communication or emotional reasons.
- The individual who has co-morbidities that may require closer monitoring as per MDT recommendation.
- Following discussions between the individual and the healthcare professional, there is mutual agreement not to enter the self-managed follow up pathway.
- The individual is deemed inappropriate by the MDT because of oncological concerns.

4.3 Follow up timeframes

- Low risk patients who are unlikely to benefit from long term clinical follow up for their breast cancer may be moved to supported self-management (SSM) and Open Access Follow-Up;
 - Ductal Carcinoma Insitu patients are moved to supported self-management (SSM) at the post-operative results appointment.
 - Invasive Breast Cancer patients who are low risk with an NPI <3.40, Oncotype score <25 (and not given chemotherapy), Predict score of <2% will be discharged to supported self-management (SSM) at their results appointment, if they have no on-going problems.
- Patients identified as moderate or high risk (NPI >3.40, an oncotype score suggestive of chemotherapy benefit >25 or >20 at oncologist discretion, predict score >2% or clinical judgement) will have professional led (PL) follow up at year 1 and year 5.
 - At year 5 they will then be discharged to the GP.
 - Throughout the 5 years they can utilise the Open Access CNS led service.
- Patients aged <45 years old at diagnosis will be followed up on PSFU in the category of their post-operative histopathology and based on the MDT recommendation.
 - Following their 5 years on PSFU they will be discharged to the care of the GP.

- They will have annual mammograms until they reach 50 years old and join the national breast screening programme.
- Patients participating in clinical trials will be followed up as per the clinical trial protocol.

4.4 Personalised Stratified Follow-up Pathway

All patients will:

- Be able to contact the **CNS/BCSW** as required with any concerns within the follow up period.
- Have access to all health, wellbeing information and support services.
- Have annual mammography (if applicable) for 5 years or until the age of 50. They will then attend via the NHS Breast Screening Programme.
- Receive hormone therapy and bone health monitoring as per national and local guidelines (if applicable).
- Be contacted to be offered access to any relevant clinical trials that may become available throughout the 5 year follow up pathway.

Professional Led (PL) patients will:

- Have clinical review by a surgeon at years 1 and 5.

Patients will not:

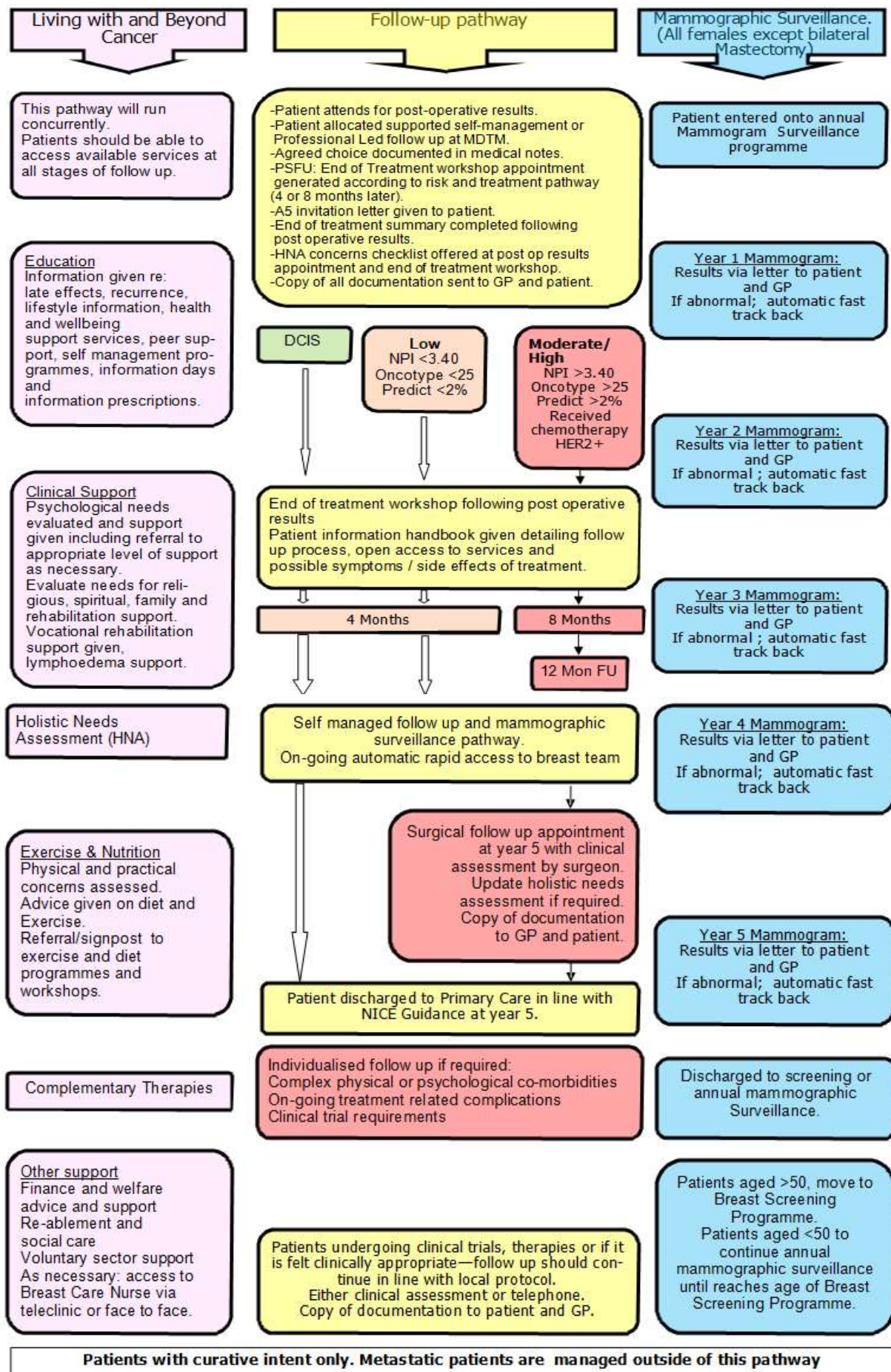
- Have 5 years of annual outpatient appointments with a breast surgeon.

4.5 Surveillance Investigations

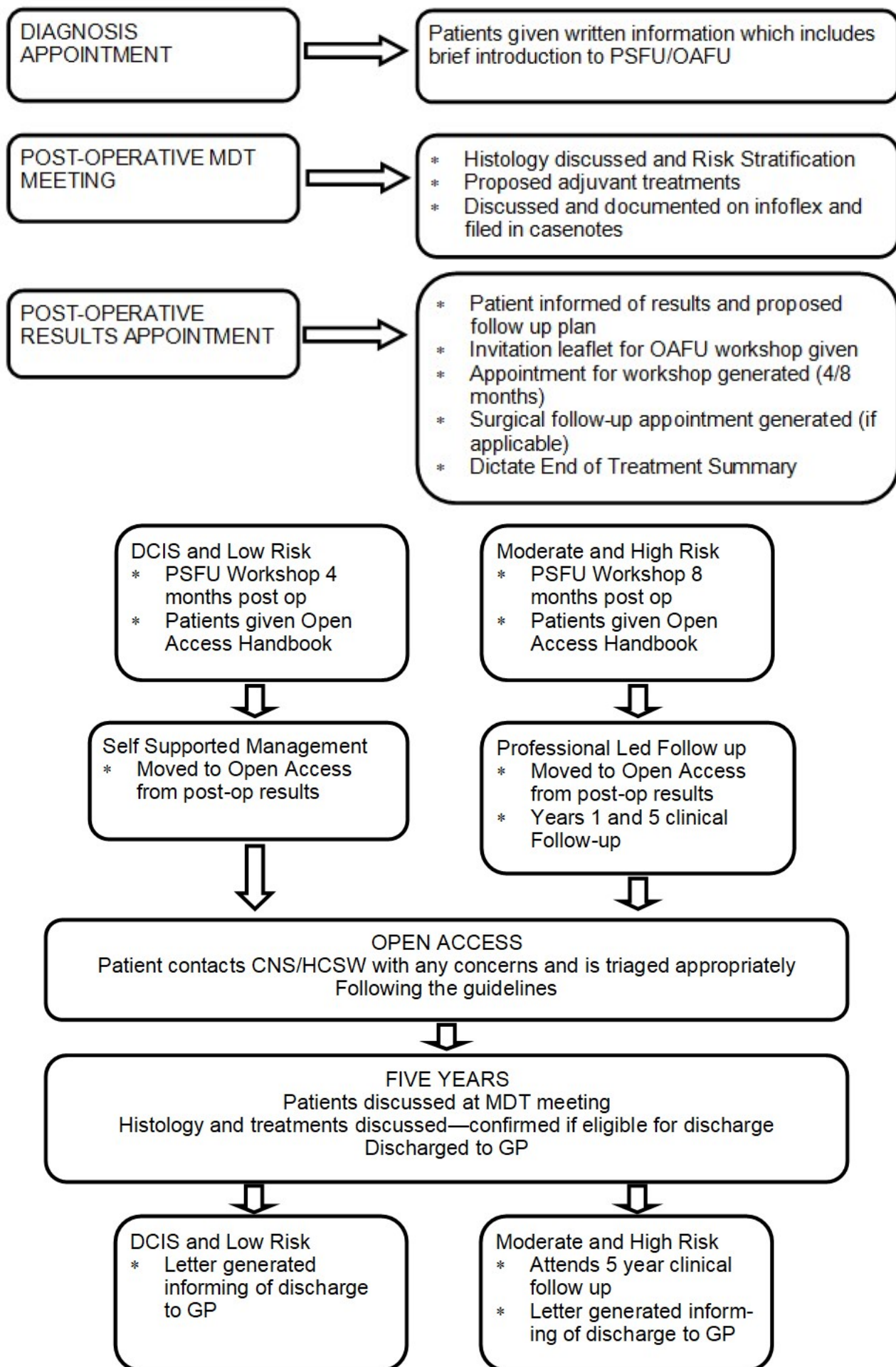
- Surveillance investigations as decided by **MDT** will be documented on Inflex and on MDT proforma filed in medical notes by the **Cancer Pathway and MDT Co-ordinator**. Outcomes will be monitored by **Cancer Pathway and MDT Co-ordinator**.
- Any investigations requested outside of MDT discussion are to be highlighted to the **Breast CNS Team/BCSW** by the **Requesting Clinician** and the **Breast CNS Team/BCSW** will add this to infoflex and monitor.
- Mammography appointments and results monitored and actioned by **Radiology**.

The following flow-charts explain the pathway.

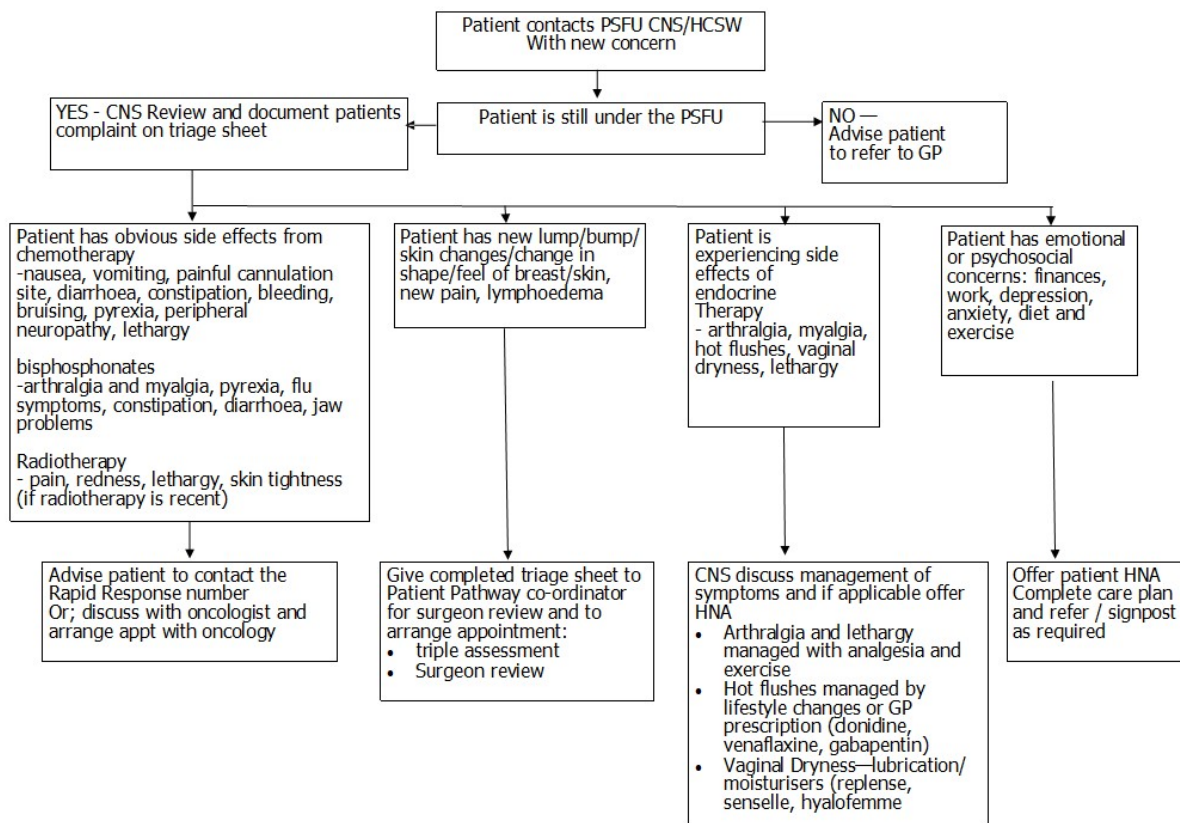
Flowchart 1 – Detailed Pathway Flow Chart



Flowchart 2 – Simplified Pathway



Flowchart 3 – Triage process



SECTION 5: EDUCATION AND TRAINING

Holistic Needs Assessment via the Macmillan Learnzone

<https://learnzone.org.uk/courses/course.php?id=788>

Implementing Personalised Stratified Follow up pathways document

<https://www.england.nhs.uk/publication/implementing-personalised-stratified-follow-up-pathways/>

Appendix A – East Midlands Cancer Alliance – Personalised Stratified Follow Up Guidelines for people with a breast cancer diagnosis



Best Practice
Examples.docx



ECAG Management
and Clinical Guidelines



National Cancer
Survivorship Initiative



MAC16788Treatment
-SummaryGuideWEB.



REFERENCES.docx

SECTION 6: MONITORING COMPLIANCE AND EFFECTIVENESS

The measures to be monitored will focus on the compliance with the personalised care package:

- Number of patients offered an HNA
- Number of patients who complete an HNA
- Number of patients with a Care Plan
- Number of patients who receive a Treatment Summary
- Number of patients contacting via the open access follow-up helpline

SECTION 7: EQUALITY IMPACT ASSESSMENT

- [Guidance on how to complete an Equality Impact Assessment](#)
- [Sample completed form](#)

Name of service/policy/procedure being reviewed:			
New or existing service/policy/procedure: Personalised Stratified Follow up			
Date of Assessment: November 2022			
<i>For the service/policy/procedure and its implementation answer the questions a – c below against each characteristic (if relevant consider breaking the policy or implementation down into areas)</i>			
Protected Characteristic	a) Using data and supporting information, what issues, needs or barriers could the protected characteristic groups' experience? For example, are there any known health inequality or access issues to consider?	b) What is already in place in the policy or its implementation to address any inequalities or barriers to access including under representation at clinics, screening?	c) Please state any barriers that still need to be addressed and any proposed actions to eliminate inequality
The area of policy or its implementation being assessed: All			
Race and Ethnicity:	None	None	None
Gender:	Female dominated patient demographic, may cause male patients to feel excluded	Males made aware of likelihood of lone male at EOT appointment and offered one on one	none
Age:	No access to electronic devices or unable to use independently.	If patients don't have access to a computer to be able to populate an HNA, they will have the opportunity to complete this over the phone with a CNS/BCSW, or a paper form can be provided.	None
Religion:	None	None	None
Disability:	None	None	None
Sexuality:	None	None	None
Pregnancy and Maternity:	None	None	None
Gender Reassignment:	None	None	None
Marriage and Civil Partnership:	None	None	None
Socio-Economic Factors (i.e. living in a poorer neighbourhood / social deprivation):	No access to electronic devices.	If patients don't have access to a computer to be able to populate an HNA, they will have the opportunity to complete this over the phone with a CNS/BCSW, or	none

	a paper form can be provided.
--	-------------------------------

What consultation with protected characteristic groups including patient groups have you carried out?

- None

What data or information did you use in support of this EqIA?

- Historic information from Male and Elderly patients regarding their diagnosis and treatment pathway

As far as you are aware are there any Human Rights issues be taken into account such as arising from surveys, questionnaires, comments, concerns, complaints or compliments?

- No

Level of impact

From the information provided above and following EqIA guidance document please indicate the perceived level of impact:

Low Level of Impact (*Delete as appropriate*)

For high or medium levels of impact, please forward a copy of this form to the HR Secretaries for inclusion at the next Diversity and Inclusivity meeting.














Name of Responsible Person undertaking this assessment:





Signature: Kathryn Grayson / Lisa Rahn

Date: 02/11/2022

SECTION 8: APPENDICES

Documents can be found in the electronic Breast Unit folder

Appendix	Document Title	Document Link
A	EMCA Personalised Stratified Follow Up Guideline	 EMCA Breast Cancer Personalised Stratifier
B	Holistic Needs Assessment (HNA) Checklist	 HNAConcernsChecklist.pdf
C	Invitation to Open Access Workshop Leaflet	 A3 OAFU leaflet.docx
D	Support Services for Patients with Breast Cancer Leaflet	 PIL202207-03-SSPBC Support services for
E	End of Treatment Summary DCIS	 Treatment Summary DCIS.docx
F	End of Treatment Summary ER-	 Treatment Summary ER-.docx
G	End of Treatment Summary ER+	 Treatment Summary ER+.docx
H	Results Appointment Reconciliation Slip	 Breast Outpatient Reconciliation Slip M
I	Breast OAFU H+W Presentation Low Risk	 Breast OAFU H&W Presentation Low Ri
J	Breast OAFU H+W Presentation Mod/High Risk	 Breast OAFU H&W Presentation Moder
K	SFH OAFU Patient Information Handbook	 Handbook Breast OAFU Patient Inform
L	End of Treatment Workshop DNA Letter	 DNA workshop letter.docx
M	OAFU Triage Sheet	 OAFU Triage.pdf

N	Adjuvant Endocrine and Bisphosphonate Guidelines	 Adjuvant endocrine and bisphosphonates
O	Low Risk Discharge Letter	 Low risk 5 year discharge letter.doc
P	Moderate/High Risk No Concerns Discharge Letter	 ModHigh risk no concerns 5 year disc
Q	Infoflex Training Guide	 InfoFlex SFU User Guides - Breast.pptx