



Breast Self-Referral Pilot

Phase 1 Evaluation



BREAST SELF-REFERRAL PILOT EVALUATION

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Objective	<p>To evaluate and review the outcomes from the 12-week breast self-referral service pilot.</p> <p>The evaluation will provide information and insight to inform proposals for the growth and sustainability of a self-referral pathway.</p> <p>This evaluation outlines the national strategic context, current pilot service delivery, benefits, risks, and issues, as well as outcomes including patient experience feedback.</p>

NATIONAL BACKGROUND TO RAPID DIAGNOSTIC CENTRES (RDC)

The breast self-referral pilot service forms part of the Wessex Cancer Alliance (WCA) response to the national Rapid Diagnostic Centre (RDC) Programme. The RDC programme forms part of the package of work in place nationally and regionally to deliver the ambition to diagnose patients with cancer faster and to improve patient experience. The RDC programme also forms part of the response to deliver the new Faster Diagnosis Standard (FDS).

The RDC specification cites self-referral as part of work that could be undertaken to open access to referrers other than primary care and forms part of their recommended approach to implementation.

This pilot service has been developed in partnership between the Rapid Investigation Service team working together with clinical colleagues from Hampshire Hospitals NHS Foundation Trust and the Winchester Rural North and East Primary Care Network and The Camrose, Gillies, and Hackwood Partnership.

THE WESSEX RDC APPROACH

The breast self-referral pathway operates using the virtual, centralised service model developed for the non-specific symptoms pathway and is facilitated through a central service hub hosted by University Hospital Southampton (UHS) and South-Central Ambulance Service (SCAS).

The service model designed and implemented by the WCA was developed to ensure equity in access across the Wessex geography ensuring that people were not disadvantaged by where they live. The centralised model means that access is not focused on any physical location and allows the service to operate with a reduced carbon footprint and minimises the need for patient and staff travel, in turn providing greater flexibility for patients and staff.

The self-referral service provides people with a virtual appointment, either by telephone or video, to assess peoples' symptoms and needs. People are then either offered advice, guidance, and safety netting to manage their symptoms or where clinically indicated are either provided with a GP appointment or referred into breast clinic on a two week wait pathway at their local hospital.

SERVICE PURPOSE AND OBJECTIVES

The breast self-referral pilot service and central virtual service hub have been set up in direct response to the national Rapid Diagnostic Centre (RDC) service specification.

The purpose is to provide a service which allows patients to self-refer when they identify that they have or may have breast symptoms to access information and onward management where appropriate. This provides an alternative option to the traditional route through primary care and aims to provide a more specialist and tailored service for this cohort of people.

Objectives for the service include:

- To provide an alternative route for people to report their symptoms
- To speed up the process for accessing a breast clinic appointment for those presenting with a breast lump
- To remove the need to access a GP appointment prior to referral to breast clinic
- To provide people with tools and information to understand their symptoms, where not suggestive of cancer, in order that their symptoms can be managed and treated as appropriate
- To reduce demand on secondary care triple assessment breast clinics by managing people with symptomatic pain presentations in different ways
- To provide excellent patient coordination and support

The service has delivered in response to the above:

- Direct self-referral access with the ability to refer onwards directly as a two week wait to breast clinic
- Rapid turn around from the point of self-referral to referral to breast clinic where clinically indicated
- Supportive virtual clinic appointments with advice and guidance as clinically indicated to enable self-management
- Safety netting and management of people outside of secondary care breast clinic where clinically appropriate
- Single point of contact patient lines to maximise patient support and deliver a positive patient experience

CURRENT SERVICE MODEL

The original pilot service model assigned people presenting with a breast related symptom into one of three management pathways.

1. **Breast lumps:** this cohort of people were triaged and where appropriate they are referred direct into breast clinic on a two week wait referral. Where not appropriate people may be offered an appointment with their GP.
2. **Breast pain:** this cohort of people were triaged and provided with advice and guidance, provided with reassurance with an appropriate plan put in place for safety netting.
3. **Any other breast presentation:** this cohort of people will either be given advice and guidance in line with that provided for breast pain presentations or offered a GP appointment in line with clinical need.

Exclusion Criteria:

- People under 30
- Cisgender males

Figure1: Breast Self-Referral Pathway

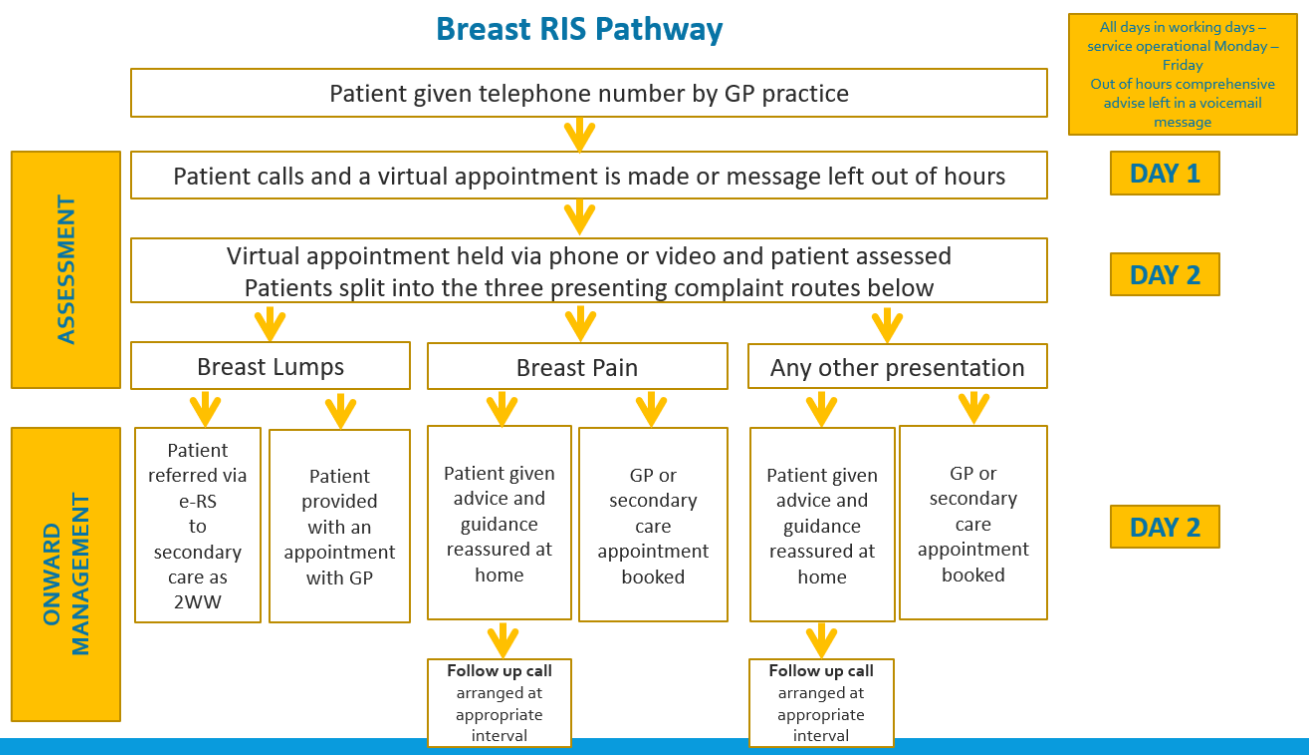
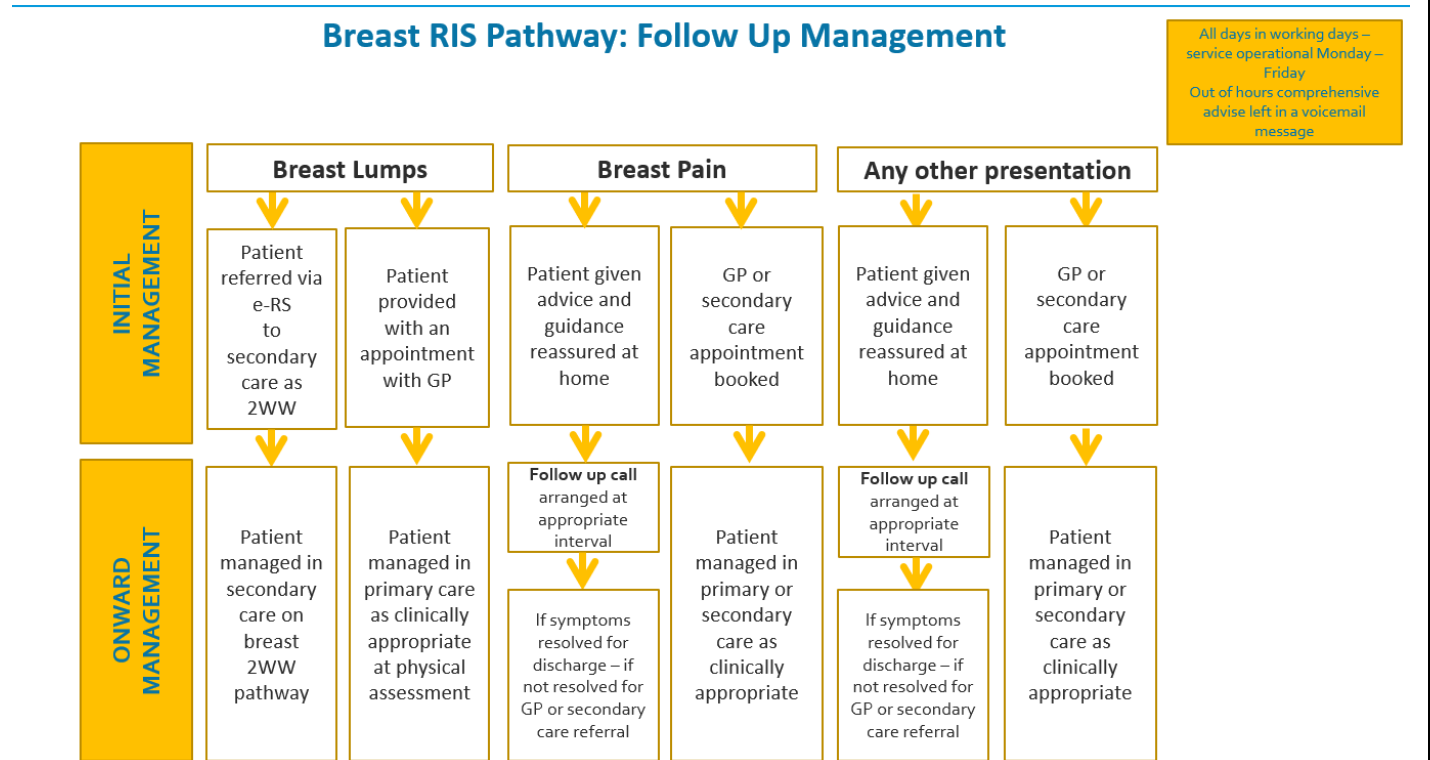


Figure 2: Breast Self-Referral Follow Up Pathway



The current service workforce is made up of:

- Consultant oversight 0.5 PA weekly (also providing project clinical leadership as well as service input)
- Band 8a Lead Nurse
- Band 7 Senior Nurse Practitioner (nursing lead for this project)
- Band 6 Nurse Practitioners x2
- Band 8a Operational Manager (operational lead for this project)
- Band 6 Deputy Operational Manager
- Band 5 Patient Navigator
- Band 4 support Navigator
- Band 3 Administrative Support

To note all posts have dual roles, also delivering the non-specific symptoms service pathway and for the Band 8a roles supporting with developments as directed by the Rapid Diagnostic Centre Programme. To further note greater input is required for all workforce as a new service and pilot than would be when running as business as usual. For further detail about workforce please see **Appendix 2**.

ACTIVITY AND OUTCOMES

Referral Numbers & Outcomes 04.08.21 – 03.11.21

- 211 self - referrals received in total by the service
- Presenting complaint (patient reported symptoms):
 - Lump: 110 (52%)
 - Pain: 76 (36%)
 - Skin change: 21 (10%)
 - Nipple change: 4 (2%)
- Management of lump presentations:
 - 2WW referral: 85 (77%)
 - GP appointment: 22 (20%)
 - Follow up and discharge: 1 (1%)
 - Went private: 2 (2%)
- Management of pain presentations:
 - Advice and follow up with the service: 40 (53%)
 - Subsequently discharged: 25 (63%)
 - Subsequent GP appointment: 4 (10%)
 - Subsequent 2WW referral: 11 (27%)
 - Advice given and no follow up: 2 (2%)
 - 2WW referral: 18 (24%)
 - GP appointment: 16 (21%)
- Management of skin changes:
 - GP appointment: 16 (76%)
 - 2WW referral: 4 (19%)
 - Recurrence (sign posting provided): 1 (5%)
- Management of nipple changes:
 - GP appointment: 3 (75%)
 - 2WW referral: 1 (25%)

Out of the total 211 patients referred 13% were discharged with advice +/- follow up, without having either a GP or breast clinic appointment or referral.

63% of those with an initial presentation of pain who were provided with follow up with the service were discharged with advice +/- follow up, without having either a GP or breast clinic appointment or referral.

64% of patients initially presented with either a lump or skin or nipple changes. Only 1% of this cohort of patients did not go on to have either a GP appointment or two week wait referral. This suggests this group of patients could be managed differently with almost all patients requiring to be seen.

Cancer Diagnoses and Conversion Rate

Out of 119 two week wait referrals made by the service 5 people were diagnosed with cancer giving a conversion rate of 4%. All 5 patients were those with an initial self-reported symptom of a lump.

For comparison the overall conversion rate for the breast pathway at Hampshire Hospitals for April to November 2021 is 4.2% against 4612 referrals.

To note that although 4% is not a high conversion rate this is a small sample to date and there will be a better indication of conversion rate once the second phase of the pilot has taken place. To further note this is in line with the national average for breast cancer pathways of 4.3%, please see the clinical report at **Appendix 1** where this is referenced.

Time Lapse Referral to Appointment

Data has been pulled to identify how long people are waiting from self-referral to their triage appointment. This is based on the time stamp at the point the referral is registered on the system after the patient phone call and the date and time of the booked triage appointment.

For the period of the pilot, 04.08.21 to 03.11.21 people received their first appointment 0.82 days following their self-referral being made. This demonstrates a rapid pathway from referral to first seen and enables onward referrals where appropriate to be undertaken with a short time lapse from initial contact with the service.

Referral Numbers Comparison

The numbers of historic and current referrals of patients by practice (for 2021 these would have originated from the pilot service not the practice however included in this way for comparison) are given below.

Given the extreme peak of referrals seen in October and November of 2021 this is very challenging to quantify and determine whether a reduction of referrals in has been seen as we have no baseline data for number of patients seen with a breast presentation in primary for 2018 – 2020.

This should be read in conjunction with the information included above looking at proportionate split on onward management destinations.

Figure 3: Referral from participating pilot practices

Count of NHS Number Row Labels	Column Labels				Grand Total
	2018	2019	2020	2021	
Practice 1	47	30	39	47	163
Aug	12	4	9	7	32
Sep	10	11	13	10	44
Oct	11	7	8	16	42
Nov	14	8	9	14	45
Practice 2	8	9	10	17	44
Aug			1	4	5
Sep	3	3	1	1	8
Oct	4	3	4	5	16
Nov	1	3	4	7	15
Practice 3	29	44	47	34	154
Aug	5	7	10	4	26
Sep	7	10	15	5	37
Oct	8	18	11	11	48
Nov	9	9	11	14	43
Practice 4	138	142	156	193	629
Aug	32	23	33	38	126
Sep	33	29	36	53	151
Oct	36	57	50	48	191
Nov	37	33	37	54	161
Practice 5	23	31	30	32	116
Aug	4	6	4	4	18
Sep	9	9	9	7	34
Oct	4	8	9	9	30
Nov	6	8	8	12	34
Practice 6	43	34	39	53	169
Aug	10	5	8	7	30
Sep	14	11	14	13	52
Oct	2	7	6	18	33
Nov	17	11	11	15	54
Practice 7	37	24	35	42	138
Aug	6	4	9	7	26
Sep	12	9	12	11	44
Oct	7	4	8	15	34
Nov	12	7	6	9	34
Grand Total	325	314	356	418	1413

AUDIT

Primary Care Staff Feedback

GPs from the seven practices participating in the pilot service were asked to provide feedback through a short survey to understand what the impact of the service had been in practices. Each practice returned collated responses from GPs.

The below provides summary headline outcomes from the survey responses:

- 100% of GPs responded that they were conscious that the service had decreased their workload
- Some GPs received comments or feedback about the service, and all cited these as having been positive
- 100% of GPs responded that they would be keen for the service to continue in their area

This demonstrates that the service delivered a notable reduction in workload for practices with fewer patients needing to be seen or virtually seen by the practice and that the practices would all support the continuation of the service with no negative feedback to provide.

There were some comments provided as suggestions for improvement or development of the service which were:

- To develop a digital solution to facilitate self-referrals in addition to the existing phone lines
- To consider whether Trusts could book patients back in for GP review if they receive a diagnosis of cancer

Regarding a digital solution work is underway to scope options to enable this as a referral route.

Regarding appointments with GPs post diagnosis, that is outside of the gift of the service which discharges people at the point of referral to breast clinic however this will be shared as a suggestion with secondary care colleagues.

Primary Care Audit of Referrals

A sample of 31 patients were audited by primary care to look at several factors seen as important for demonstrating a safe and quality service. The sample was produced by selecting every fourth person from the self-referral spreadsheet containing all referrals in time and date order, from each practice.

Practices were asked to identify whether people had contacted practices after discharge from the service. Out of 31 people the only people who had been in contact with the practice after discharge were those who had a GP appointment booked for them by the service as their onward management route. No patients selected as part of the audit sample, at the time of audit had contacted practices with repeat concerns about breast symptoms, or the self-referral service.

Practices were asked to identify, out of the people who were booked appointments with their GP, how many of those went on to be referred to secondary care as a two week wait. 6 people out of 9 who were seen by the practice following an appointment having been booked by the self-referral service were referred onwards as a two week wait. 4 out of 6 of those people had initially reported a skin or lump presentation.

Out of the three skin presentations randomly selected as part of the sample all three were booked appointments by the self-referral service with their GP. Two out of the three people were referred in to secondary care as a two week wait by the practice after being seen and one was reassured by the practice. Referencing back to overall referral numbers 76% of all people with skin presentations were booked appointments with their GP as a first step by the service. Conclusions drawn from this are that those presenting with skin changes should be excluded from the self-referral service as no value is added by their self-referral appointment.

Secondary Care Audit – Referral Appropriateness

An audit has been undertaken in secondary care by the pilot consultant lead to review appropriateness and effectiveness of the pilot service. The report can be seen in full at **Appendix 1**.

Key points to note are given below:

- Conversion rate confirmed as in line with that seen nationally
- Some patients referred could potentially have been managed in primary care, 32 out of 119 (27%), because of which refinements are being made to the triage criteria to lower this number based on audit findings
- No cancers have been detected so far in people who were triaged to self-management

Ethnicity Break Down of People Self-Referring

91.8% of Hampshire’s resident population are White British and 3.3% white other making this breakdown representative of the overall population in Hampshire based on the pilot sample. (Hampshire County Council, 2020)

PATIENT FEEDBACK

The breast self-referral pilot service worked with the Wessex Cancer Alliance’s patient and public involvement partner, Wessex Voices, to ensure robust patient feedback was collated and evaluated. A semi structured telephone interview was designed to tease out information from people about their experiences of using and views of the breast self-referral service and offered to those contacting the service.

Wessex Voices spoke with 31 people to gather peoples’ views and produced an independent report and associated recommendations based on the feedback gathered.

Please see below the headline findings and recommendations which are directly taken from the report:

Headline findings

Most people (29 out of 31) were satisfied, if not impressed, with their experience of the service and would recommend it to others.

People did however identify some areas for improvement. Some of these are enhancements for the RIS. Most relate to the interactions with GP surgeries when people were referred back there. These are outlined in the recommendations.

Overall feedback

Twenty-nine out of 31 people were satisfied with the RIS breast service. Only two people were not (one because of the problem with their onward referral and the other because of the response from the GP practice nurse).

Most said they would recommend it to others. The speed with which they were seen provided people with reassurance and allayed their anxieties. They would like to see it more widely advertised and rolled out to other areas.

“One of the best experiences with a health service in a long time. Highly recommend and would go back to them in future.”

“Fabulous, absolutely fabulous. Women who get to use this service will be much better off. I would recommend to others. Quicker than seeing a GP.”

Recommendations

- 1. For GP surgeries to provide more positive messaging about the nature of the service so people have confidence in it*
- 2. Where people have symptoms that need physical examination, or when people are adamant they need to see a GP, clarify whether they have this option and the timescales*
- 3. And/ or find a way of being able to securely access images from patients*
- 4. Provide links to NHS recommended videos and other resources to ensure people feel confident in examining their own breasts before the appointment with the nurse*
- 5. Ensure on answering the phone or via the answerphone that it is clear to patients they are accessing the breast symptom service*
- 6. Consider offering an out of hours service – even slightly before and after typical working hours for those who may find it difficult to call during work*
- 7. Give clear instructions about dialling into video calls before appointments*
- 8. Review whether it is effective for the RIS to set up GP appointments on behalf of patients if they are not aware of patients’ other commitments*
- 9. Work with GP practices to ensure patients who are referred back are seen by a GP in a timely way and that the RIS written summary is available at the consultation*
- 10. Ensure all patients are sent a written summary in their preferred way and encourage them to take these to any follow up GP or other appointments*
- 11. Promote the service more widely as soon as possible*
- 12. Review whether the demographics of those accessing the service reflects that of the GP areas*

Summary

The patient feedback demonstrates that most people found the service efficient, reassuring and would recommend it to others.

The clear area identified for improvement centres around those people presenting with skin changes and similar and the need then to be seen by the GP and the efficiency with which people were able to be seen at their practice.

This will be explored further in the recommendations coupled with audit information about onward destinations for those people who were provided with a GP appointment for this kind of presentation. This cohort of people, based on patient feedback, would benefit from a different approach for their symptoms.

As part of any wider service roll out there is also clear feedback about messaging from practices leaving people unsure what the service is and confused as to whether they still have the right to see their GP. There would need to be increased engagement with primary care and further guidance to inform staff about the service offer. For a wider roll out there would also be information made available to people through a variety of channels outside of their practice. Information giving was centred around GP practices for the purposes of this geographically small pilot.

SERVICE BENEFITS & ISSUES

Benefits

- The service provides a new self-referral access route for people increasing choice and access.
- The service facilitates rapid turnaround from the point of self-referral to referral to breast clinic where clinically indicated.
- The service provides virtual clinic appointments with advice and guidance as clinically indicated to enable self-management and patient empowerment.
- The service provides a single point of contact patient line to maximise patient support and deliver a positive patient experience.
- The service has received feedback from people using the service which shows it to be reassuring and anxiety reducing.
- The service is preventing some people from being seen, where not clinically indicated, in both secondary and primary care.

Issues

- The service adds the most value for those with a pain presentation with the remaining 64% of patients with either lumps or skin or nipples changes requiring primary or secondary care face to face appointments. Management for both these cohorts of patients requires further consideration.
- The service is heavy on administrative burden and requires a digital solution to enable wider access to self-referral (in progress).
- Due to the numbers of referrals received from a small population sample, approximately 3.3% of the Wessex population consideration needs to be given to develop a safe, sustainable, and robust workforce model to enable wider adoption of self-referral and consideration of management of pain presentations from primary care more widely.

SUMMARY

The breast self-referral service was well received by people using the service and was found to be reassuring and to provide a good patient experience.

There is evidence from feedback that providing a self-referral route and specialist advice through virtual triage was successful and welcomed by the patients surveyed.

Audit has found that to date no cancers have been missed through use of the self-referral approach to triage.

Survey feedback from primary care has found that the self-referral service reduced workload and is welcomed as a service to be continued.

The national team lists self-referral in the Faster Diagnosis Framework as innovations and as part of transformational change objectives. Self-referral pathways are described in that document as being useful to support widening of access for patients, supporting earlier diagnosis and reducing barriers between primary and secondary care and therefore should be explored and implemented in Wessex.

RECOMMENDATIONS

Inclusion and Exclusions

The evaluation of outcome information has highlighted some areas for consideration and has already prompted some changes to the service exclusion criteria as part of the second phase of the pilot.

Additional criteria have already been added as follows and it is recommended these remain:

- To ensure the presenting symptom is not an existing problem that has been reviewed at the GP practice previously
- The patient must be willing to have a virtual consultation and does not request a physical review / wish to see their GP
- The patient has capacity to partake / consent to a virtual consultation
- The patient is not pregnant or breast feeding*
- The patient does not have symptoms that can be visibly seen (e.g., changes to the skin) these would require a physical examination at the GP surgery*

*It is recognised that where patients are sign posted from their GP surgery and that it would be outside the remit of reception staff to confirm the above.

Service Model

Recommendations for service development and considerations to enable wider roll out of self-referral:

- Skin presentations to be excluded from the self-referral service, patient cohort should be seen as currently by their GP for assessment.
- Triage process to be refined to reduce further the number of people seen in secondary care that could have been managed in primary care to maximise positive impact on secondary care. For example, for people referring who are pre-menopausal who present with a short history of a new breast lump to consider review in 1-2 weeks as several people fitting these criteria had had their lump resolve prior to clinic meaning these had been hormone related. To be defined as part of triage re-fresh.
- To explore opportunities and governance around accessing images sent to the self-referral service.
- To continue to develop a digital route in for self-referral.
- To consider the option to provide an out of hours option, either earlier or later for appointments.
- To investigate increase range of information available for patients. Self-examination videos etc. that are endorsed.
- Workforce model options to be explored and views sought, please see **Appendix 2**, in particular around opportunities for staff rotation.

Roll Out and Engagement

- To ensure as part of any wider roll out that practices are aware of and able to offer the service leaflet to patients when they are offered the pilot service contact details. The leaflet is essential to ensuring patients have the appropriate information to make an informed choice about whether they wish to use the pilot service.
- To ensure that practices can provide face-to-face appointments rather than an additional virtual triage when patients have already been virtually triaged by the breast self-referral service.
- For any wider roll out to plan and implementation to undertake robust public information giving and engagement with practices and other community health settings to promote the service and increase knowledge and awareness.
- Secondary care colleagues to be engaged in development of an agreed workforce model which would support the introduction of self-referral across Wessex.

APPENDIX 1: Secondary Care Outcomes Report

Initial secondary care outcomes of breast symptom triage pilot

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*HHFT

RDS

Introduction

Breast symptomatic referral pathways have been under unprecedented pressure with units across England struggling to meet the targets for 2 week wait for all referrals. Figures for 2020 were 609,047 symptomatic breast referrals. It is generally felt among secondary care professionals that about 20% of referrals (~121,809) are for breast pain alone which could have been managed outside of secondary care. Reducing the number of referrals to secondary care will improve the capacity for everyone to be seen in a timely fashion. Education and self-management of patients with breast pain will help reduce both anxiety and the need for clinical evaluation.

The rapid diagnostic service in conjunction with local primary care networks (population approximately 80,000) and a secondary care breast unit developed a telephone-based triage system for breast symptoms. The primary aim of the project was to allow a rapid onward referral of patients with red flag symptoms to secondary care without prior GP involvement, to triage patients for GP review and to provide advice and guidance to those without red flag symptoms with appropriate safety nets.

Of 211 patients triaged in 3 months by specially trained nursing staff, 61 were reviewed by their GP either immediately or after follow-up. 119 patients were referred directly to secondary care without GP review immediately or after safety net review. 13% did not require either primary or secondary care review.

Results

Of 119 patients referred to the NHS breast unit 5 cancers were diagnosed (4% conversion rate). Figures for England are 5.5% suspected cancer and 1.3% breast symptoms – combined 4.3%.

On review of the patients' clinical details in secondary care it was found that potentially 32 of the 119 patients could have been managed in primary care. The 4 most common reasons were: pain that had not resolved but no abnormality found in breast clinic, a lesion in the skin of the breast that would not have been referred to the breast unit for example a sebaceous cyst in the axilla, breast nodularity that had either resolved prior to attending clinic (cyclical change) or that did not require any further investigation.

No cancers have so far been detected in people that were triaged to self-management or GP review.

Conclusions

The breast triage service allows rapid onward referral to secondary care for those with appropriate symptoms. The conversion rate of referral to cancer is equivalent to England rates for 2WW suspected cancer referrals.

There is a considerable reduction in the number of people that needed to be reviewed by the GP for breast symptoms. There is a separate review being undertaken for the patient's experience and whether the additional information provided by the triage staff helps alleviate some of the anxiety around breast symptom pathways.

Breast pain only symptoms can predominantly be self-managed with appropriate advice and guidance.

Additional refinement of the Triage process is underway to attempt to reduce the number of women seen in secondary care that could have been managed in primary care.

https://www.cancerdata.nhs.uk/cwt_conversion_and_detection

Accessed 18th Jan 2022