NHS
Wessex
Cancer Alliance

Breast self-referral pilot stage 2 evaluation

BREAST SELF-REFERRAL PILOT EVALUATION (STAGES 1 & 2- August 2021 to March 2024)	
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Objective	To evaluate and review the outcomes from the breast self-referral service pilot, both stages 1 and 2, which commenced in August 2021. The evaluation will provide information and insight to inform proposals for the growth and sustainability of a self-referral pathway. This evaluation outlines the national strategic context, current pilot service delivery, benefits, risks, and issues, as well as outcomes including patient experience feedback.

SUMMARY

The breast self-referral service represents a considerable improvement in patient care both for the NHS, by increasing capacity, and for those with breast pain only, who can have more time for reassurance and family risk assessment without unnecessary investigations.

Overall the key take home messages from the implementation of this pathway are:

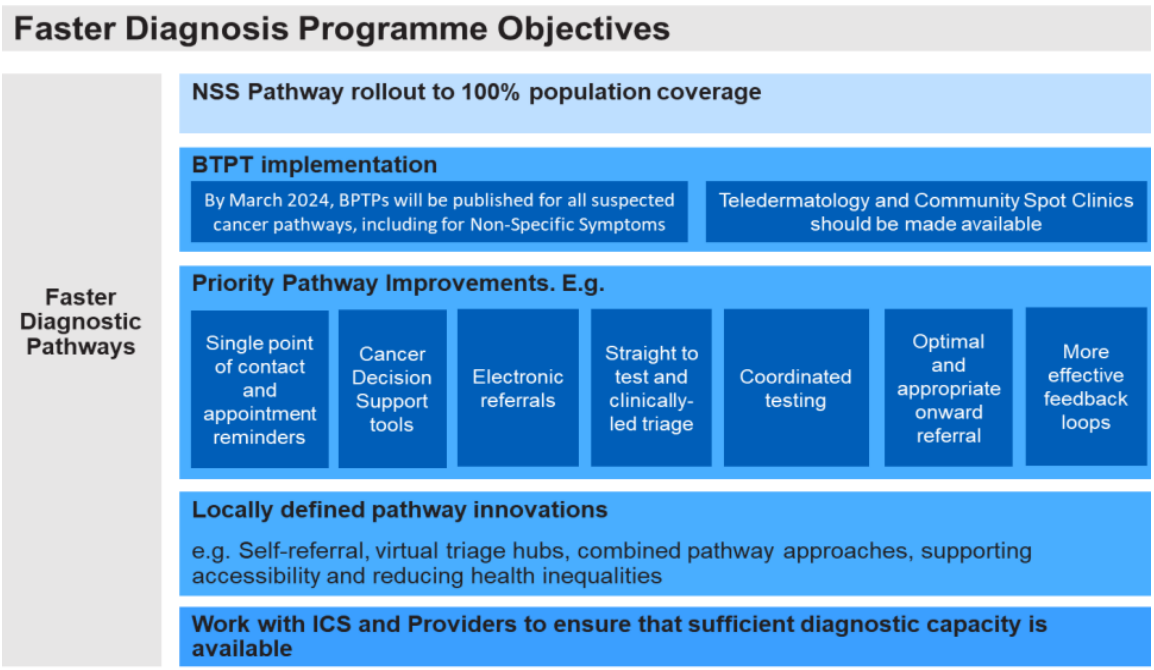
- The breast virtual triage service allows rapid onward referral to secondary care for those with appropriate symptoms.
- The conversion rate of referral to cancer is equivalent to England rates for suspected cancer referrals.
- There is a considerable reduction in the number of people that need to be reviewed by the GP for breast symptoms from this approach. Once the service has been established, considerable NHS savings can be expected with an increase in GP capacity.
- The pathway supports the NHS 10-year plan in terms of a shift from hospital to community, and from analogue to digital.
- Breast pain only can be self-managed with appropriate advice and guidance.

- Patients discharged to self-management must have clear instructions for re-presentation.
- Longer appointments allow for better reassurance. This appears to reduce re-presentations.
- Both patients and GPs have evaluated this service highly. The service has been shown to be safe and effective.
- The pathway is most efficient when staffed by specialist breast clinicians.
- The service promotes eco-friendly practices, operating with a reduced carbon footprint and minimising the need for patient and staff travel.

NATIONAL BACKGROUND TO RAPID DIAGNOSTIC CENTRES (RDC)

The breast self-referral pilot service was initiated as part of the Wessex Cancer Alliance (WCA) response to the national Rapid Diagnostic Centre (RDC) Programme in 2020/21. At this time the RDC programme formed 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 formed part of the response to deliver the new Faster Diagnosis Standard (FDS). The RDC specification cited self-referral as part of work that could be undertaken to open access to referrers other than primary care and formed part of their recommended approach to implementation.

The RDC programme ended with the introduction of the Faster Diagnosis Framework in 2022, and from then on self-referral has featured as an objective under locally defined pathway innovations within this framework, as detailed in the table below:



Source: Faster Diagnosis Framework 2022, page 10.

This pilot service was developed in partnership between the Wessex Rapid Investigation Service (RIS) team working together with clinical colleagues from Hampshire Hospitals NHS Foundation Trust (HHFT) and three Primary Care Networks (PCNs): the Winchester Rural North and East Primary Care Network; The Camrose, Gillies, and Hackwood Partnership; and Andover Primary Care Network.

The pilot cohort covers approximately 34% of the North and Mid Hampshire (N&MH) catchment footprint (c.163,000 patient population across 3 PCNs, out of c.474,000 N&MH total population, or c.56,000 women aged >30 across 3 PCNs, out of c.161,000 total women >30 in N&MH footprint).[1]

THE WESSEX SELF-REFERRAL APPROACH

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

The RIS 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.

For stage 1 of the pilot, the self-referral service solely provided people with a virtual appointment, either by telephone or video, to assess their symptoms and needs. People were then either offered advice, guidance, and safety netting to manage their symptoms or, where clinically indicated, were either provided with a GP appointment or referred into breast clinic on a fast-track urgent suspected cancer (previously two-week wait) pathway at their local hospital.

For stage 2 of the pilot (23/24 onwards), an additional PCN was added to the included cohort (Andover), and two breast advanced nurse practitioners were recruited to run the clinics using an integrated approach to workforce between the RIS and HHFT. A face-to-face nurse-led community clinic was also introduced in addition to the virtual clinics, providing the opportunity for physical assessment for those patients who are not confident or able to perform self-examination, along with completion of a basic family history assessment and symptom management advice.

SERVICE PURPOSE AND OBJECTIVES

The purpose of the breast self-referral initiative was to provide a service which allows patients to self-refer when they identify that they have, or may have, breast symptoms, enabling them to access information and onward management where appropriate. This provides an alternative option to the traditional route through making an appointment in 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

[1] *North & Mid Hants LDS- Dorset Insight and Intelligence Service, accessed May 2024.*

The service has delivered in response to the above:

- Direct self-referral access with the ability to refer onwards directly as to breast clinic on an urgent suspected cancer pathway
- Rapid turnaround 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
- Support with examination and assessment in a community setting where appropriate

CURRENT SERVICE MODEL

The 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.

The criteria for the self-referral pathway was developed in line with NG12 guidelines for suspected cancer recognition and referral. Following feedback received during phase 1 of the pilot, the exclusion criteria was adapted to ensure that the most suitable patients were referred via this pathway. Appropriate alternative pathways exist for those patients not meeting the eligibility criteria for self-referral. The updated exclusion criteria is outlined below:

Exclusion Criteria:

- People under 30
- People assigned male at birth- including cisgender males and transgender women
- People who are already under the care of a healthcare professional for their breast symptom(s)
- People who are pregnant or breastfeeding (or have breastfed within the last 3 months)
- People with signs of infection (where an urgent GP appointment is required)

The pathway developed for the initial stage 1 breast self-referral service is outlined in Figure 1 below. The follow-up pathway for stage 1 is outlined in Figure 2.

Figure1: Breast Self-Referral Pathway (stage 1)

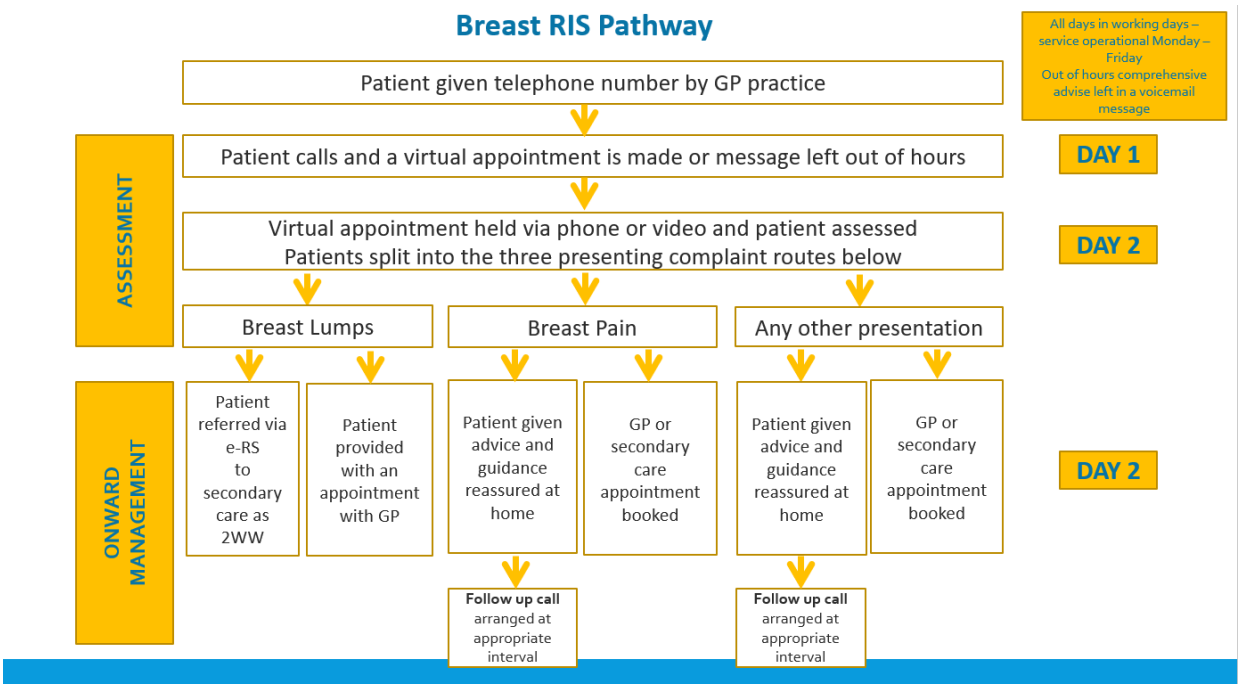
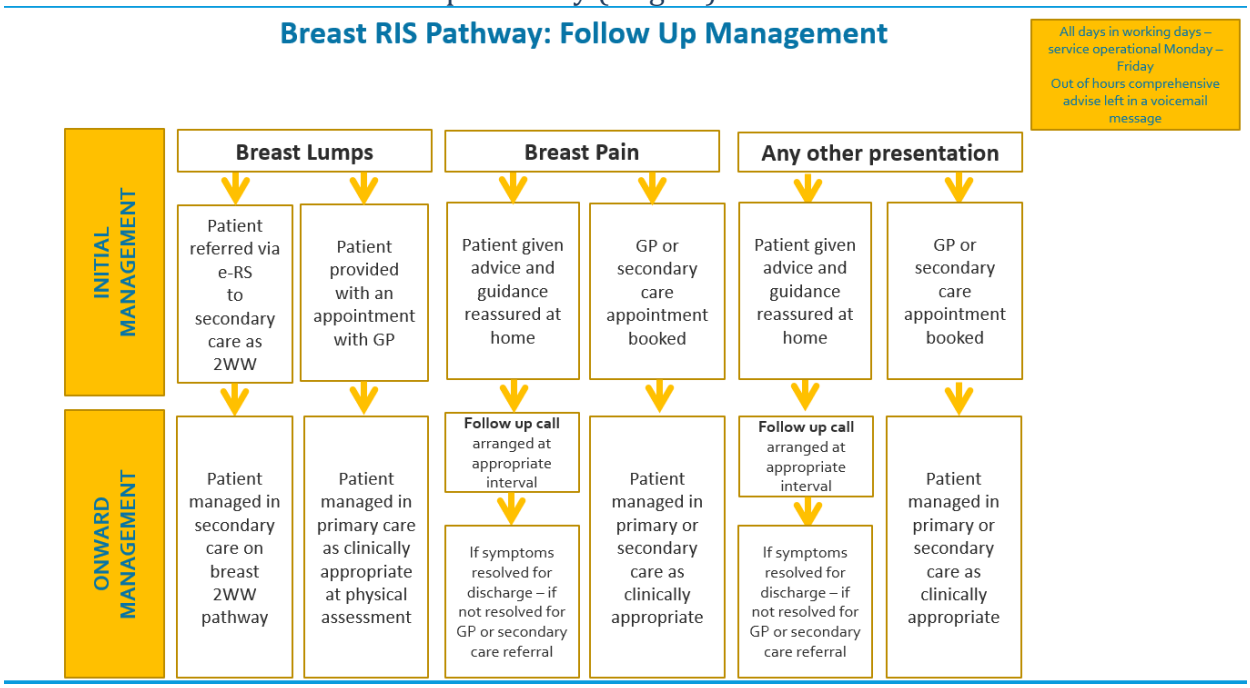


Figure 2: Breast Self-Referral Follow Up Pathway (stage 1)



Based on outcomes and feedback received during stage 1 of the pilot, the pathway was updated for stage 2. This included the introduction of a face-to-face clinic for symptoms and an integrated approach to workforce, as well as exploration of a digital method for referral. The updated pathway is outlined below in Figure 3 & 4, with the changes highlighted in yellow.

Figure 3: Updated Breast Self-referral pathway (stage 2)

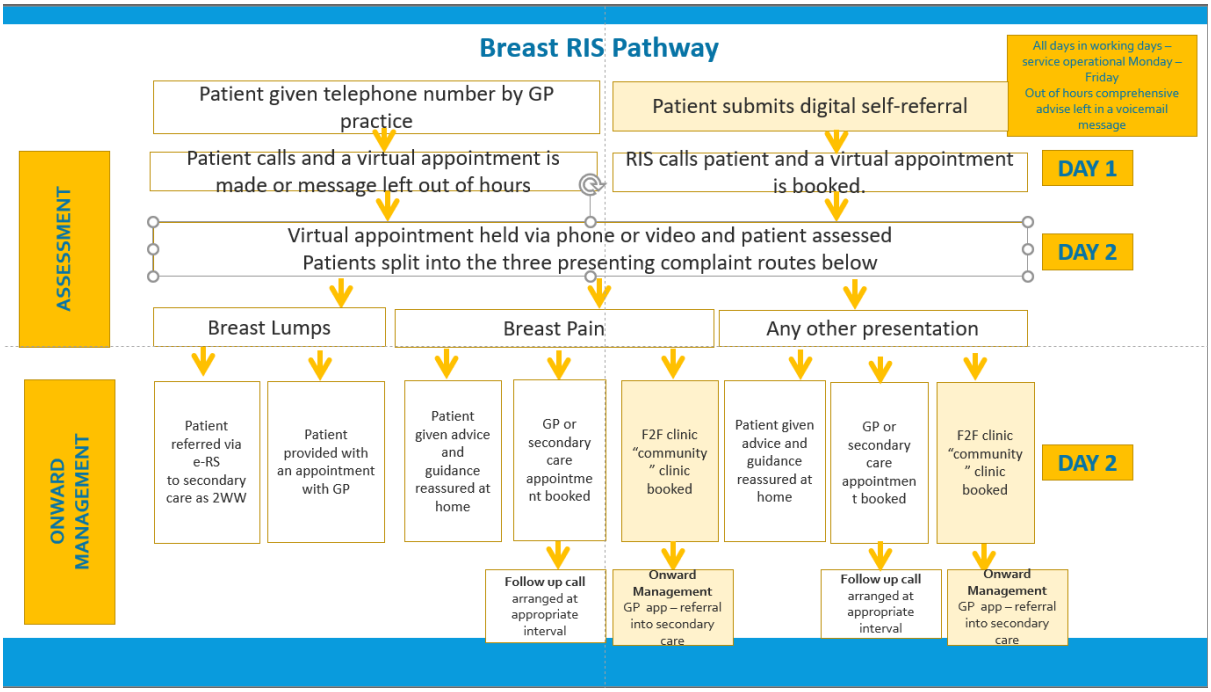
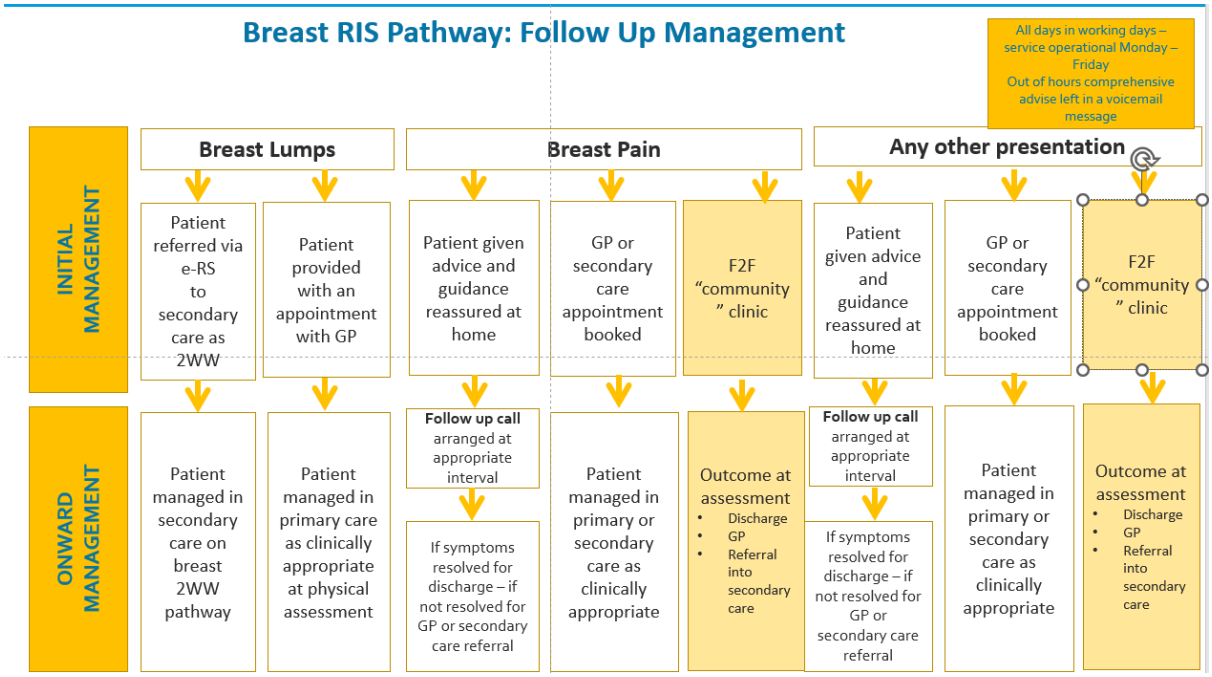


Figure 4: Updated breast self-referral follow up pathway (stage 2)



The self-referral service workforce for the pilot was made up of:

- Consultant oversight 0.5 PA weekly (providing project clinical leadership as well as service input)
- Band 7 Trainee Advanced Nurse Practitioners- progressing to Band 8a post-training (x2)
- Band 8a Operational Manager

- Band 6 Deputy Operational Manager
- Band 5 Patient Navigator
- Band 4 Support Navigator
- Band 3 Administrative Support

Primary care oversight is also provided by a Wessex Cancer Alliance GP. To note all operational/ administrative posts have dual roles, also delivering the non-specific symptoms service pathway. 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.

ACTIVITY AND OUTCOMES

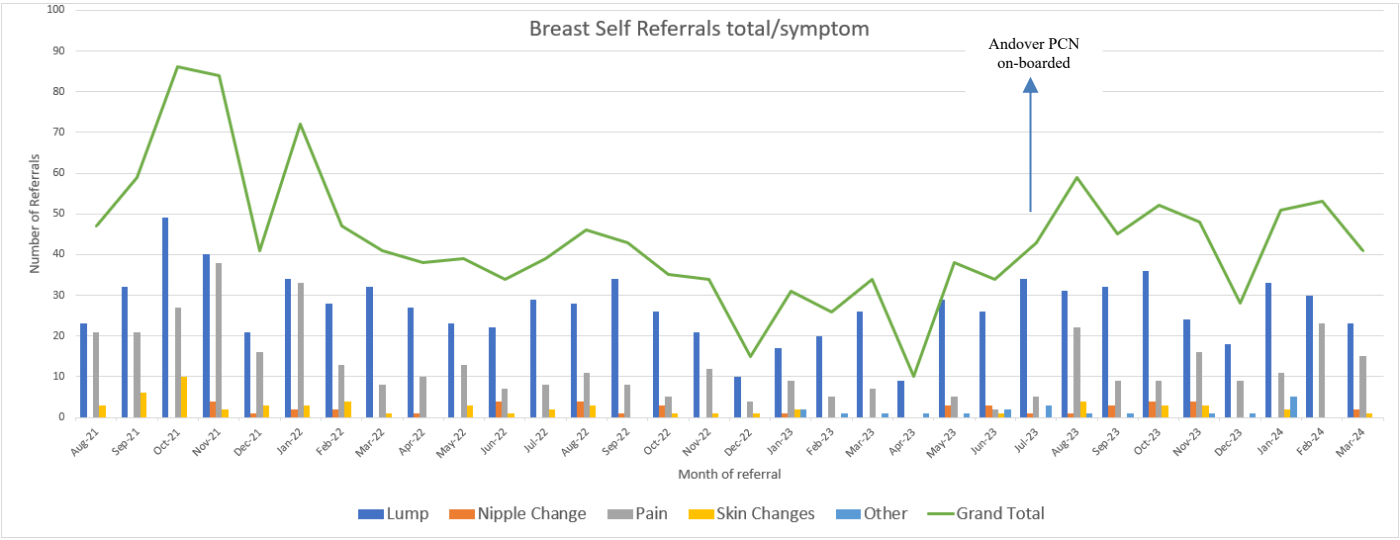
Referral Numbers & Outcomes:

1393 self-referrals were received in total by the service from August 2021 to end of March 2024.

Presenting complaints (patient reported symptoms):

- Lump: 867 (62.2%)
- Pain: 402 (28.8%)
- Skin change: 60 (4.3%)
- Nipple change: 44 (3.2%)
- Other: 20 (1.4%)

Figure 5: Overview of breast self-referrals received



An overall summary of the outcomes recorded for the self-referral pilot is outlined below.

Phase 1 (Aug 21-Mar 23):

- Discharge: 103 (11.7%)

- GP appointment: 283 (32.1%)
- HHFT referral: 493 (56%)
- Self-discharge: 0 (0%)
- Did not attend: 2 (0.2%)

Phase 2 (Apr 23-Mar 24):

- Discharge: 123 (24.6%)
- GP appointment: 24 (4.8%)
- HHFT referral: 341 (68.1%)
- Self-discharge: 3 (0.5%)
- Did not attend: 10 (2%)

From the introduction of specialist ANPs running the clinic in phase 2 of the pilot, the number of patients being discharged to self-management increased significantly (+11.3% change from phase 1 to phase 2) and the number of patients being booked into an appointment with their GP also decreased significantly (-27.6% change from phase 1 to phase 2). This has demonstrated the positive impact of having experienced clinicians running the clinics.

Management of lump presentations

Figure 6: Overview of outcomes for lump presentations

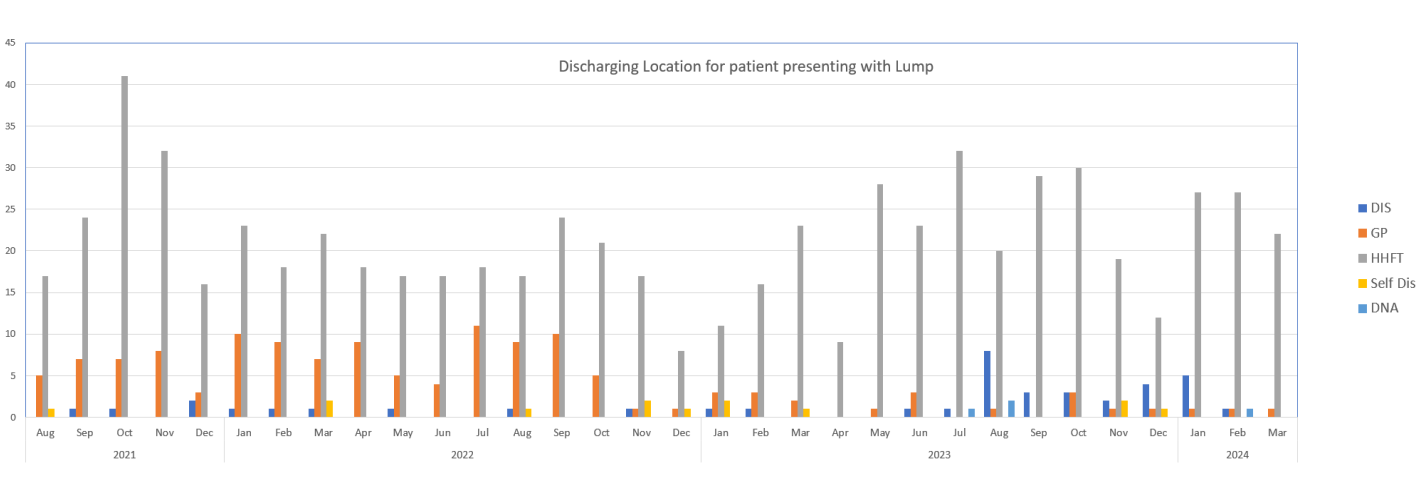


Figure 6 demonstrates that the majority of patients presenting with lumps are referred on HHFT via a fast-track urgent suspected cancer referral, in line with NICE guidance. It is noted that from the introduction of the specialist breast ANPS in phase 2 of the pilot, the number of patients being discharged in this cohort increased and the number of patients referred for a GP appointment decreased, which again supports the benefits of having experienced staff running the clinics.

Overall for the pilot period, 78% of patients with breast lumps were referred in to secondary care, with 15% being booked an appointment with their GP. The number of patients with lumps referred to GP decreased to 4% in phase 2 of the pilot with input from specialist ANPS, and the number of patients referred directly into secondary care increased to 86%. Despite this, the cancer conversion rate improved from 2021 to 2023.

Management of pain presentations

Figure 7: Overview of outcomes for pain presentations

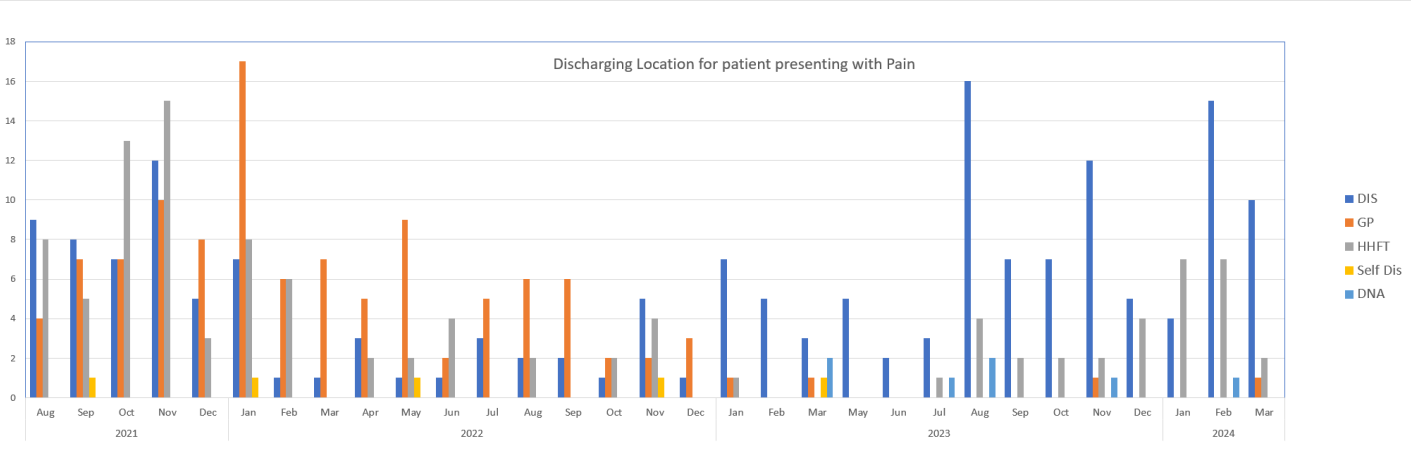


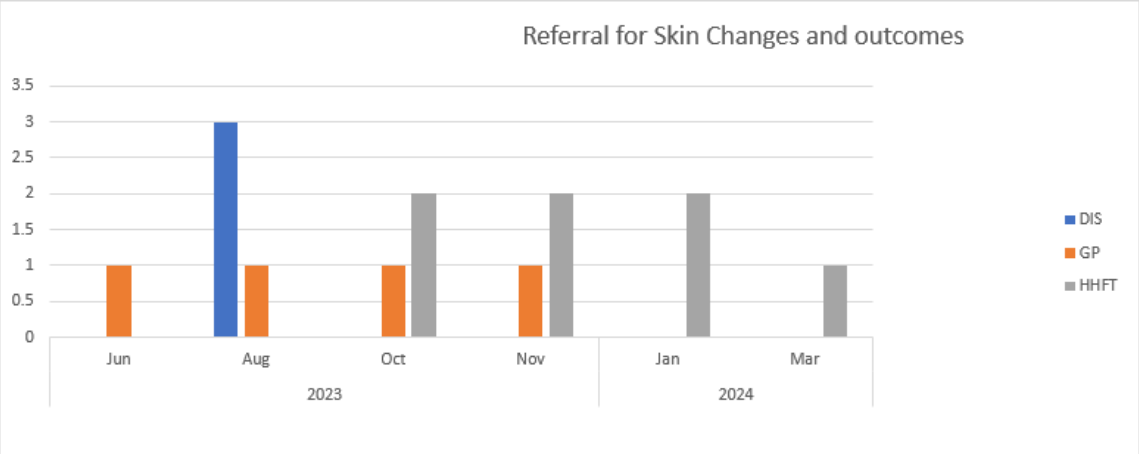
Figure 7 demonstrates that for phase 1 of the pilot when the clinics were being run by the RIS nursing team, a high number of patients presenting with pain were being booked an appointment with their GP. However, from the introduction of the specialist ANPs in phase 2 of the project, there was a significant increase in patients presenting with pain being discharged to self-management, which reaffirms the benefits of having experienced staff running the clinics. For phase 1 of the pilot, 27% of breast pain patients (62/228) were given advice and self-managed. For phase 2 with the introduction of the ANPs this increased to 69% of pain patients being given advice and discharged to self-management.

For phase 2 of the pilot (Apr 23-Mar 24) the service reviewed 126 patients presenting with breast pain. 91 of these patients were managed via virtual triage: 21 were referred to secondary care clinic, 2 were booked an appointment with their GP, 3 did not attend or cancelled, and 60 were discharged to self-management. 41 patients were seen in the community clinic: 10 were referred to secondary care clinic (HHFT), 3 did not attend, and 28 were discharged to self-management. Out of these patients, 6 were reviewed both virtually and face-to-face in the community clinics (4 were discharged to self-management and 2 were referred to secondary care). Overall during phase 2, 60 patients presenting with breast pain (47.6%) were managed completely virtually without the need for any imaging or having an appointment with either a GP or secondary care.

Overall, across the full pilot period 43% of patients presenting with breast pain were discharged to self-management (69% for phase 2). This has demonstrated the potential of the pathway to deliver both cost efficiencies and improved patient experience for this cohort. Overall, our evaluation has demonstrated that the majority of patients presenting with breast pain only can be safely self-managed without the need for an appointment with either their GP or secondary care.

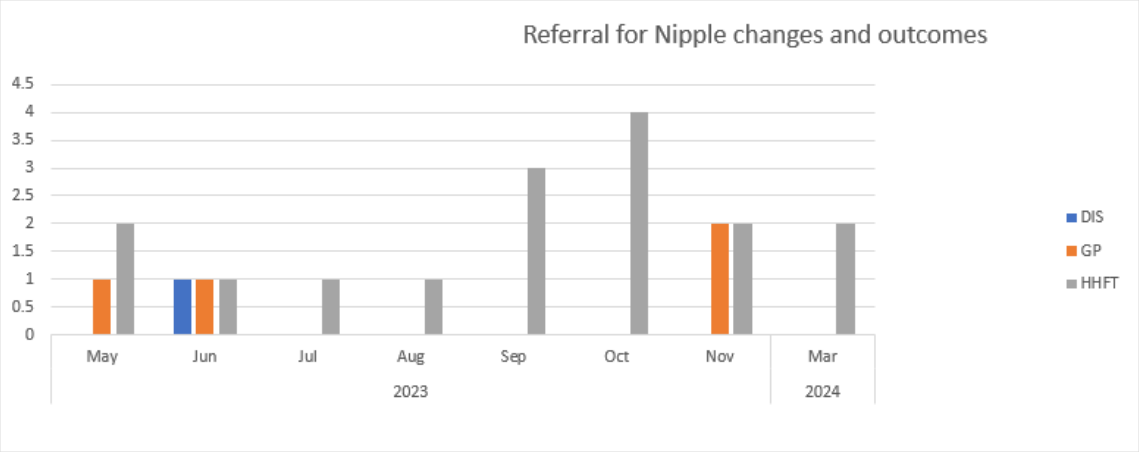
Management of other presentations

Figure 8: Overview of outcomes for skin changes



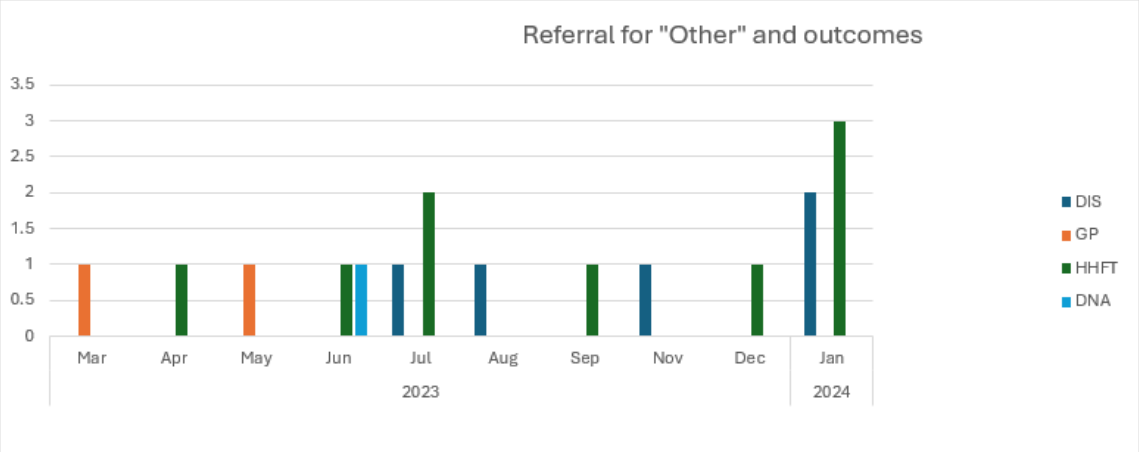
During the full pilot period 14 patients were reviewed for breast skin changes. 3 were discharged to self-management, 4 were booked an appointment with their GP, and 7 were referred to the HHFT clinic.

Figure 9: Overview of outcomes for nipple changes



During the full pilot period 21 patients were reviewed for nipple changes. 1 was discharged to self-management, 4 were booked an appointment with their GP, and 16 were referred to the HHFT clinic.

Figure 10: Overview of outcomes for all other outcomes

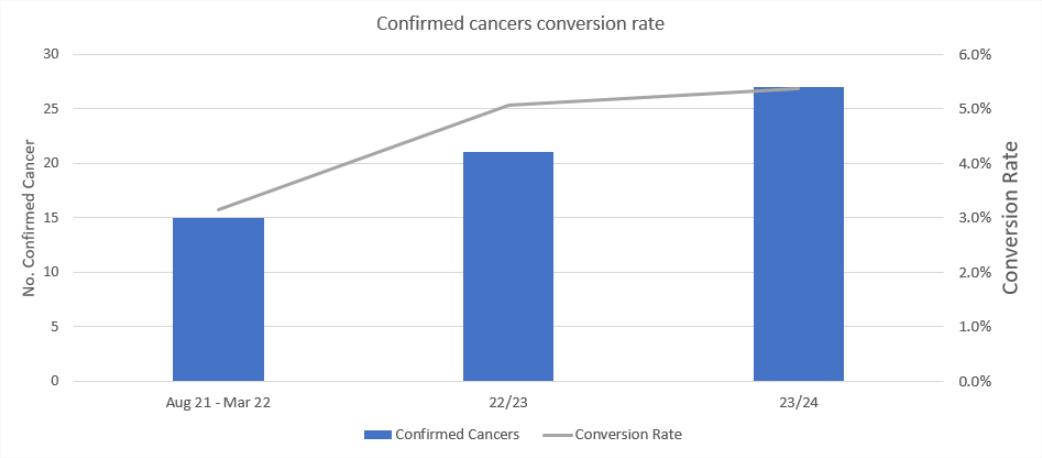


During the full pilot period 17 patients were reviewed for other breast symptoms. 5 were discharged to self-management, 2 were booked an appointment with their GP, 9 were referred to the HHFT clinic and 1 did not attend.

Overall for this cohort of 52 patients, 9 patients (17%) were discharged to self-management, 10 patients (19%) were booked an appointment with their GP, and 32 patients (62%) were referred to HHFT, suggesting that patients presenting with these symptoms may be better managed face-to-face rather than a virtual assessment service.

Cancer Diagnoses and Conversion Rate

Figure 11: Conversion rates for self-referral pilot



Overall from the pilot, 55 people were diagnosed with cancer following RIS referral to secondary care, giving a conversion rate of 3.9% from all referrals into the service. 51 cancers were diagnosed in those with an initial self-reported symptom of a lump (5.9% conversion), 2 with pain (0.5% conversion rate), 1 with nipple changes (2.3% conversion rate) and 1 with other breast symptoms (5% conversion rate).

Out of the patients referred for a GP appointment following triage, 8 were diagnosed with cancer following subsequent referral to secondary care. 5 patients were those with an initial self-reported symptom of a lump, 1 with pain and 2 with skin changes.

Of those referred to the HHFT one stop clinic, cancer conversion rate for this pathway has improved from 3% in phase 1 to 5.4% in phase 2 with increased clinician knowledge and experience. This correlates well with the breast national average GP referral conversion rate, which was 5.7% in 2021 (GIRFT). For comparison the overall conversion rate for the breast pathway at Hampshire Hospitals for April to November 2021 was 4.2% against 4612 referrals. Please see the clinical report at **Appendix 1** where this information is referenced.

To date no cancers were missed through use of a self-referral approach to triage. One patient presented with a lump but saw her GP prior to triage call, was examined and reassured, and four months later a cancer was detected incidentally on CT scanning. Another patient was diagnosed with cancer who was discharged from virtual triage and then four months later presented in the independent sector with a lump. At the point of virtual triage she had breast pain but was not sure whether she had a lump or not and so a follow-up call was made two weeks after the original virtual appointment when she reported that all of the issues had resolved. She did not come back through the NHS.

49 of 1393 (3.5%) cases have returned to their GP since their discharge from the pilot, with 19 cases referred on to secondary care via the urgent suspected cancer pathway. No cancers were found in that cohort, with only one benign biopsy and five cases referred onto the family history pathway.

Time Lapse Referral to Appointment

Data has been pulled to identify how long people were 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 initial period of the pilot, August 2021 to February 2022, patients received their first appointment 1.15 days following their self-referral call. 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.

For the overall pilot (stage 1 and 2 combined) from August 2021 to March 2024, the average wait for first appointment was 2.1 days. It is noted that between November 2022 and March 2023 there were notable staff shortages within the RIS which impacted on turnaround times during this period, with average turnaround times during that period increasing to 3.84 days.

COMMUNITY CLINICS

Stage 2 of the pilot saw the introduction of nurse-led community clinics, with the recruitment of 2 trainee advanced breast nurse practitioners who have led on both the virtual triage and community clinic elements of the pathway from March 2023 onwards. The community clinics were introduced following feedback received during phase 1 of the pilot, with the aim to provide opportunity to examine patients who were not able to do this for themselves, with this cohort previously having to be booked into an appointment at their GP surgery post-triage. The anticipated impact was therefore that less patients would require a GP examination for stage 2 of the pilot. Out of 63 RIS self-referral patients reviewed in the community clinics in 23/24, 62.1**%** (41 patients) were immediately discharged without requiring further assessment by their GP or secondary care. Of those who required follow-up, 100% (21 patients) were discharged following further assessment.

In addition to the RIS self-referral patients, HHFT mastalgia patients (who were referred with breast pain as their only symptom) were also sent to the community clinics instead of the one stop clinic, following appropriate clinical triage on receipt of referral into secondary care. Out of a total of 313 HHFT patients seen in the community clinics, 73.9**%** (241 patients) were discharged immediately after nurse-led assessment.

2 clinic sessions were run per week, with capacity for 8 patients per session. In order to offer the patients a choice of location and day, one session was run from Andover Health Hub in the morning and the other was run from Basingstoke Hospital in the afternoon. A full overview of the outcomes from these clinics is outlined in Figure 12 below.

Figure 12: Community clinic outcomes summary table

Community clinic outcomes (Mar 23-Mar 24)	**RIS (self-referral)**	**HHFT (mastalgia)**	**Totals**	**Overall %**
Total patients attended	63	313	376	96%
Total DNA	3 (4.5%)	13 (3.9%)	16	4%
Immediate discharge	41 (62.1%)	241 (73.9%)	282	72%
Further OPA	21 (31.3%)	44 (13.5%)	65	17%

Discharge to PIFU	0 (0%)	8 (2.4%)	9	2%
Further imaging only	1 (4.7%)	20 (6.1%)	21	5%
Discharged at further OPA	*21 (100%)*	*44 (100%)*	*65*	*100%*

The evaluation of these clinics has shown that most patients with breast pain as their only symptom do not require review in a triple assessment clinic and can be discharged immediately after nurse-led review. Of those who did require further assessment, all were discharged after follow-up or further imaging. This demonstrates the impact of this clinical model both in terms of clinical effectiveness and cost efficiencies, with these patients not needing to go on to have additional investigations in a consultant led clinic with associated radiological work-up.

IMPACT ON REFERRALS

An overview of breast urgent suspected cancer and symptomatic referral numbers for HHFT is outlined in Figure 13 below. This data shows a clear upward trend in breast USC referrals and a slight downward trend in symptomatic referrals. Figure 14 shows the overall referral trend of breast referrals via a statistical process control (SPC) chart as a comparison.

Figure 13: HHFT breast and symptomatic referrals trends

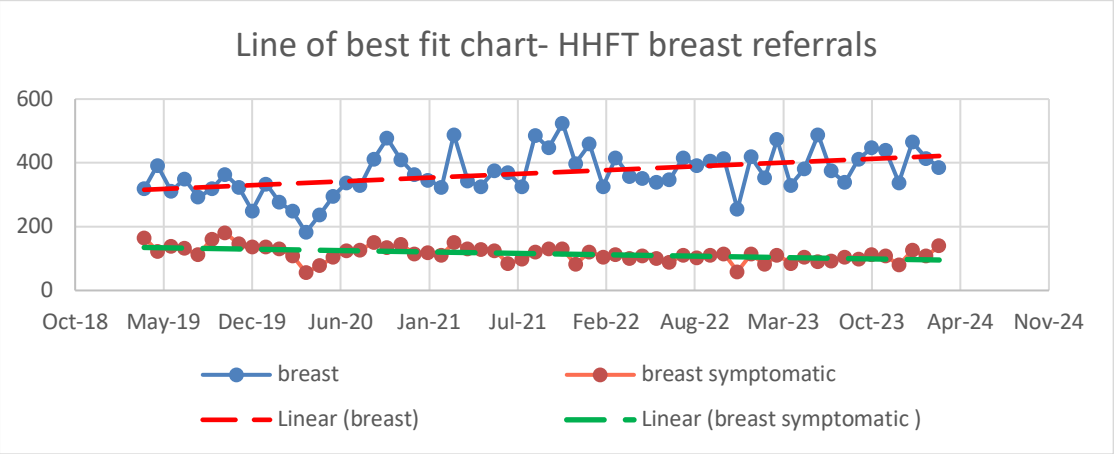
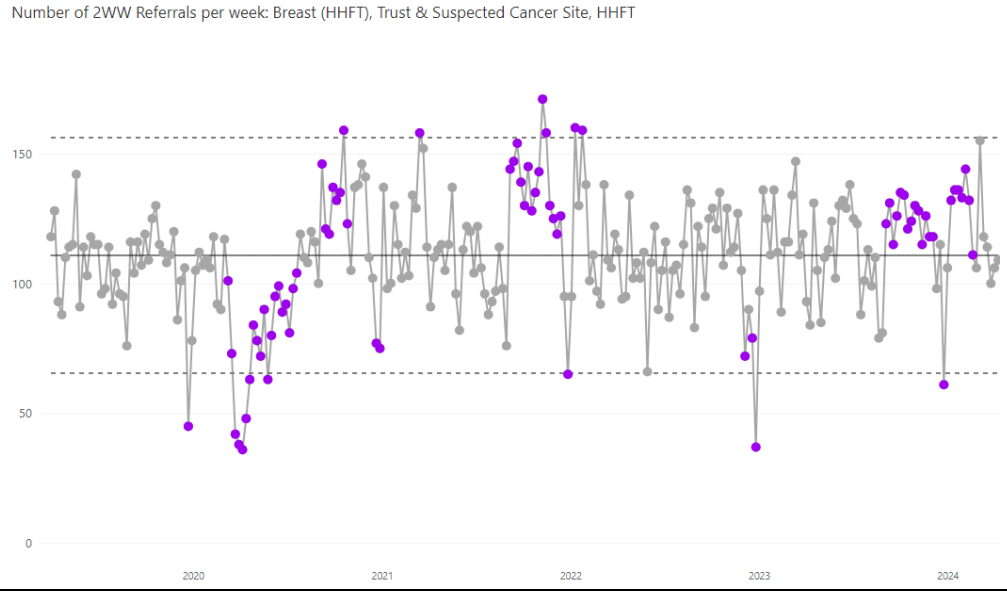


Figure 14: HHFT breast referrals SPC



Given the extreme peak of referrals seen in October and November of 2021 it is very challenging to quantify and determine whether a reduction of referrals has been seen as a result of our pilot, as we have no baseline data for number of patients seen with a breast presentation in primary care prior to the impact of the COVID-19 pandemic. It is acknowledged that data reliability, particularly in terms of the recording of breast symptomatic referrals prior to 2022, has led to difficulty in being able to demonstrate any clear impact on referral rates from this pilot. **Appendix 2** shows the local and national data we have been able to source for the two pathway routes in our area.

The data provided below in Figure 15 outlines the percentage change in HHFT breast USC and breast symptomatic referrals based on data submitted in Somerset Cancer Register (SCR), provided by the Dorset Insight and Intelligence Service (DiiS).

Figure 15: HHFT breast referrals (all PCNs)

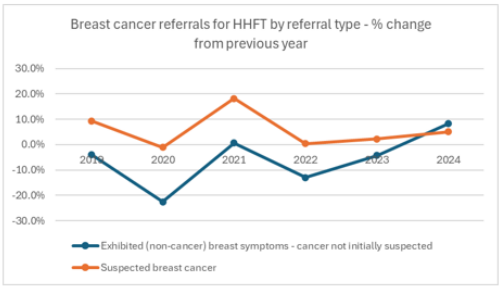
Insights – HHFT – All PCNs

NHS Wessex Cancer Alliance

A total of 47,701 breast cancer referrals have been made to HHFT between 2018 to 2024.

Between 2021 and 2024 there has been an overall increase in referrals by 4%; during this period referrals under suspected breast cancer increasing by 8% but exhibited (non-cancer) breast symptoms reducing by nearly 10%.

Year on year comparison referral rates to HHFT have fluctuated, with reductions in 2020 and 2022, increases in referrals in the last 2 years.



Total referrals By Referral type	Ref Year: 2018	2019	2020	2021	2022	2023	2024	Grand Total
Exhibited (non-cancer) breast symptoms - cancer not initially suspected	1866	1794	1390	1399	1217	1166	1262	10558
Suspected breast cancer	4120	4504	4459	5271	5290	5410	5687	37129
Other		2		8	1	1	1	14
Grand Total	5986	6300	5849	6678	6508	6577	6950	47701

Previous year % change: By Referral type	2019	2020	2021	2022	2023	2024
Exhibited (non-cancer) breast symptoms - cancer not initially suspected	-3.9%	-22.5%	0.6%	-13.0%	-4.2%	8.2%
Suspected breast cancer	9.3%	-1.0%	18.2%	0.4%	2.3%	5.1%
Other	-	-100.0%	-	-87.5%	0.0%	0.0%
Grand Total	5.2%	-7.2%	14.2%	-2.5%	1.1%	5.7%

% Change Year: By Referral type	2018 to 2024	2021 to 2024
Exhibited (non-cancer) breast symptoms - cancer not initially suspected	-32.4%	-9.8%
Suspected breast cancer	38.0%	7.9%
Other	-	-87.5%
Grand Total	16.1%	4.1%

Data source: Somerset Cancer Register – Breast Referrals.

Whilst not conclusive on its own, this data does suggest that this pilot may gave had an impact on reducing the number of breast symptomatic referrals into HHFT, by removing those with breast pain from requiring review under a secondary care pathway.

PCN referral data

The monthly trend in breast referrals into HHFT split by PCN are given below in Figure 16, with the 3 PCNs included in the pilot highlighted. Please note that these figures include both GP referrals and onward referrals into secondary care made by the RIS. This should be read in conjunction with the information included above looking at proportionate split on onward management destinations for each symptom.

Figure 16: Breast referrals into HHFT – by PCN

Insights – HHFT Referrals (USC and symptomatic combined) – All PCNs

NHS Wessex Cancer Alliance

The tables below show the number of referrals per year to HHFT, increase or decrease from previous year and overall increase or decrease since 2018 and 2021 to 2024, by PCN.

Total Referrals	Ref Year:							
PCN	2018	2019	2020	2021	2022	2023	2024	Grand Total
UNKNOWN	864	775	713	853	760	721	701	5387
Andover PCN	677	674	647	710	654	780	762	4904
Winchester City PCN	611	661	675	635	610	667	716	4575
Winchester Rural North & East PCN	621	592	500	587	614	537	658	4109
Mosaic Healthcare PCN	513	523	548	615	682	569	634	4084
Winchester Rural South PCN	505	561	488	562	605	600	655	3976
Whitewater Loddon PCN	432	478	448	519	622	581	564	3644
Rural West PCN	367	394	395	453	365	405	436	2815
A31 Group PCN	335	350	376	387	351	453	360	2612
Camrose, Gillies & Hackwood Partnership PCN	244	389	293	390	385	431	459	2591
Chandler's Ford PCN	296	326	303	416	367	337	408	2453
Eastleigh Health PCN	246	322	298	321	343	346	432	2308
Unallocated	129	132	63	75	49	25	21	494
East Hants PCN	72	41	37	62	36	31	57	336
Romsey & North Baddesley PCN	33	39	37	30	20	32	22	213
Other PCN <100	41	41	28	55	44	61	64	334
Grand Total	**5986**	**6298**	**5849**	**6670**	**6507**	**6576**	**6949**	**44835**

	Previous year % change:					
PCN	2019	2020	2021	2022	2023	2024
UNKNOWN	-10.3%	-8.0%	19.6%	-10.9%	-5.1%	-2.8%
Andover PCN	-0.4%	-4.0%	9.7%	-7.9%	19.3%	-2.3%
Winchester City PCN	8.2%	2.1%	-5.9%	-3.9%	9.3%	7.3%
Winchester Rural North & East PCN	-4.7%	-15.5%	17.4%	4.6%	-12.5%	22.5%
Mosaic Healthcare PCN	1.9%	4.8%	12.2%	10.9%	-16.6%	11.4%
Winchester Rural South PCN	11.1%	-13.0%	15.2%	7.7%	-0.8%	9.2%
Whitewater Loddon PCN	10.6%	-6.3%	15.8%	19.8%	-6.6%	-2.9%
Rural West PCN	7.4%	0.3%	14.7%	-19.4%	11.0%	7.7%
A31 Group PCN	4.5%	7.4%	2.9%	-9.3%	29.1%	-20.5%
Camrose, Gillies & Hackwood Partnership PCN	59.4%	-24.7%	33.1%	-1.3%	11.9%	6.5%
Chandler's Ford PCN	10.1%	-7.1%	37.3%	-11.8%	-8.2%	21.1%
Eastleigh Health PCN	30.9%	-7.5%	7.7%	6.9%	0.9%	24.9%
Unallocated	2.3%	-52.3%	19.0%	-34.7%	-49.0%	-16.0%
East Hants PCN	-43.1%	-9.8%	67.6%	-41.9%	-13.9%	83.9%
Romsey & North Baddesley PCN	18.2%	-5.1%	-18.9%	-33.3%	60.0%	-31.3%
Other PCN <100	0.0%	-31.7%	96.4%	-20.0%	38.6%	4.9%
Grand Total	**5.2%**	**-7.1%**	**14.0%**	**-2.4%**	**1.1%**	**5.7%**

	% Change Year:	
PCN	2018 to 2024	2021 to 2024
UNKNOWN	-18.9%	-17.8%
Andover PCN	12.6%	7.3%
Winchester City PCN	17.2%	12.8%
Winchester Rural North & East PCN	6.0%	12.1%
Mosaic Healthcare PCN	23.6%	3.1%
Winchester Rural South PCN	29.7%	16.5%
Whitewater Loddon PCN	30.6%	8.7%
Rural West PCN	18.8%	-3.8%
A31 Group PCN	7.5%	-7.0%
Camrose, Gillies & Hackwood Partnership PCN	88.1%	17.7%
Chandler's Ford PCN	37.8%	-1.9%
Eastleigh Health PCN	75.6%	34.6%
Unallocated	-83.7%	-72.0%
East Hants PCN	-20.8%	-8.1%
Romsey & North Baddesley PCN	-33.3%	-26.7%
Other PCN <100	56.1%	16.4%
Grand Total	**16.1%**	**4.2%**

Data source: Somerset Cancer Register – Breast Referrals.

Whilst there is not a significant impact seen in terms of a reduction in referral numbers into secondary care from the 3 pilot PCNs, it is important to note that overall numbers per PCN are small and the majority of patients presenting via the self-referral pathway were those with lumps who would have been referred directly onto secondary care post-triage, and these patients would still be included within these figures. This should also be considered in the context of seeing an annual increase in breast USC referrals both locally and nationally.

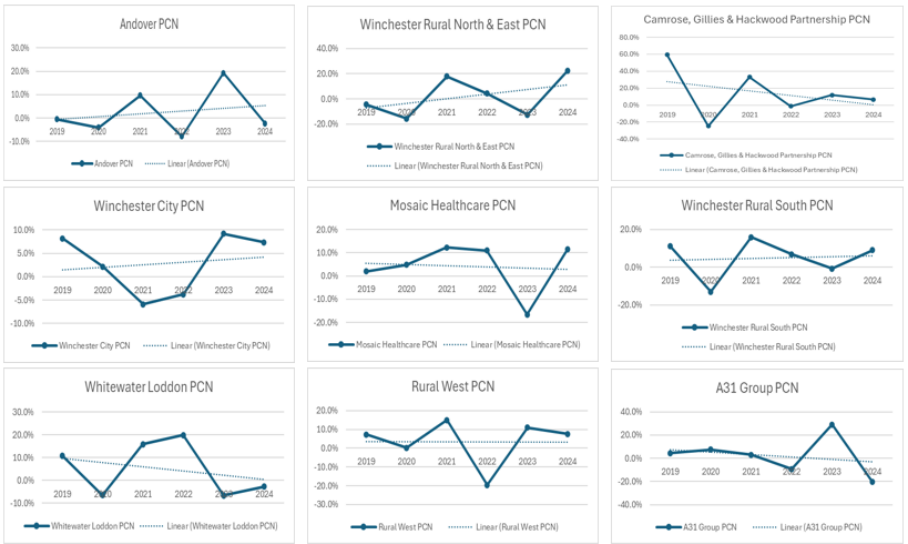
An overview of the percentage change in breast referrals (USC and symptomatic combined) into HHFT, split by PCN, is outlined below in Figure 17 for 2018-2024 (pre-covid), and 2021-2024 (post-covid and post launch of the pilot).

Figure 17: PCN Breast Referral trends (HHFT only)

Insights – HHFT – Mid & North Hampshire PCNs Charts

NHS Wessex Cancer Alliance

	Previous year % change:	
PCN	2018 to 2024	2021 to 2024
Andover PCN	12.6%	7.3%
Winchester City PCN	17.2%	12.8%
Mosaic Healthcare PCN	23.6%	3.1%
Winchester Rural North & East PCN	6.0%	11.7%
Winchester Rural South PCN	29.7%	15.7%
Whitewater Loddon PCN	30.8%	8.9%
Rural West PCN	18.8%	-4.0%
Camrose, Gillies & Hackwood Partnership PCN	88.1%	17.7%
A31 Group PCN	7.5%	-7.0%
Grand Total	**22.2%**	**7.9%**



Data source: Somerset Cancer Register – Breast Referrals.

Overall breast referrals to HHFT by PCNs in the Mid and North Hampshire locality have increased by 22.6% from 2018 to 2024. During the Covid period, referrals dropped by 5.4%, but since 2021, referrals have continued to grow at a steadier pace, with an 8.6% increase from 2021 to 2024.

Camrose, Gillies & Hackwood Partnership PCN has seen a significant increase of 88.1% in referrals from 2018 to 2024, with the greatest increase in referrals in 2021 by 33.1% compared to the previous year. Referrals have continued higher than others in subsequent years. Whitewater Loddon PCN and Winchester Rural South PCN also showed increasing referrals by 30.6% and 29.7% respectively over the same period, with continued growth in more recent years. Andover PCN has one of the highest number of referrals, and continues to see growth in referrals across the 2018 to 2024 period. Winchester Rural North & East PCN saw only a modest 6.0% increase in referrals from 2018 to 2024, since 2021 the rate of increase in referrals has picked up to 12.1%. Winchester City PCN has also seen significant growth in referrals from 2018 to 2024. Notably, the growth has remained higher compared to other PCNs, with continued increases in recent years. Rural West PCN and A31 Group PCN have both seen a reduction in referrals since 2021 to 2024. The full data pack with further information can be found in **Appendix 2**.

Population coverage

Another way to look at potential impact on referrals is to calculate the percentage of referrals from participating practices compared to those that were not participating as a proportion of the total population, as outlined in the table below.

	Population of DGH catchment (%)[2]	Total of USC referrals 2024 (%)[3]
Included PCNs	164131 (32%)	2085 (26%)
Excluded PCNs	352117 (68%)	6068 (74%)

This data would suggest fewer referrals from participating practices compared to those not included in the pilot. To note, this data includes referrals to other providers not just HHFT, and patients that attended via the virtual triage and were then subsequently referred on to one-stop or mastalgia services were recorded as an USC referral from their GP within secondary care and are also included within these figures.

Overall

Whilst we have tried to determine the effect of the project on the number of patients referred on the breast pathway to secondary care, this has been difficult to fully evaluate because of the lingering effect of the pandemic in the early phases of the project and issues with data quality. There is also a significant geographical overlap in patients referred by our PCNs to alternative providers who do not have a self-referral route which may impact on uptake, and numbers overall as a percentage of the total population remain small.

Patients referred through the virtual pathway to the one stop service were recorded as if a usual primary care referral so it has not been possible to separate out those who self-referred and those referred following a GP review in this data. The pandemic altered referral numbers, with a reduction and subsequent bounce in 2020 and 2021 respectively. Cancer diagnoses were predicted to peak in 2023/24 as a result of the pandemic effect. There are year on year increases in breast cancer referrals and diagnoses with increasing age, number and unfitness (particularly obesity) in the population.

[2] Data sources:
https://app.powerbi.com/view?r=eyJrIjoiNGZhOTc3ZGQtNmUwOS00M2M3LWFlZTItZjliMzNlYjExNmM5IiwidCI6IjM3YzM1NGIyLTg1YjAtNDdmNS1iMjIyLTA3YjQ4ZDc3NGVlMyJ9
https://app.powerbi.com/view?r=eyJrIjoiNGZhOTc3ZGQtNmUwOS00M2M3LWFlZTItZjliMzNlYjExNmM5IiwidCI6IjM3YzM1NGIyLTg1YjAtNDdmNS1iMjIyLTA3YjQ4ZDc3NGVlMyJ9
(Accessed 8/4/25)

[3] DiiS- accessed 8/4/25

PCN populations are not static with population changes more common in some areas than others. Our pilot city practice (CGH) has a large population of mobile, young patients and a large expanse of new homes built. This practice has also experienced significant staffing changes and increasing use of non-doctor clinicians and locum GPs. Due to changes in PCN funding, increased numbers of non-doctor clinicians are employed in primary care. While we strongly support the use of appropriately trained clinicians in NHS clinical roles, we suspect that many of these individuals are unlikely to have the training, mentorship and expertise of GP trainees and thus the threshold for secondary care referral is low which has impacted on secondary care demand. Collective community knowledge of the management of breast pain symptoms outside of the traditional one-stop service should further reduce requests for referrals.

For all PCNs in the catchment, the participating 32% of the population referred 26% of the HHFT USC breast one stop patients. Non-participating practices cover 68% population and refer 74% of the USC patients. This suggests a reduction in referrals of 6% correlating with the calculations above.

AUDIT

Primary Care Staff Feedback

GPs from the 7 practices participating in the first phase of 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 has been underway from January 2023 to scope options to enable this as a referral route. Due to existing restrictions with local IT systems and company policies around use of robotic process automation, development for this has currently been paused, but we aim to revisit this again if the pathway is expanded.

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 has been shared as a suggestion with secondary care colleagues.

Primary Care Audit of Referrals

Stage 1 audit summary

For phase 1 of the pilot, 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 the be referred to secondary care. 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 on an urgent suspected cancer pathway. 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 into secondary care by the practice after being seen and one was reassured by the practice. Referencing back to stage 1 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 were that those presenting with skin changes could be excluded from the self-referral service as limited value is added by their self-referral appointment.

Stage 2 audit summary

A further audit sample of 106 patients was scrutinised for stage 2 of the pilot. This sample looked at patients from two PCNs who had initially contacted the service between April and August 2023. Again, practices were asked to review how many people had contacted their GP after discharge from the service and how many went on to have a fast-track urgent suspected cancer referral following their GP presentation.

Out of 106 people audited, 11 patients had been in contact with their GP after discharge from the service. 6 of these patients had a GP appointment booked for them by the service as their onward management route. Of the remaining 5 patients, 1 had self-discharged from the self-referral pathway (choosing to see their GP instead of having a virtual assessment) and 1 had a six-week follow-up planned with the service but contacted their GP in the interim (this was not declared to the service by the patient at their 6-week review).

The final 3 patients who presented to their GP had been referred onto HHFT on a USC pathway by the service. 1 patient visited their GP one day prior to their virtual triage appointment with the service and did not declare this; this resulted in a duplicate referral to the HHFT breast team. 1 patient attended their GP with a small ribcage lump (different to the breast lump), with no onward referral made. 1 patient contacted their GP one week after their triage appointment as they were concerned they had not been seen by secondary care yet; the GP declined to make a further referral on the basis of duplication. None of the patients selected as part of the audit sample, at the time of audit, had contacted practices with repeat concerns about breast pain, or the self-referral service.

In total for this second audit, 7 patients were referred onto a USC pathway following presentation to their GP. 5 of these had a GP appointment booked for them by the service as their onward management route (4 with self-declared symptoms of lumps and 1 with skin changes). As mentioned above, 1 was a duplicate referral for a lump which was not declared by the patient, and 1 self-discharged from the RIS and was referred onto secondary care by their GP with breast pain as their self-declared symptom.

No missed cancers were identified as part of this audit. 2 of the patients sampled who re-presented to their GP went on to have a confirmed diagnosis of cancer. Both of these patients had a GP appointment booked for them by the service as their onward management route. One patient had a breast lump and required physical assessment due to possible symptoms of infection; their GP prescribed antibiotics for 1 week and then made a USC referral after symptoms did not improve. The second declared skin changes and were seen by their GP one day after triage where it was noted there were no clear lumps but that the breast felt different and therefore referred on to secondary care. This was noted to be a complicated presentation after a fall and therefore the service's decision to refer for GP review was appropriate. In both instances no delays were identified to the pathway as a result of the patient utilising the self-referral pathway, with both patients being reviewed by their GP within 4 days of their initial call to the service.

Overall for the full pilot period (stages 1 and 2), 8 patients who were booked GP appointments by the service as their onward management route went on to have a confirmed cancer diagnosis (as outlined above). No delays were identified as a result of the self-referral aspect of these 8 pathways that would have impacted on their onward management. All patients were seen by their GP within 0-4 days of their triage appointment with the service.

Secondary Care Audit – Referral Appropriateness

An audit has also been undertaken in secondary care by the pilot consultant lead to review appropriateness and effectiveness of the pilot service for phase 1 (Aug 21-Mar 23). The report can be seen in full in **Appendix 1**.

Key points to note are given below:

- Conversion rate was confirmed as in line with that seen nationally
- Some patients referred could potentially have been managed in primary care - 32 out of 119 (27%). As a result refinements were made to the triage criteria to lower this number based on audit findings for stage 2.

Ethnicity Break Down of People Self-Referring

A breakdown of ethnicity for all patients is provided for the full pilot period below in Figure 18.

This outlines that most patients presenting to the self-referral pathway were White British or White Other. 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). The demographic breakdown for North & Mid Hants is demonstrated in in Figure 19 below for comparison.

Figure 18: Ethnicity of breast self-referral patients

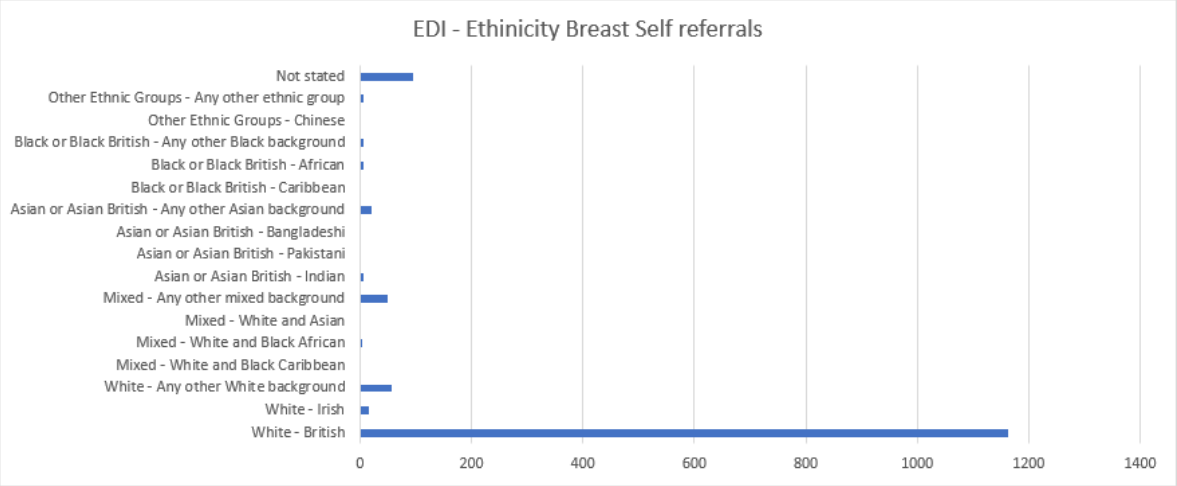
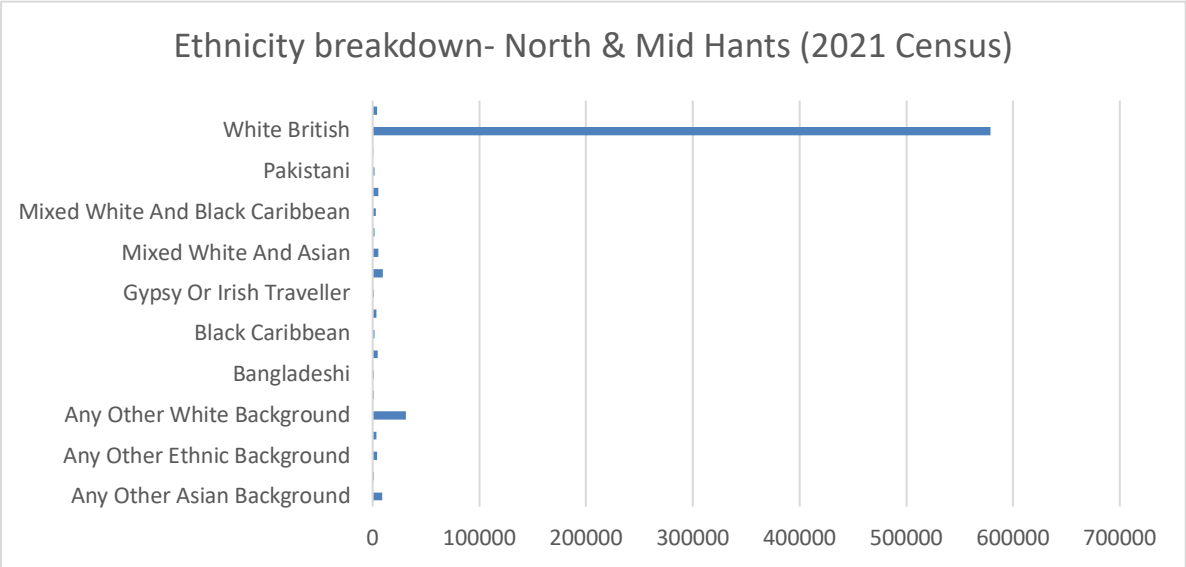


Figure 19: Ethnicity for North & Mid Hants (2021 census)



PATIENT FEEDBACK

Phase 1 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

29 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

National ASPIRE project patient feedback (stage 2)

For stage 2 of the pilot, the breast self-referral pathway was onboarded onto the ABS ASPIRE national breast pain project. As part of this, patient experience feedback was collected via an anonymous questionnaire from patients consenting to take part in the study.

20 breast self-referral patients responded to the survey between July 2023 and December 2023, with a summary of the feedback as follows:

- 100% of patients responded as 'very satisfied' with overall experience.
- Free text feedback box showed 10 positive, 1 negative, 2 neutral responses.
- The negative response related to an aspect of the administrative process and was investigated by the operational lead for the pilot. The neutral responses related to processes outside of our control, such as that of the postal service.

*Patient responses received to the question **"Please tell us what could have been done differently to make your appointment better",** taken directly as written from the ASPIRE Redcap system, demonstrate that patients had a positive overall experience:*

- Everything was done very well
- Absolutely nothing, it was such a reassuring experience. It was very quick for an appointment and given plenty of time to ask questions. I felt the nurse was very thorough in understanding my problem. And the advice was spot on, all quick resolved. Excellent reassuring that this wasn't something sinister. A fantastic platform for NHS to implement elsewhere.
- Nothing, everyone I spoke to was caring, helpful & professional. I felt listened to and given appropriate advice & reassurance
- Nothing, it was a brilliant service
- Nothing differently. My issues were covered efficiently and thoroughly. Very satisfied.
- Very happy with the care I was given, Thank you!
- efficient service - seen within a few days
- I really can't think of anything that would make it better. It was a prompt, efficient, informative and reassuring. Thank you

Local RIS feedback questionnaire

Alongside the ASPIRE survey, a local RIS patient feedback questionnaire was also available to patients who utilised the self-referral pathway. For phase 2 of the pilot we received 5 responses to this survey. Overall 4/5 patients rated the pathway as 'Excellent' and 1 patient rated their experience as 'Fair'. On review of the comments left on feedback rated 'fair', the patient's dissatisfaction appeared to be around not having access to imaging on the pathway.

A summary of the feedback received is outlined below.

How would you rate the self-referral breast pathway?

- *Excellent*
- *Excellent*
- *Fair*
- *Excellent*
- *Excellent*

How satisfied were you that your questions regarding breast pain were answered fully?

- *Very satisfied*
- *Very satisfied*
- *Somewhat dissatisfied*
- *Very satisfied*
- *Very satisfied*

How satisfied were you that your questions regarding family history were answered fully?

- *Very satisfied*
- *Very satisfied*
- *Somewhat dissatisfied*
- *Not applicable*
- *Very satisfied*

Were the breast team able to reduce any concerns or anxieties?

- *Yes, partially*
- *Yes, fully*
- *Yes, partially*

- *Yes, fully*
- *Yes, fully*

How satisfied were you with the outcome of your referral to the Rapid Investigation Service: Breast Self-Referral Service?

- *Very satisfied*
- *Very satisfied*
- *Somewhat dissatisfied*
- *Very satisfied*
- *Very satisfied*

Please add any further comments about your experience and feel free to include any further information about the questions mentioned above.

- *Very helpful and a very prompt response*
- *Really pleased with this service. I was contacted next day and referred for further investigation, whilst being reassured that it's most likely benign. Thank you for a wonderful service*
- *Good concept. Not helpful if lump is found. Delayed me going elsewhere with better action (ultrasound)*
- *Excellent, speedy service and very pleased with both people I spoke to, thank you*
- *Sylke was great at reassuring me at this early stage of appts. Thank you*

Summary

The patient feedback demonstrates that most people found the service efficient, reassuring and would recommend it to others. Based on the feedback received in phase 1, adaptations were made to the pathway for phase 2.

As part of any wider service roll out, there has also been 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 if it were to be rolled out further across the region. 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.
- The service has supported with evidencing the success of alternative management pathways for people with breast pain outside of the urgent suspected cancer pathway.

Issues

- The service adds the most value for those with a pain presentation. Those with either skin or nipples changes requiring primary or secondary care face to face appointments require further consideration if the pathway is to be rolled out further.

- The service is heavy on administrative burden and requires a digital solution to enable wider access to self-referral. Development of a digital tool is currently in progress.
- Due to the numbers of referrals received from a small population sample for the pilot, 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.
- The service works best by employing additional experienced clinicians who work as part of the breast MDT, to retain competencies, CPD, improve flexibility and cover and reduce attrition. This needs to be factored into any longer-term planning and business cases for retaining and expanding the service.

COST ANALYSIS

Cost assumptions

Based on standard NHS tariffs, the mean cost of the standard patient pathway with a GP appointment leading to an ERS referral to a one-stop clinic is £247.[4] For the 1393 patients involved in the self-referral triage pilot, this would equal a total cost of £344,071.

The cost of a specialist nurse-led virtual triage appointment is £52.[5] Assuming that the pattern of referrals & outcomes followed that of Phase 2 for all 1393 patients:

- 24.6% of patients were discharged following triage: 343 x £52 = £17,836
- 68.1% required onward referral to HHFT and would have had both virtual assessment and one-stop: 949 x (£52+£247) = £283,751
- 4.8% of patients required GP follow up following triage (GP appointments not costed, but 1326 fewer GP appointments were required): 67 x £52 = £3484
- 2.5% did not attend or self-discharged (not costed).
- Total costs for this cohort would be: £305,071 (£219 per patient)
- Total savings compared to all patients being referred directly to secondary care one-stop clinic would be: £39,000 (£28 per patient)

Potential cost savings

Extrapolated to the average number of one-stop appointments per breast unit of 6000 per year, there is a potential saving of £168,000 per Trust per annum, plus an additional 5712 GP appointments freed.

In 24/25 in Wessex, 29,640 referrals were received into the breast one stop clinics (USC and symptomatic referrals combined). If all these patients were seen in a one stop clinic the cost for this based on the figures above would have been £7,321,080.

If the outcomes and figures from the pilot were scaled up so that all patients came via the self-referral virtual triage route instead, the cost would be £6,491,160. There would therefore be a potential saving of £829,920 per year for Wessex, with a potential 28,217 GP appointments freed.

The cost assumptions above do not include any staffing costs and are solely based on NHSE tariffs (provided by the HHFT finance team) for the different appointment types utilised during the pilot. Workforce costs have been included in a separate section below.

[4] *NHSE Agenda for Change Y23/24, NHS Cost Code 22/23*
[5] *NHSE Agenda for Change Y23/24, NHS Cost Code 22/23*

Workforce plan & rollout costs

Current RIS administrative function:

Service	Whole time equivalent (WTE)/ PA	Salary AFC 2526 costs	Total WTE Cost inc on costs@30%	Total cost
RIS Operational Manager 8a	1	£62,682	£81,487	£ 81,487
Patient Navigator B5	1	£37,796	£49,135	£ 49,135
RIS Admin support B3	2.8	£24,937	£32,418	£ 90,771
TOTAL				**£ 221,392**

- No further senior support is required with the activity created from the breast self-referral pathway. The WTE for the 8a and 5 will remain.
- The 2.8 WTE B3 currently deliver the NSS pathway. Cross cover, shared tasks and responsibilities can be delivered for both pathways on implementation, increasing sustainability.

The RIS current nursing team delivering the non-specific symptoms (NSS) pathway will remain unchanged and unaffected. The operational delivery between the NSS and Breast self-referral pathway from a clinical perspective is delivered differently with the nursing teams requiring differing skill sets. Therefore, within this workforce plan the role of the current RIS nursing team is not illustrated.

The table below outlines our calculation of workforce requirements for rolling out this pathway across Wessex, for both administrative and nursing staff. This has been calculated based on the pilot needing 15 ACP hours per week, however this could potentially be reduced depending on staff experience levels.

Additional resource hours required to expand the breast self-referral pathway pan-Wessex:

Provider Trust	USC Breast referral pa	Pilot Referral pa *	% of population covered by pilot for Provider	Pilot Admin hours	Pilot Nursing hours	Additional Admin Hours required for full population coverage	Additional Nursing Hours required for full population coverage	potential roll out referrals	% of Total Referrals *	Total Nursing Hours required	Total Admin Hours required
A -Pilot Site	6288	883	32%	8	15	25	31.9	2759	43.9%	47	33
B	5280							2317		39	28
C	2976							1306		22	16
D	1788							785		13	9
E	7692							3375		57	40
F	6960							3054		52	37
									TOTAL	**231**	**163**
							Whole Time Equivalent	**37.5**	**WTE**	**6**	**4**
							Efficiency savings through scale	**25%**		**4.6**	**3.3**

* *Percentage of referrals received through pilot assumed the same across all providers*

- Nursing staff for the pathway are proposed to be B7-8a
- Administrative staff for the pathway are proposed to be B3

Additional requirements- RIS operational team:

	Year 1	Year 2	Year 3	Year 4	Year 5
Band 6 WTE	2	2	2.6	2.6	2.6
Band 7 WTE	1	1	1	2	2
Band 6 WTE	£ 100,573.20	£ 100,573.20	£ 130,745.16	£ 130,745.16	£ 130,745.16
Band 7 WTE	£ 62,153.00	£ 62,153.00	£ 62,153.00	£ 124,306.00	£ 124,306.00
Band 3 WTE	1	2	3	3	3.3
Band 3 WTE	£ 32,418.10	£ 64,836.20	£ 97,254.30	£ 97,254.30	£ 106,979.73
Total WTE footprint	**4**	**5**	**6.6**	**7.6**	**7.9**
Total Cost per annum	**£ 195,144.30**	**£ 227,562.40**	**£ 290,152.46**	**£ 352,305.46**	**£ 362,030.89**

- Additional Operational workforce requirements are calculated from numbers and resource hours used during the duration of the pilot.

Additional requirements, senior clinical oversight:

	PA's	Annual Salary	Inc 30% Service costs
Annual Salary	10	£ 130,000.00	£ 169,000.00
Consultant PA's	4	£ 52,000.00	£ 67,600.00
		TOTAL	**£ 67,600.00**

- *1 consultant PA = 4 hours.*

Recommendation would be for recruitment to at least two consultants across different providing trusts for balanced opinion and governance perspectives

Income and expenditure summary

Further financial assumptions and analysis have been included in **Appendix 3,** including information around potential revenue and return on investment.

The income significantly exceeds expenditure each year, supporting a strong Return on Investment.

Financial Summary	**2027/2028**	**2028/2029**	**2029/2030**	**2030/2031**	**2031/2032**
	£k	**£k**	**£k**	**£k**	**£k**
First attendances	1,804,693	2,368,6593	3,067,301	3,374,031	3,711,435
Follow Up Attendances	229,843	301,668	390,646	429,711	472,682
Total Income	**2,034,536**	**2,670,328**	**3,457,948**	**3,803,743**	**4,184,177**
Revenue - Staff costs	262,744	295,162	357,752	419,905	429,630
Non-pay costs	10,000	11,000	12,100	13,310	14,641
overheads	27,274	30,616	36,985	43,321	44,427
Total Expenditure	**300,018**	**366,778**	**406,837**	**476,537**	**488,699**
Surplus / (Deficit)	1,734,518	2,303,550	3,051,111	3,327,206	3,695,478

CONCLUSION

The national team lists self-referral in the Faster Diagnosis Framework 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.

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 self-referral pathway demonstrated the biggest impact for those presenting with breast pain, with the majority of those presenting with pain as their only symptom being suitable for discharge to self-management following nurse-led assessment, without any need for GP review or secondary care assessment in a one stop clinic with associated imaging back-up. Therefore, this pathway has demonstrated potential benefits and cost efficiencies in terms of offering alternative management for patients with breast pain as their only symptom, which is a national priority area of focus for 2024/25 and continuing into 2025/26.

Now that the pilot has been evaluated, the on costs are expected to less than those that were required for the initial set up. Cost analysis for expanding the pathway demonstrates that this approach delivers a strong return on investment.

Commissioners should be strongly encouraged to explore digital options using the template that we developed during the pilot, as this will significantly reduce the administrative burden at secondary care and also provide timely advice to patients.

The benefit for secondary care is predominantly that they will have additional staff available to be incorporated into the delivery teams. We would also recommend that alongside self-referral, secondary care providers have face-to-face mastalgia clinics available, and they will also need to make provision for the small number of patients that need imaging without further clinic appointments.

RECOMMENDATIONS

Inclusion and Exclusions

The evaluation of outcome information from phase 1 of the pilot 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. Following evaluation of the community examination clinics after one year, it was determined that a virtual model alone was most cost effective and provided sufficient assessment of the patient to determine appropriate next steps.

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 or indications of infection) these would require a physical examination at the GP surgery*
- Triage process 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.

*It is recognised that this should be confirmed by the GP surgery prior to signposting the patient to self-refer.

Service Development

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

- 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 increased range of information available for patients. Self-examination videos etc. that are endorsed.
- Workforce model options to be explored and views sought**,** in particular around opportunities for staff rotation. As mentioned above, the service works best by employing additional staff outside of the current workforce in primary or secondary care, but who work as part of the breast MDT.
- Currently patients under 30 years of age are excluded from the pathway, in line with the NG12 criteria for referral to a USC pathway. It has been suggested at a local clinical advisory group meeting that this may need to be revisited if there are plans to expand the pathway more widely.

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 GP practices can provide face-to-face appointments rather than an additional virtual triage when patients have already been virtually triage 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.

APPENDIX 1: Secondary Care Outcomes Report

Initial secondary care outcomes of breast symptom triage pilot- Phase 1

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 5.3% suspected cancer and 1.2% breast symptoms (22/23- NDRS).

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 if equivalent to England rates for fast-track urgent 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.

Source: https://www.cancerdata.nhs.uk/cwt_conversion_and_detection (Accessed 18th Jan 2022)

APPENDIX 2: Referral trend data

Breast referrals breakdown by Wessex Providers:

Breast	HHFT		UHS		PHU		UHD		IOW		DCH	
Financial year	Breast	% growth	Breast	% growth	Breast	% growth	Breast	% growth	Breast	% growth	Breast	% growth
23/24	4815	6.46%	4360	-9.66%	5721	22.61%	5461	6.54%	1299	13.15%	1658	12.79%
22/23	4523	-5.69%	4826	-1.23%	4666	-14.07%	5126	-12.69%	1148	3.24%	1470	-1.34%
21/22	4796	14.14%	4886	8.46%	5430	94.90%	5871	23.21%	1112	29.45%	1490	-2.68%
20/21	4202	11.11%	4505	14.86%	2786	#VALUE!	4765	9.52%	859	-12.35%	1531	-13.16%
19/20	3782		3922		missing data		4351		980		1763	

Breast symptoms	HHFT		UHS		PHU		UHD		IOW		DCH	
Financial year	Symptom	% growth	Symptom	% growth	Symptomatic	% growth	Symptom	% growth	Symptomatic	% growth	Symptom	% growth
23/24	1250	3.99%	1596	179.02%	1676	-25.71%	966	37.80%	658	2.17%	806	9.21%
22/23	1202	-12.13%	572	12.16%	2256	7.74%	701	37.45%	644	-11.66%	738	-15.75%
21/22	1368	-3.80%	510	36.36%	2094	88.48%	510	-35.85%	729	24.83%	876	102.78%
20/21	1422	-14.95%	374	-57.64%	1111	#VALUE!	795	25.99%	584	11.66%	432	369.57%
19/20	1672		883		missing data		631		523		92	

*PHU data only available from 31/08/2020

* *UHS known data capture issue for breast symptomatic referrals prior to October 2022

The data above gives an indication of what size of workforce might be required to expand the service more widely in Wessex, as a comparison to HHFT. As HHFT have only rolled out to a third of their population for this pilot, we would need to upscale the information provided in this report by 3x, which would give an indication of the size of workforce required to cover all GP practices in that area.

Wessex Totals by financial year:

Wessex totals

Financial year	Breast	% growth	Symptom	% growth
23/24	23314	7.15%	6952	13.72%
22/23	21759	-7.74%	6113	0.43%
21/22	23585	26.47%	6087	29.02%
20/21	18648	26.02%	4718	24.13%
19/20*	14798		3801	

*PHU data not available for FY19/20

* *UHS known data capture issue for breast symptomatic referrals prior to October 2022

National Breakdown:

Year	Breast referrals	% growth	Breast Symptomatic	% growth
20/21	425386	-2.27%	128364	-27.40%
19/20	435253	4.12%	176807	-7.80%
18/19	418017	20.35%	191768	-1.12%
17/18	347323	4.24%	193937	-8.05%
16/17	333195	6.19%	210906	-7.56%
15/16	313786	13.76%	228153	-0.51%
14/15	275840	9.22%	229331	5.45%
13/14	252559	#DIV/0!	217471	#DIV/0!

Statistics » Cancer Waiting Times Annual Reports (england.nhs.uk)

*National data after 20/21 is not available.

HHFT referral data split by PCN- full data pack:

Download our Breast Referral Rates report by PCN (July 2025)

APPENDIX 3: Financial assumptions and analysis	
Core assumptions / rationale	• 10% Trust overheads have been included in the financial model. • Pay costs are based on 25/26. • National tariffs move to payment by results approach allowing for income attraction to activity. • 10% increase year on year for non-pay costs • The expectation is the six providers will not experience any reduction in income. • Overall impact on cost for commissioners should be £0. Referrals would go through a different pathway if not RIS. • Percentage of referrals sent by primary care across Wessex are expected to mirror that of the pilot primary care networks.

Support services requirement

- Digital support included within RIS infrastructure.
- There are no proposed changes to any of the clinical pathways currently in place therefore would not have an impact on other support services.

IT impact

- TPP SystmOne- Core charges for System will not be increased through introduction of self-referral pathway.
- Digital tool for digitalised self-referrals developed during pilot. Circa £10k per annum for employment of IT robots.
- Additional users to IT infrastructure.

Revenue requirement

Pay:

Year 1	Year 2	Year 3	Year 4	Year 5
£ 262,744.30	£ 295,162.40	£ 357,752.46	£ 419,905.46	£ 429,630.89

Non-Pay (digital tool for self-referrals)

Year 1	Year 2	Year 3	Year 4	Year 5
£ 10,000	£ 11,000	£ 12,100	£ 13,310	£ 14,641

Total: (inc of 10% over heads)

Year 1	Year 2	Year 3	Year 4	Year 5
£300,018.73	£336,778.64	£406,837.71	£476,537.01	£488,699.08

Impact on WTE

Year 1	Year 2	Year 3	Year 4	Year 5
4.4	5.4	7	8	8.3

Whole Time Equivalent (WTE) increases from 4.4 in Year 1 to 8.3 in Year 5, reflecting scaling roll out and growth.

Impact on activity

- New attendances grow from 8,000 to 16,452 over five years.
- Follow-up attendances (30% of new) grow from 2,400 to 4,936.

				Growth at 10%	
	Year 1	Year 2	Year 3	Year 4	Year 5
New attendances	8000	10500	13597	14957	16452
Follow Up Attendances @ 30%	2400	3150	4079	4487	4936

Proposal scenarios – indicative income under PbR

- Based on Treatment Function Code 103 – Breast Surgery

				Growth at 10%	
	Year 1	Year 2	Year 3	Year 4	Year 5
New attendances	£ 1,804,693.25	£ 2,368,659.89	£ 3,067,301.76	£ 3,374,031.94	£ 3,711,435.13
Follow Up Attendances @ 30%	£ 229,843.01	£ 301,668.95	£ 390,646.92	£ 429,711.61	£ 472,682.78
TOTAL	**£ 2,034,536.26**	**£ 2,670,328.84**	**£ 3,457,948.68**	**£ 3,803,743.55**	**£ 4,184,117.91**

Income and expenditure summary

The income significantly exceeds expenditure each year, supporting a strong Return on Investment.

Financial Summary	2027/2028	2028/2029	2029/2030	2030/2031	2031/2032
	£k	**£k**	**£k**	**£k**	**£k**

	First attendances	1,804,693	2,368,6593	3,067,301	3,374,031	3,711,435
	Follow Up Attendances	229,843	301,668	390,646	429,711	472,682
	Total Income	**2,034,536**	**2,670,328**	**3,457,948**	**3,803,743**	**4,184,177**
	Revenue - Staff costs	262,744	295,162	357,752	419,905	429,630
	Non-pay costs	10,000	11,000	12,100	13,310	14,641
	overheads	27,274	30,616	36,985	43,321	44,427
	Total Expenditure	**300,018**	**366,778**	**406,837**	**476,537**	**488,699**
	Surplus / (Deficit)	1,734,518	2,303,550	3,051,111	3,327,206	3,695,478

Impact on always improving – productivity	• Supporting 10-year plan for innovation and digitalisation of pathways. • Improving outcomes for patients. • Improving time to diagnosis. • Centralising care.
Financial risks and mitigations	**Financial risk of spending:** • Changes in national tariff. Mitigation - Negotiate a tariff of block funding through commissioners to meet core operational costs for the full 5 years. This will allow the pathway to be implemented but the high return on investment will not be realised. However, the service will remain self-funding. • Referral numbers below expected. High return on investment allows flexibility on core costs. If a significant reduction is seen against plan, the workforce model will be adjusted accordingly. • Activity delivered below expected. Work through demand and capacity models to maximise productivity. Activity will be monitored monthly. **Financial risk of not spending:** • Wessex provider trusts remain below target or struggling to meet Faster Diagnosis standard. • Unable to support overwhelmed primary care systems support access to health care for patients. • Delays in access to care, result in unfavoured outcomes.

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