Best practice case study: The Christie, Manchester

The Christie is an internationally recognised centre for the treatment of cancer and the largest single site cancer centre in Europe, treating more than 44,000 patients a year with 2500 new breast cancer patients each year. The SBC Nursing team at The Christie provides a service for approximately 300 newly diagnosed SBC patients per annum on top of their existing complex caseload. In addition to 2.5 whole-time equivalent CNSs dedicated to SBC, the team has recently employed a data analyst to help bring all the SBC patients together in a database to improve the efficiency of the clinic and patient follow-up.

This case study highlights how it has maximised resources through nurse-led care and stratification of patient follow-up, which may be an adaptable approach for other sites.

Outreach

Services are provided at The Christie Hospital site in Manchester and in a number of community settings including: a mobile chemotherapy unit, outreach services to neighbouring non-specialist NHS trusts and in people's homes. The trust operates a hub and spoke model, linking in with breast care nurses and oncology teams across the region.

Service Improvement

The Christie Breast Care Nursing (BCN) team have led on a major service improvement project since 2015. Originally practicing as a service which supported both primary and secondary patients, the team recognised that there was a disparity between the care these two groups of patients were receiving. As a tertiary centre, patients coming for adjuvant chemotherapy and radiotherapy already had a BCN at their peripheral hospital, whereas for the majority of metastatic patients the support largely came from The Christie hospital. With only 2.5 whole-time equivalent CNSs it was unsustainable to support this large case load in an efficient and effective manner. Therefore in July 2015, following a Macmillan service review and large scoping exercise, The Christie BCN service became a designated Macmillan Secondary Breast Care (SBC) nursing service.

Holistic Needs Assessment for Stratified Follow-up Pathways

To ensure the clinic has a holistic focus, newly diagnosed patients attend a 45-minute holistic needs assessment (HNA) carried out by a CNS around four weeks after their diagnosis. This includes using a modified version of the Hospital Anxiety and Depression Scale and Concerns Checklist.
Patients are then stratified to specific follow-up pathways according to their disease burden, level of psychological support required and results of the HNA. Patients also receive written information and a resource pack to ensure they understand their diagnosis and treatment options.

Learnings

A co-production approach has been crucial to the clinic's success and continual learning approach, with a patient focus group meeting bi-monthly to discuss the service development. The success of the clinic has been recognised, with the team receiving the Cancer Nursing Practice award at the 2017 RCNi Awards.

The team has learnt a lot from their experiences which can be shared and may be useful for other nursing teams. These include:

Challenge	Learning
Identifying new SBC patients across multiple consultants	Ensure close working alongside doctors and being very clear about referral criteria. Liaise with breast cancer nurses in peripheral sites and attend meetings to communicate service development at every level
Practical issues including ensuring administrative support is in place and proper data collection recorded to monitor success of clinic	Management and board level support imperative. Appropriate research and planning went into how to evaluate the service from the outset to ensure it could demonstrate it improved patient care. The team has recently employed a data analyst to help bring all the SBC patients together in a database to improve the efficiency of the clinic and patient follow-up.
Large, complex caseload	In addition to nurse-led clinic, a telephone clinic was established for follow-up appointments as well as bi-annual health and well-being days. Patients are being stratified to plan appropriate follow-up
Ensure all patients and relatives have access to appropriate support	The CNSs regularly liaise with GPs, local breast care nurses, community palliative care nurses, district nurses and local

	hospices to try to achieve high-quality care

The team feels the nurse-led clinic and stratified follow-up allows for a proactive rather than reactive way of working. This approach helps the team to provide better information for patients, helps to act on issues before they reach crisis point, and uses the nursing resources they have more effectively. Medical appointments can focus on medical issues, and the CNSs can support the medical appointment but also focus on supporting patients in relation to their psychological and social needs. Working closely with palliative care, the team feels that the approach also facilitates earlier advanced care planning for the end of life.