Healthy London Partnership
Transforming cancer services team for London
Primary Care perspective on cancer: future priorities
Dr Pawan Randev GP
My Practice Area
Our practice nurses
The Measham Marchers – London to Brighton
The Practice – 13,000 patients

8 Partners – 4 full time
1 Salaried GP
1 GP Trainee
1 Full Time Practice Manager
2 Nurse Practitioners
4 Part time Practice Nurses
5 HCA/Clinic Team staff
2 Secretaries
12 P/T Reception staff
7 Dispensers
5 F/T Administrative staff
As a Cancer Lead,

Involved in Cancer Service improvement from 1998
Cancer Lead in 5 different organisations – Networks to PCG/CCG/PCT/SCN
GP Trainer and former Appraiser
Interest in Education and Training
GP Clinical Lead TCST
Chair Pan London Primary and Community Education Group
Have led and supported many primary care cancer education initiatives
Be Clear on Cancer

If you’ve been coughing for 3 weeks, it might not be ‘only a cough’, so tell your doctor.

Everyone gets a cough now and again, but if you’ve had one for over three weeks you should see your doctor. Coughing could be a sign of lung cancer. Of course, in the vast majority of cases it won’t be serious. But if there is something wrong, finding it early means it’s more likely to be treatable, so tell your doctor.
My focus today

Background for London

What is primary care now and what can it become?

Organisations at scale – Federations and Networks/MCP

Workforce – traditional and changes

Role changes and evolution

Leadership in practices – shared and devolved

Making every contact count – every staff member counts!
Cancer in the Capital

Population

- 8.6 million (larger than pop of Scotland). 40% non-white British origin & 300 languages spoken, young, transient & growing fast
- 3/10 most deprived local authorities nationally in London but pockets of significant wealth resulting in stark health inequalities
- Cancer Awareness Measures undertaken in CCGs reveal poor awareness of signs and symptoms of cancer
- 20 Trusts which include world renowned centres of excellence & deliver leading edge innovation
- 32 CCGs & 1,400 GP practices, more single-handed GPs than nationally & lower levels of practice staffing

Services

- 40% of CCGs have 1 year survival lower than England average
- 30% of patients had to see their GP more than once or twice before being referred for cancer
- 25% of people are diagnosed with cancer via an emergency route
- 60% of patients in London are satisfied with support they received from GPs and practice nurses after cancer diagnosis.
- Refer to test and test to result delays. GPs have lower direct access to investigations compared to nationally
- Variation in diagnostics uptake (CA125 & gastroscopy below)
- 9/20 Trusts not meeting non-obstetric ultrasound 14 day target
- 50% Trusts waiting time longer than 6 weeks for colonoscopy
- 2.5 fold variation between Trusts offering lung cancer surgery
- All cancer screening programmes perform lower. Uptake is even lower in younger BAEM & deprived pops

Between 2011 – 2013, there were equal number of cases diagnosed for men and women, but more males died from cancer.
**Incidence and Staging in London**

40% CCGs have lower 1 year survival than national average. Bowel screening uptake ranges between CCGs from 38% to 58%. Also similar variation within CCGs. Screening reduces colorectal mortality by 16%. Despite younger population incidence increasing, 40% of cancers can be prevented by changes to lifestyle. Cancers diagnosed late & CCG variation.

Most CCGs in London do not meet the national average for screening.

Camden had a sharp decrease in breast screening in the most recent time period, as did Islington.

Havering, Bromley and Bexley had a substantially slower uptake of bowel screening.

Camden has a noticeably worse uptake of cervical screening over the entire time period.

Overall, bowel screening has a worse uptake over all regions and time periods.

---

**England and London incidence trends 2001-2013**

**2013 Staging data by sector**

- Stage 0 %
- Stage 1 %
- Stage 2 %
- Stage 3 %
- Stage 4 %
- Unstageable %
- Unknown %
A minimum of 5,000 other staff working in general practice by 2020/21. This five year programme will include:

- Investment in an extra 3,000 mental health therapists to work in primary care by 2020, which is an average of a full time therapist for every 2-3 typical sized GP practices.
- Current investment of £31 million to pilot 470 clinical pharmacists in over 700 practices to be supplemented by new central investment of £112 million to extend the programme by a pharmacist per 30,000 population for all practices not in the initial pilot – leading to a further 1,500 pharmacists in general practice by 2020.
- Introduction of a new Pharmacy Integration Fund.
A general practice nurse development strategy, with an extra minimum £15 million national investment including improving training capacity in general practice, increases in the number of pre-registration nurse placements, measures to improve retention of the existing nursing workforce and support for work schemes for practice nurses.

National investment of £45 million benefitting every practice to support the training of current reception and clerical staff to play a greater role in navigation of patients and handling clinical paperwork to free up GP time.

Investment by HEE in the training of 1,000 physician associates to support general practice.

Introduction of pilots of new medical assistant roles that help support doctors, as recommended by the RCGP.

£6 million investment in practice manager development, alongside access for practice managers to the new national development programme.

£3.5 million investment in multi-disciplinary training hubs in every part of England to support the development of the wider workforce within general practice.

Health and wellbeing

£16 million extra investment in specialist mental health services to support GPs suffering with burn out and stress, and support retention of GPs, in addition to the £3.5 million already announced.

Over the past decade, the number of GPs (full time equivalents) working in general practice has risen by over 5,000.

But we know that many practices now face recruitment issues and are increasingly reliant on temporary staff. Moreover, a higher proportion of older GPs are signalling that they are considering leaving the workforce early.

#GPforwardview
Achieving World-Class Cancer Outcomes: Taking the strategy forward

May 2016

Five Year Forward View #futureNHS
Annex C: All recommendations by workstream

**Prevention**

<table>
<thead>
<tr>
<th>#</th>
<th>Recommendation summary</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>To publish a tobacco control plan</td>
</tr>
<tr>
<td>3</td>
<td>To publish a national obesity action plan</td>
</tr>
<tr>
<td>4</td>
<td>To develop a national strategy to address alcohol consumption</td>
</tr>
<tr>
<td>5</td>
<td>To determine the level at which HPV vaccination for boys would be cost-effective and roll out</td>
</tr>
<tr>
<td>8</td>
<td>To provide lifestyle advice to cancer patients</td>
</tr>
<tr>
<td>12</td>
<td>To establish a cancer screening team under the Director of Screening in PHE</td>
</tr>
<tr>
<td>13</td>
<td>To examine the evidence for lung and ovarian cancer screening</td>
</tr>
<tr>
<td>14</td>
<td>To evaluate the potential for risk-based prevention and surveillance programmes</td>
</tr>
</tbody>
</table>

**Early diagnosis**

<table>
<thead>
<tr>
<th>#</th>
<th>Recommendation summary</th>
</tr>
</thead>
<tbody>
<tr>
<td>10</td>
<td>To roll out FIT into the bowelscope screening programme</td>
</tr>
<tr>
<td>10</td>
<td>To incentivise GPs to take responsibility for driving increased uptake of FIT and bowel scope</td>
</tr>
<tr>
<td>11</td>
<td>To roll out primary HPV testing into the cervical screening programme</td>
</tr>
<tr>
<td>15</td>
<td>To continue Be Clear on Cancer</td>
</tr>
<tr>
<td>16</td>
<td>To encourage implementation of NICE referral guidelines</td>
</tr>
<tr>
<td>17</td>
<td>To mandate GP direct access to key investigative tests for suspected cancer</td>
</tr>
<tr>
<td>18</td>
<td>To incentivise the establishment of ‘safety-netting’ by GPs</td>
</tr>
<tr>
<td>19</td>
<td>To establish a national diagnostic capacity fund</td>
</tr>
<tr>
<td>21</td>
<td>To pilot multi-disciplinary diagnostic centres</td>
</tr>
<tr>
<td>22</td>
<td>To pilot self-referral</td>
</tr>
<tr>
<td>23</td>
<td>To pilot CNS in GP practices to coordinate diagnostic pathways</td>
</tr>
<tr>
<td>24</td>
<td>To establish a new four-weeks-to-diagnosis standard</td>
</tr>
<tr>
<td>25</td>
<td>To undertake a Significant Event Analysis for patients diagnosed following an emergency admission</td>
</tr>
</tbody>
</table>
Prevention

The prevention agenda for cancer relates to both new primary cancers as well as recurrence. Smoking cessation, healthy diet and physical activity are key interventions for improving survival rates and quality of life. We can reduce the current rate of 1 in 2 expecting to be diagnosed with cancer with healthier lifestyles.

- More than 4 in 10 cases of cancer are caused by aspects of our lifestyles which we have the ability to change. Tobacco remains the main risk factor, followed by obesity.
- We need to continue to raise awareness of the impact risk factors have on our health, especially in vulnerable populations, and support people to make changes.
- Efforts to tackle smoking rates should continue at pace, with the ultimate aim of reaching less than 5% prevalence in adults by 2035.
- Vaccination and chemo-prevention will play an increasing role.
- With increasing numbers of people surviving their primary cancer, we need a stronger focus on preventing secondary cancers.
- Evidence from the United States shows that exercise following a cancer diagnosis can prevent recurrence of cancer by 40% - this is more cost effective than chemotherapy and much greater reduction in patients developing consequences of cancer treatment.

http://www.cancerresearchuk.org/sites/default/files/achieving_world-class_cancer.pdf
On Line resources

BMJ Learning

Home You are currently not logged in to BMJ Learning.

1 hour ★★★☆☆ (6) GPs, GP trainees, Practice nurses...

Screening for cervical cancer

Start module Add to portfolio

Through interactive case histories learn how to advise women who are worried about cervical cancer, and what information to give them.

Learning outcomes

After completing this module you should know:

- How to advise women who are worried about cervical cancer
- What information you should give them
- How to advise women who have questions about the NHS cervical screening programme.

Written by:
BMJ Learning in association with the NHS Cancer Screening Programmes

Peer reviewed by:
Olivia Byrnes
Screening for bowel cancer

Through interactive case histories, learn how to advise people who are worried about bowel cancer, and what information to give them.

Learning outcomes

After completing this module you should know:

+ How to advise people who are worried about bowel cancer
+ What information you should give them
+ How to advise people who have questions about the new NHS bowel cancer screening programme.

Written by:
BMJ Learning with the NHS bowel cancer screening programme

Last updated
Understanding Screening – Interactive Guide

Screening

Screening – Angela Raffle
This comprehensive yet succinct module on screening will help the experienced practitioner to expand their teaching methods, and it will get the novice up to speed on the evaluation and delivery of screening. The first part covers evidence about screening, and the second part comprises four further chapters covering skills relating to application of this evidence in daily practice.

- Introduction
- Chapter 1 - What screening is and is not
- Chapter 2 - What screening does
- Chapter 3 - The screening programme
- Chapter 4 - Measuring what screening does
- Chapter 5 - Measures of test performance
- Chapter 6 - Handling media interviews
- Chapter 7 - Commissioning quality screening
- Chapter 8 - Screening prior to evidence
- Chapter 9 - Interview with Sir Muir Gray

"really clear and informative. I wanted to commend you on putting such a useful resource together"

"very helpful and easy to understand"

"I used the module with students doing the Doctorate in Public Health and it gave them a very clear understanding of all the key concepts, it is an excellent teaching resource. The students just loved it"
MECC possibilities…

Adding screening advice to appropriate LTC reviews

55-59 year olds to be reminded of Bowelscope

“Cross-selling” screening (Cervical and mammogram/Bowel)

Diabetes and bowel cancer screening

Alarm symptom recognition advice

VBA Smoking and Weight

*However the starting point is understanding for yourself and helping yourself*
Training needs MECC

What is the competency?
How is feedback elicited and given in practice?
“How am I driving?”
Use of video/audio/patient simulators
Motivational Interviewing – time issue
VBA
Priority of this advice – the most significant health benefit for an individual
Lifestyle – add on or essential?
Added to LTC recording templates/audited
Nurse/NP/Pharmacist/HCA/GP
Central Resources

Guidance

Making Every Contact Count (MECC): practical resources

From: Public Health England
First published: 26 January 2018
Last updated: 13 April 2018, see all updates
Part of: Housing for health

These documents support the local implementation and evaluation of MECC activity and the development of training resources.

Documents

Making Every Contact Count (MECC): consensus statement
Ref: PHE publications gateway number 2015760, NHS England publications gateway number 19996. PDF, 5Mb, 15 pages.
This file may not be suitable for users of assistive technology. Request an accessible format.

Making Every Contact Count (MECC): evaluation framework
Ref: PHE publications gateway number 2015744 PDF, 5Mb, 28 pages.
This file may not be suitable for users of assistive technology. Request an accessible format.

Making Every Contact Count (MECC): implementation guide
Ref: PHE publications gateway number 2015622 PDF, 3Mb, 17 pages.
This file may not be suitable for users of assistive technology. Request an accessible format.

Making Every Contact Count (MECC): quality marker checklist for training resources
Cues(Q) of possible Cancer

Many patients present with symptoms

GPs need to decide which patients to investigate and refer

Decision support tool must mirror setting where decisions made

Symptoms based approach needed (rather than cancer based)

Must account for multiple symptoms

Must have face clinical validity eg adjust for age, sex, smoking, Family history

Need to be able to update to meet changing requirements, populations, recorded data
Symptom Check List

The following check list is not exhaustive but allows the clinician to ensure that symptoms the patient is experiencing are included in the QCancer calculation.

QCancer uses a current symptoms algorithm therefore all symptoms should be reviewed and re-recorded if present.

Pre-existing information from the medical record will also be evaluated if within the indicated time frames.

Does the patient currently have.... (brackets denote how long symptoms are considered by QCancer e.g. 1m for 1 month)

- Appetite loss (1m)  [24-Aug-2015]
- Abnormal or Unexplained weight loss (1m)  [24-Aug-2015]
- Abdominal pain (1m)  [24-Aug-2015]
- Abdominal swelling (1m)  [24-Aug-2015]
- Difficulty swallowing liquids (1m)  [No previous entry]
- Difficulty in swallowing solids (1m)  [No previous entry]
- Indigestion (1m)  [24-Aug-2015]
- Heartburn (1m)  [24-Aug-2015]
- Cough (12m)  [24-Aug-2015]
- Change in bowel habit (12m)  [24-Aug-2015]
- Constipation (12m)  [24-Aug-2015]
- Painless rectal bleeding (1m)  [No previous entry]
- Painful rectal bleeding (1m)  [15-Jul-2015]
- Blood in vomit (1m)  [24-Aug-2015]
- Blood in sputum (1m)  [15-Jul-2015]
- Blood in urine (1m)  [No previous entry]
- Lump on neck (1m)  [No previous entry]
- Night sweats (1m)  [15-Jul-2015]
- Spontaneous bruising (12m)  [No previous entry]
### Female Specific Check List

- Post-menopausal bleeding (1m)
- Inter-menstrual bleeding (1m)
- Post-coital bleeding (1m)
- Breast lump (1m)
- Nipple discharge symptom (1m)
- Deformation of breast (1m)
- Persistent mastalgia (1m)

### Family History

<table>
<thead>
<tr>
<th>Item</th>
<th>Date</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family History of Gastrointestinal cancer</td>
<td>15-Jul-2015</td>
<td>FH: Intestinal ...</td>
</tr>
<tr>
<td>Family History of Breast cancer</td>
<td>No previous entry</td>
<td></td>
</tr>
<tr>
<td>Family History of Ovarian cancer</td>
<td>No previous entry</td>
<td></td>
</tr>
</tbody>
</table>

### Clinical History

<table>
<thead>
<tr>
<th>Item</th>
<th>Date</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Smoking status</td>
<td>24-Aug-2015</td>
<td>60 /day</td>
</tr>
<tr>
<td>Alcohol status</td>
<td>24-Aug-2015</td>
<td>90 U/week</td>
</tr>
<tr>
<td>Height</td>
<td>02-Oct-2012</td>
<td>164 cm</td>
</tr>
<tr>
<td>Weight</td>
<td>02-Oct-2012</td>
<td>67 kg</td>
</tr>
<tr>
<td>Body Mass Index</td>
<td>24-Aug-2015</td>
<td>24.9 kg/m2</td>
</tr>
<tr>
<td>Haemoglobin estimation</td>
<td>15-Jul-2015</td>
<td>6.4 g/L</td>
</tr>
</tbody>
</table>
Consultation Mode

Active LION, Sea (Mrs)

Consultation

1. <No Problem>

- **Result**
  - QCancer risk calculator 34.47%

- **History**
  - Appetite loss - anorexia
  - Abdominal pain
  - Difficulty swallowing solids
  - Heartburn
  - Cough Severity: Moderate, Frequencies: Discontinuous
  - Constipation
  - Painless rectal bleeding
<table>
<thead>
<tr>
<th>Date</th>
<th>Consultation Text</th>
</tr>
</thead>
<tbody>
<tr>
<td>12-Oct-2015</td>
<td>GP Surgery (MEASHAM MEDICAL UNIT)</td>
</tr>
<tr>
<td></td>
<td>Result: QCancer risk calculator 34.47%</td>
</tr>
<tr>
<td></td>
<td>History: Appetite loss - anorexia • Abdominal pain • Difficulty swallowing solids • Heartburn • Cough Severity: Moderate, Frequencies: Discontinuous • Constipation • Painless rectal bleeding</td>
</tr>
<tr>
<td>26-Aug-2015</td>
<td>GP Surgery (MEASHAM MEDICAL UNIT)</td>
</tr>
<tr>
<td></td>
<td>Empty consultation</td>
</tr>
<tr>
<td>24-Aug-2015</td>
<td>GP Surgery (MEASHAM MEDICAL UNIT)</td>
</tr>
<tr>
<td></td>
<td>Result: QCancer risk calculator 63.03%</td>
</tr>
<tr>
<td></td>
<td>History: Heartburn • Cough • Change in bowel habit • Constipation</td>
</tr>
<tr>
<td>24-Aug-2015</td>
<td>GP Surgery (MEASHAM MEDICAL UNIT)</td>
</tr>
<tr>
<td></td>
<td>Result: QCancer risk calculator 48.23%</td>
</tr>
<tr>
<td></td>
<td>History: Appetite loss - anorexia • Abnormal weight loss • Abdominal pain • Difficulty swallowing solids • Blood in vomit - symptom</td>
</tr>
<tr>
<td>15-Jul-2015</td>
<td>GP Surgery (MEASHAM MEDICAL UNIT)</td>
</tr>
<tr>
<td></td>
<td>Problem: Monitoring of patient (First)</td>
</tr>
<tr>
<td></td>
<td>History: active surveill</td>
</tr>
<tr>
<td>15-Jul-2015</td>
<td>GP Surgery (MEASHAM MEDICAL UNIT)</td>
</tr>
<tr>
<td></td>
<td>History: Abdominal pain • Indigestion symptoms • Constipation • Painful rectal bleeding • Blood in vomit - symptom Moderate • Night sweats • H/O: inter-menstrual bleeding • Cigarette smoker 50 / day</td>
</tr>
<tr>
<td></td>
<td>Family History: Fh: Intestinal cancer</td>
</tr>
<tr>
<td></td>
<td>Result: Haemoglobin estimation 6.4 g/L • QCancer risk calculator 14.3 %</td>
</tr>
<tr>
<td></td>
<td>Additional: Active surveillance • Blood test requested • Refer for NMR scanning</td>
</tr>
<tr>
<td>13-Jul-2015</td>
<td>Administration note (MEASHAM MEDICAL UNIT)</td>
</tr>
<tr>
<td></td>
<td>Assessment: Wells DVT score - previous documented DVT 1 / ! Wells DVT score - active cancer 1 / ! Wells DVT score - paralyse or recent immob. of lower extremity 0 / ! Wells DVT score - recent Wells DVT score - local tenderness along deep venous system 1 / ! Wells DVT score - calf swelling Wells DVT score - entire leg swollen 0 / ! Wells DVT score - collateral superficial veins 1 / ! V 1 / ! Wells DVT score - alternative diagnosis at least as likely 0 / ! - Wells deep vein thrombosis</td>
</tr>
<tr>
<td>08-Jun-2015</td>
<td>GP Surgery (MEASHAM MEDICAL UNIT)</td>
</tr>
<tr>
<td></td>
<td>Empty consultation</td>
</tr>
<tr>
<td>23-Jan-2015</td>
<td>GP Surgery (MEASHAM MEDICAL UNIT)</td>
</tr>
<tr>
<td></td>
<td>Problem: PSA (prostate specific antigen) monitored in primary care. (Review)</td>
</tr>
</tbody>
</table>
Achieving World-Class Cancer Outcomes: Taking the strategy forward

May 2016

Five Year Forward View #futureNHS
## Annex C: All recommendations by workstream

### Patient experience

<table>
<thead>
<tr>
<th>Recommendation summary</th>
<th>Oversight</th>
</tr>
</thead>
<tbody>
<tr>
<td>54 • To commission the Cancer Patient Experience Survey (CPES) annually</td>
<td>Data &amp; Improvement</td>
</tr>
<tr>
<td>54 • To increase BME representation in CPES</td>
<td>Data &amp; Improvement</td>
</tr>
<tr>
<td>54 • To link CPES data with other datasets</td>
<td>Data &amp; Improvement</td>
</tr>
<tr>
<td>54 • To develop a methodology to collect patient experience data for under 16s</td>
<td>Data &amp; Improvement</td>
</tr>
<tr>
<td>55 • To develop a metric(s) to encourage providers and commissioners to focus on improving people’s experiences of their care</td>
<td>Data &amp; Improvement</td>
</tr>
<tr>
<td>61 • To ensure access to a CNS or other key worker for all patients and to develop and evaluate the role of support workers</td>
<td>Data &amp; Improvement</td>
</tr>
<tr>
<td>62 • To encourage providers to provide a directory of local services</td>
<td>Data &amp; Improvement</td>
</tr>
<tr>
<td>56 • To develop online decision and communication aids</td>
<td>Digital Revolution</td>
</tr>
<tr>
<td>57 • To enable patients to have online access to all test results and other communications in secondary and tertiary providers</td>
<td>Digital Revolution</td>
</tr>
<tr>
<td>58 • To develop a smartphone app for collation of all diagnosis and treatment-related information and correspondence</td>
<td>Digital Revolution</td>
</tr>
<tr>
<td>59 • To undertake a strategic review of digital technologies</td>
<td>Digital Revolution</td>
</tr>
</tbody>
</table>

### Living with and beyond cancer

<table>
<thead>
<tr>
<th>Recommendation summary</th>
<th>Oversight</th>
</tr>
</thead>
<tbody>
<tr>
<td>41 • To pilot a comprehensive care pathway for older patients</td>
<td></td>
</tr>
<tr>
<td>49 • To pilot assessment of holistic needs at the point of diagnosis to evaluate the benefit of earlier palliative care and/or AHP intervention</td>
<td></td>
</tr>
<tr>
<td>63 • To establish a programme on living with and beyond cancer</td>
<td></td>
</tr>
<tr>
<td>64 • To develop a metric on quality of life</td>
<td></td>
</tr>
<tr>
<td>64 • To roll out PROMs across breast, colorectal and prostate cancer</td>
<td></td>
</tr>
<tr>
<td>65 • To encourage commissioning of the Recovery Package</td>
<td></td>
</tr>
<tr>
<td>66 • To develop a guideline on living with and beyond cancer</td>
<td></td>
</tr>
<tr>
<td>67 • To incentivise stratified follow-up pathways of care for patients treated for breast cancer</td>
<td></td>
</tr>
<tr>
<td>67 • To pilot stratified follow-up pathways of care for other tumour types, ideally including prostate and colorectal and some rarer cancer types</td>
<td></td>
</tr>
<tr>
<td>70 • To review the cancer rehabilitation workforce</td>
<td></td>
</tr>
<tr>
<td>71 • To pilot the commissioning of integrated evidence-based depression care</td>
<td></td>
</tr>
<tr>
<td>72 • To pilot community oncology nurse services and community pharmacy services for management of consequences of treatment and adherence</td>
<td></td>
</tr>
<tr>
<td>73 • To promote best practice in approaches to support people living with and beyond cancer</td>
<td></td>
</tr>
<tr>
<td>74 • To ensure that supporting people with cancer to return to work is a key focus</td>
<td></td>
</tr>
<tr>
<td>75 • To ensure that CCGs commission appropriate integrated services for palliative and end of life care</td>
<td></td>
</tr>
</tbody>
</table>
In 2010, there were enough people living with and beyond cancer to fill Wembley stadium twice. This number is expected to double by 2030.

The percentage of people having a cancer care review varies across London and West Essex. We also know that CCRs are often unstructured, opportunistic, brief and patients don’t always know they are having them (Macmillan 2013). QOF does not specify any quality or outcome standards for conducting good cancer care reviews.
Prostate Project Croydon

Primary care follow-up of patients with prostate cancer

A tool kit for primary care nurses
Essential

- Registered Nurse
- 2 years or more experience in primary care setting OR prior experience in a specialist role such as a CNS in urology or oncology OR completion of an Advanced Nurse Practitioner pathway at level 6 or 7
- To have experience in managing long term conditions such as diabetes, asthma etc.
- To have completed the recommended and additional free to access modules (see page 6)

Desirable:

- Physical assessment/Clinical reasoning skills
- Attendance at Prostate Cancer UK primary care master class (free to attend, available to book at the Prostate Cancer UK website under health professionals, education section)

5. Using this Framework

Assessment of competency: the nurse will identify a suitable clinician who is currently caring for this group of patients to mentor and assess him/her. This may be a GP or Practice Nurse or Advanced Nurse Practitioner. It is recognised that there are transferable skills and knowledge that the nurse will be able to draw on in caring for this patient group, in particular communication and consultation skills which will have been developed through for example, chronic disease management clinics.

Benner’s “novice to expert” model (1984) can be used to define competency in the key areas:

- Novice: stage in skill acquisition where no background understanding of the situation exists, so that context-free rules and attributes are required for safe
Stratified follow-up care for people with prostate cancer

Sandra Dyer and colleagues describe the testing of a follow-up pathway to manage patient transitions from secondary to primary care

Abstract | Full-text | References | PDF

**Sandra Dyer** Prostate cancer project nurse lead. Transforming Cancer Services Team for London, South East Commissioning Support Unit

**Sarita Yaganti** Cancer strategy implementation lead. Transforming Cancer Services Team for London, South East Commissioning Support Unit

**Jaimin Patel** Prostate cancer project GP lead. Transforming Cancer Services Team for London, South East Commissioning Support Unit

Correspondence to: Sandra.dyer1@nhs.net

*Primary Health Care* 26, 2, 24-30. [http://dx.doi.org/10.7748/phc.26.2.24.s22](http://dx.doi.org/10.7748/phc.26.2.24.s22)

Accepted: 01 October 2015 Published in print: 25 February 2016 Submitted date: 18 August 2015

**Double blind peer review**

Prostate cancer is the most common cancer in men in the UK ([Office for National Statistics 2013](https://www.ons.gov.uk)) and more men are now surviving because of improved treatments ([Cancer Research UK 2015](https://www.cancerresearchuk.org/)). A national initiative to provide follow-up pathways as alternatives to traditional hospital...
Stratified Follow up – shared care and shared information

Transforming Cancer Services Team

Treatment Summaries: improving current delivery in London - a guide for GP cancer leads

To: Primary care cancer leads and Macmillan GPs in London

From: Dr. Atul Saha and Dr. Martin Sheely, TCST GP Advisors
(contact: secru.tcsslondon@nhs.net)

Date: June 2016

Background

We know that better support for people after cancer treatment can deliver significant benefits in terms of improved quality of life. It can also encourage behaviours that are more likely to prevent recurrence and reduce unplanned or acute presentations with late consequences of treatment (Achieving World Class Cancer Outcomes: A Strategy for England 2015-2020).

Recommendation 65 from the strategy document states: "NHS England should accelerate the commissioning of services for people living with and beyond cancer, with a view to ensuring that every person with cancer has access to the elements of the recovery package by 2020."
Cancer Care Review

Proposed Cancer Care Review Pathway
Questions please
pawan.randev@nhs.net