Primary Care Cancer Checklist

Transforming Cancer Services Team for London

July 2018

Primary Care Cancer Checklist

This tool was developed by the TCST for use by GP practices, networks/federations and CCGs.

The tool is supported by the London wide LMCs and the London Transforming Primary Care programme.

There are three aspirational areas (leadership, training and systems of care) for:

* conducting a local stocktake of service delivery
* supporting sustainable local change plans
* prioritising local improvements in cancer care

Area 1: Leadership

- **Leadership: A named 'Cancer Clinical Lead'** and /or named nursing and non-clinical cancer champions. The role includes attending a cancer update at least annually, disseminating learning and overseeing practice systems. **P**
- **Practice Profile** is reviewed and discussed by practice annually– led by Practice cancer lead, supported by local CCG Cancer Lead or Macmillan GP/CRUK Facilitator. This supports development of a Practice Cancer Action Plan. **P**
- **Regular, multi-professional, clinical cancer meetings** with all emergency and new cancer presentations discussed. Decision taken as to who is the named person for care coordination from point of diagnosis through to long term conditions management/palliative care and end of life (GP, primary care nurse). Regular review of good quality cancer SEAs, in particular for all cancer patients presenting as an emergency. **P**
- **Annual RCGP Routes to Diagnosis Audit** for all cancers. **P**
- **Quality Improvement Activity** featuring cancer undertaken in last year (based on SEA/audit information) **P and N/F**

Key
P= Practice
N= Network
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Area 1: Leadership

- **Be Clear on Cancer and other national cancer screening /awareness campaigns** supporting activities by organisation? **N/F and P**
- **Cancer decision support tools** – activated, audited and used? **P and N/F**
- **NICE Suspected cancer: recognition and referral guideline (NG12) -** all GPs and locums aware of and using the new guidance. **N/F and P**

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Area 2: Training

- Have practice staff attended **cancer education** events or completed eLearning modules in the last year: GP/Nurse/staff (SEA/ Audit/ NG12/ Safety netting/ communication skills/ living with and beyond cancer) **N/F and P**
- **Practice Nurses** have completed the Macmillan Course, or similar, and practice staff having cancer awareness training. Nursing leadership and support is available post training e.g. action learning sets, peer support, supervision **N/F and P**
- Have all staff had **Very Brief Advice (VBA) training** on increasing physical activity, smoking cessation, and alcohol reduction? Is it part of LTC, Health Checks and new patient consultations? **N/F and P**

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Area 3: Systems of care

- **Information management**: Cancer register/template with agreed coding/templates (e.g. for diagnoses, treatment, recording of stage at presentation, route of diagnosis, cancer care reviews) is kept up to date (QOF CAN001). Confirm that this data is consistent with local prevalence of cancer. **N/F and P**
- Is up-to-date **2ww referral forms software** set up in practice IT system and used with tracking of referrals? **P**
- Are referred patients consistently offered **support leaflets in appropriate language format? P**
- **Safety netting**: All patients referred under 2 week wait system or referred urgently for 'direct access' diagnostic tests to exclude cancer to be entered onto a 'practice safety netting system' with actions to review, chase or resolve in diarised format. This is regularly reviewed by admin staff and Cancer Clinical Lead (once established it could be extended to those patients identified to be at risk but not yet referred, and those patients discharged following treatment to be followed up in primary care). **N/F and P**
- All patients contacted as appropriate following a new diagnosis and receive a good quality, holistic **Cancer Care Review** within 6 months (QOF CAN002) and/or after primary treatment has ended (locally commissioned service), using the Macmillan or other appropriate template. **P**

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Systems of care (continued)

- Cancer is treated as a long term condition as part of the **London 4 point model of care**, so that people affected by cancer (both patients and carers) are included within the criteria for accessing long term conditions support and care planning **N/F and P**
- Practice has an up to date **service directory and referral pathways** to support people living with and beyond cancer and their carers (to address their physical, social and psychological rehabilitation needs, including availability of physical activity programmes). Practice plan to increase physical activity in target group. **N/F and P**
- Does the practice use the **Good Practice Screening Guide**? Is there a designated practice screening lead? Awareness of own Bowel/Cervical/Breast screening uptake rates. Does the practice have a plan for implementation of the primary care best practice screening standards, including plan in place to reach national target in bowel? Are women over 70 made aware of opt in mammography option? Is Bowel scope being offered locally and is uptake being supported by the organisation? **N/F and P**
- **Be Clear on Cancer or local awareness initiatives** and supportive activities by practice? **N/F and P**
- Does the practice have **direct, timely access to imaging** and investigation i.e. USS, CT, MRI, and endoscopy? **N/F and P**

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Systems of care (continued)

- Have the practice/Federation GPs and primary care nurses undertaken the **Training Needs Analysis** questionnaires covering Early Diagnosis and Living with and Beyond Cancer? **N/F and P**
- Feedback from people affected by cancer is actively sought each year, action taken and improvement is demonstrated (national cancer patient experience survey). **N/F and P**

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CCG Checklist

- **Leadership: Named 'Cancer Clinical Lead'** and /or Macmillan GP. A named Cancer manager.
- **A working group for cancer issues –** earlier diagnosis and living with and beyond cancer, with secondary care/patient/primary care/CEPN representatives as a minimum
- **Educational events supported by local CEPNs featuring earlier diagnosis of cancer** - also NICE NG12 guidance. A local strategic plan for training and education of primary care and community staff
- **Clear links with Public Health** – linking with system wide promotion of Be Clear on Cancer campaigns, production of a strategic local Cancer Plan, and using local Cancer Awareness Measures data to plan population level awareness/screening uptake enhancement campaigns. Smoking Cessation Services provision.
- **Strategy for improving GP access to diagnostic investigations** – Xray, ultrasound and CT/MRI in line with NICE NG12 guidance

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Systems of care (continued)

- **Local strategy for increasing cancer screening uptake** – aiming for 75% by 2020 for bowel, and aligned to national targets for breast and cervical screening.
- **Awareness and use of Partner organisation resources** ie TCST, Cancer Research UK facilitators programme and CCG Macmillan GPs posts.

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For more information

Please contact the Transforming Cancer Services Team:

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🖱 https://www.healthylondon.org/resource/primary-care-cancer-checklist/