Royal College of General Practitioners

Person-Centred Care

PATIENT PATHWAYS: INVIDIDUALS WITH CANCER

WHAT ARE THE CURRENT PATHWAYS?

Key junctions in patient care involve the relationship between primary and secondary care once a diagnosis is suspected or has been made, and then after treatment has been completed.

Primary and secondary care interactions occur at two key stages in the cancer pathway: once a diagnosis is suspected or has been made, and after treatment in secondary care has been completed.

Although the management for each individual and each type of cancer varies, these two points in the pathway are universal.

Prior to diagnosis, cancer prevention is important, and measures such as smoking cessation and screening should be considered.

Cancer Prevention This stage of the pathway involves improving aspects of a patient's lifestyle which evidence has demonstrated can increase the risk of cancer e.g. smoking or obesity. Promotion of routine screening and educating patients to recognise concerning symptoms are important for early diagnosis. This stage in the pathway is generally already established as an area in which person-centred care can be impactful for improved outcomes and patient experience. The RCGP cancer toolkits are a useful aid for GPs.

Recognition and diagnosis Pathways for suspecting and diagnosing cancer are generally streamlined and outlined clearly, with two-week wait referrals. Although patients are seen quickly, the patient experience can be daunting and confusing. This tends to stem from lack of information about the

nature of the referral. It is not unusual for individuals to be unaware that a diagnosis of cancer is suspected or that they are being referred directly for an investigation rather than an appointment.

Although individuals are managed by secondary care at this stage, they often wish to return to their GPs to discuss issues or for clarification.

Treatment in Secondary Care Patients have a holistic needs assessment in secondary care which uses a person-centred approach. It considers all aspects of the individual's life including their spiritual, psychological and physical wellbeing. A treatment summary should be sent to primary care.

Health and wellbeing events provide an opportunity to inform and educate patients about the clinical and holistic aspects and ongoing management of their health. They provide information about local facilities, supportive care and opportunities that are available to individuals and their families. Every patient with cancer should be offered the opportunity to attend a health and wellbeing event at the end of treatment to support self-management of their condition. They are facilitated via secondary care and the Macmillan nurses. They occur a few times per year and use a social prescribing model.

Aftercare in Primary Care Informed by the Treatment Summary, the cancer care review is completed by a GP or practice nurse to discuss the person's needs. It should be carried out after a cancer diagnosis. Once treatment has been completed, the patient is referred back to primary care.

WHAT ARE THE CHALLENGES OF THE CURRENT PATHWAYS?

The main challenges of the pathway relate to information sharing between secondary care and primary care. Although a personalised assessment is done in secondary care (holistic needs assessment) and primary care (cancer care review), two assessments tend to be done in isolation.

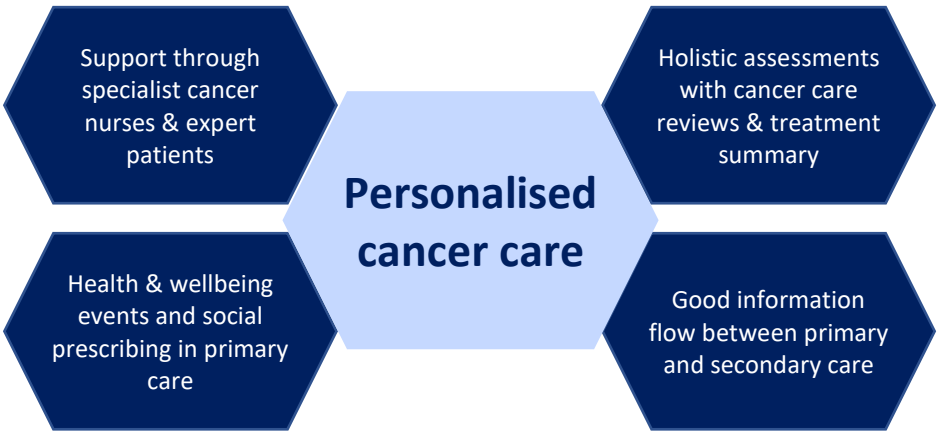
Treatment after diagnosis takes place in secondary care but patients often want to discuss diagnosis/treatment with their GPs. Clinical information is often not available to GPs which can make it difficult for GPs to support patients.

Although the diagnosis of cancer is streamlined across the country, the provision of care post-diagnosis varies between localities and surgeries. There is understanding that the process should be personalised and proactive but not a clear pathway or processes for implementation.

WHAT WOULD A MORE PERSON-CENTRED PATHWAY LOOK LIKE?

The holistic assessment in secondary care clearly aims to recognise and address what is important to patients. However, information sharing with primary care is needed for the continuity of this model. There may be a role for specialist cancer care nurses in primary care. For example, making contact with any patient with a new diagnosis of cancer and involvement in cancer care reviews.

Patient representatives or 'expert patients' could be used as directories of care/support in the community. Link workers may also provide a link between individuals and the wider community. Patients can access health and wellbeing events as a 'one-off'. Embedding social prescribing in primary care can ensure that this is a resource available throughout the patient journey.



WHAT WOULD BE THE BENEFITS OF A MORE PATIENT-CENTRED PATHWAY?

With improved information flow between primary and secondary care, the holistic needs assessment follows the patient back into primary care thereby improving continuity of care.

Having a designated health professional for 'cancer' and a clearer pathway for assessment after diagnosis will streamline care and improve continuity. Many patients with cancer have other long-term conditions. Addressing what matters to patients can aid self-care and activation. This may impact on clinical outcomes, use of services and most importantly, wellbeing.

TOP TIPS FOR MAKING THIS PATHWAY MORE PERSON-CENTRED

1. Improve information sharing from secondary to primary care after diagnosis.

2. Designated PN/HCA for 'cancer' in surgeries.

3. Streamline and clear pathway for assessments in primary care after diagnosis.

4. Involvement of community support and patient experts/representatives.

5. Ensuring individuals understand nature of two-week referrals through written information or clear communication, taking into account health literacy.