Bath and North East Somerset,
Swindon and Wiltshire
Integrated Care Board

GWH Facing Surgeries:
Cancer Care Review
Guidance and Information Toolkit

Date: 1st Feb 2023

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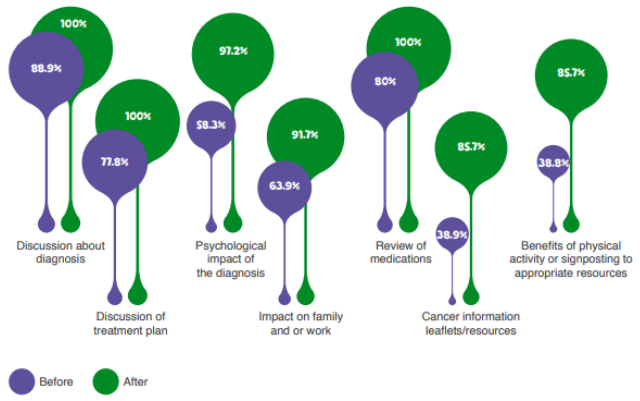
Introduction

The incidence of cancer within the United Kingdom has never been higher with the current statistic now standing at 1:2 (*Cancer Statistics for the UK.* 2015). More than 50% of people with a cancer diagnosis now live for more than 10 years, 70% with additional long term conditions (LTC), which increase with age (Macmillan, 2015). 67% of people living with cancer and another LTC often have additional personal or practical support needs which need to be addressed in primary care.

People living with a cancer will have an existing relationship with their GP surgery to manage their health needs, therefore the introduction of Cancer Care Reviews (CCRs) are needed as these provide a means for a discussion with a clinician about any support that is needed after a cancer diagnosis. More than 54% of people who received a cancer diagnosis in 2020 felt they did not receive adequate support from their GP surgery within Swindon and more than half of people surveyed by Macmillan (*2020 trust results.* 2020) were found to have unmet emotional needs after their diagnosis. Unmnet needs after a cancer diagnosis are likely to manifest as additional GP contacts, averaging between 3-5 additional contacts for up to 10 years post diagnosis (Khan, Evans and Rose, 2011).

An evaluation by Macmillan showed that clinicians using the CCR templates within primary care are more likely to meet the needs of their patients.



(Macmillan, 2020)

In Swindon there are pockets of deprivation, LD and BAME communities, which are more likley to experience ill health and therefore cancer diagnoses; people from these communities are often less likely to access care and experience worsened health outcomes. The current strategy states that access to health and social care should be equitable for these communities and therefore within the context of cancer and CCRs, these should be accessible for anybody with a cancer diagnosis (*Swindon_s_health_and_wellbeing_strategy_2017_2022*).

The current requirement for providing CCRs within primary care as per the Quality Outcome Framework (QOF) is to provide a discussion of support within 3 months of diagnosis and a full CCR within 12 months (*B1333_Update-on-Quality-Outcomes-Framework-changes-for-2022-23_310322*). This should be a holistic discussion which includes all aspects of physical, practical, emotional, family and spiritual needs underpinned in a structured, pre-planned appointment.

For this reason, we have created a standard operating procedure that all surgeries within the locality can adopt into practice which outlines a structured and safe way to conduct and complete equitable CCRs. This document is intended to provide the most recent guidance and information for carrying out CCRs.

Suggested Standard Operating Procedure for CCRs

(GWH Facing Practices)

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See notes on reverse relating each numbered section

1. Diagnosis of cancer sent to practice from secondary care

- Check if new diagnosis, has this been discussed with patient already? (Basal Cell Carcinoma does not require CCR)
- Code to record and task referring GP
- Consider whether metastasis diagnosis
- Attach HNA (and/or) treatment plan if included into record attachments in patient notes

2. Plan regular Cancer Care Review slots into practice rota

3. Run weekly/monthly reports 'QOF Work to do' identifying patients for:

- 3-month support discussion or
- 12 Month full CCR
- **NB: 3-month patients should ideally be booked 6-8 weeks from diagnosis with the same GP that referred**

4. Telephone contact to patient

(either 3-month/12- month appointments).

- Assess for adjustments (LD, Language Line, Hearing/Visual impairment and Capacity)
- Send Macmillan Concerns Checklist (HNA)
- Book an appropriate review (Telephone/Video/F2F/Home Visit) confirmation by text or letter
- Missed contact: after 3 attempts or declines appointment → 7.0 Safetynetting Protocol

Admin/Booking

5a. Patient attends 3-month support appointment (CAN005)

- Use 3-month discussion template to record and structure discussion
- Ensure QOF * box is ticked
- Use Macmillan Concerns Checklist (HNA) to guide holistic discussion
- Provide signposting and information in written format to underpin appointment
- Set expectations around 12-month CCR and set recall
- Safetynet accordingly
- SNOMED Codes in notes section

5b. Patient attends 12-month CCR (CAN004)

- Use CCR template to record and structure discussion
- Ensure QOF * box is ticked
- Use Macmillan Concerns Checklist (HNA) to guide holistic discussion
- Provide signposting and information in written format to underpin appointment
- Safetynet accordingly
- Make decision on whether additional appointments needed to support – set recall
- Request feedback (if appropriate)
- SNOMED Codes in notes section

Clinician (GP/Nurse/Social Prescriber)

6. Patient DNA appointment → 7.0 Safetynetting Protocol

7.0 Safetynetting protocol: for non-responders, non-attenders and declined appointments.

- Explore reasoning for declined appointment/non-attendance
- Rebook if possible (for non-attenders)
- Check patients details correct
- 3-month QOF can still be claimed as 'offer of support' given even if declined
- Cancer Champion (Swindon) or GP Cancer Lead (Wilts) to assess/contact patient to ascertain reasoning behind non-engagement
- As a **last** resort, patient can be exempted from 12-month CCR QOF (see example of this in notes)
- If declined at 3-months, still requires booking for 12-month CCR using same protocol

Clinician OR Admin

Notes to accompany the SOP

As the cancer landscape is changing, with more people surviving and accessing screening, diagnosis and treatments sooner primary care will be supporting people to live with cancer as a long-term condition and may require regular reviews going forward. It is imperative that an assessment of an individual's working circumstances are considered and supported with a relevant MED3, and that the individual is signposted to financial help and support, as well as knowing that their prescription charges will be waivered. Although historically CCRs may have been completed by GPs, there is growing evidence that nurses who complete CCRs are more likely to adopt a holistic approach which include all areas of health (physical, practical, emotional, family, spiritual and signposting). The National Cancer Patient Experience Survey 2020 highlights that only 56% of patients feel that their GP Practice were able to meet all their needs after a cancer diagnosis in the Swindon area. Research also shows that unmet needs in general practice result in additional contacts to the surgery; between 3-5/year for up to 10 years after diagnosis (Khan., et al. 2008). So a good quality holistic review is more likely to better meet the needs of your patients and reduce surgery contacts.

For assistance and practical advice on CCRs please contact Julie.cracknell3@nhs.net or refer to guidance on macmillan.org.uk

1. New diagnoses should be looked at and assessed whether these are a new diagnosis and/or metastasis – coded to record using correct cancer SNOMED codes. Task referring GP for information. Attach any treatment plan, end of treatment summary or Holistic Needs Assessment that accompany the diagnosis. Important to know whether the diagnosis has been discussed with the patient at this stage and level of distress experienced. Please note that Basal Cell Carcinoma does not require CCR.
2. Plan into your surgery rota regular slots for cancer sessions. These can be differing in length depending on whether the appointment is for the CAN005 (3-month offer of support or CAN004 12-month CCR). A suggested length for a 12-month CCR would be 30 minutes but can be flexible depending on the individuals needs. A suggested length for the 3-month discussion could be 15 minutes.
3. Reports can be easily run in SystemOne using the reporting tab; Reporting→QOF Tools→QOF Work to Do→Select both CAN004 and CAN005→Run Report. Here you will be presented with a list of patients and their due date for their 3-month discussion or 12-month CCR. This report should be run regularly to include new patients.
4. The list of patients can then be used to prioritise bookings into cancer clinic slots. The patients should be invited in priority order dependent of their 'Action Due' date to avoid missing the 3-month or 12-month deadlines. Contact each patient that needs booking in by telephone (this gives an opportunity to ascertain any adjustments before the review such as interpreter, LD Easy Read information, hearing or visual impairment or capacity issues). Although this may seem time consuming, by doing this you ensure that there is equitable access for all for cancer care. Offer the concerns checklist via letter, text (AccuRX Florey), eHNA or at the appointment, the importance of completing this document should be

communicated to the patient as it provides a communication tool for assessing all areas of concern. The HNA dropdown within the Ardens template equates to the same thing as the concerns checklist published by Macmillan. The HNA/Concerns checklist is available in 16 languages. By spending this extra time contacting and assessing, clinician time will be optimised. Declined appointments and continual missed contact need to be assessed by the cancer champion and reasons explored for this (e.g. depression or lapsed patient details) and if absolutely certain they don't want the appointment then a recall can be set for 6-months. N.B. the 3-month QOF flag should still be ticked as an offer of support has been given but not accepted, however the same process must be attempted for the 12-month CCR.

5. At the appointment, use of the concerns checklist/HNA can underpin your discussion. This needs to be captured using the Ardens cancer template for either the 3-month discussion or the 12-month CCR. Template can be accessed by using the Auto Consultation Tab within SystemOne→ArdensConditions→Cancer. The main cancer menu will appear with the option to choose 3-month or CCR and gives access to the resources section within the same menu. For users of EMIS (Wilts) please use The EMIS template is located in: EMIS Library > EMIS Protocols > Third Sector Partnerships > Macmillan/Cancer Support > Macmillan Cancer templates.This template can be accessed from the template picker by searching.
   Ensure that all elements of the template are used and where possible add in as much detail using the pencil icon next to the dropdown boxes. A Personalised Care and Support Plan can be then produced for the patient to take away. For each concern identified, please try and get your patient to prioritise these if a few are ticked. Discuss and signpost for each issue the patient may have. To collect qualitative data and improve your own services, use the CCR feedback template to collect qualitative data relating to CCRs produced by the Thames Valley Cancer Alliance. At the end of the 3-month discussion appointment, you can verbalise the invitation for the 12-month CCR. Don't forget to safetynet your patient for any 'Red Flag' symptoms and check they know the local contact. Full SNOMED codes below:

SNOMED codes for Personalised Care

Completed by	Personalised Care Intervention	SNOMED Code
Secondary Care	Holistic Needs Assessment	Holistic needs assessment (procedure) SCTID: 787261000000106
Secondary Care	End of Treatment Summary	Cancer End of Treatment Summary Plan (record artifact) SCTID: 1324891000000103
Primary Care Requirement of QOF	Informed conversation within 3 months of diagnosis (QOF – CAN005)	Provision of information about cancer support services available in primary care (procedure) SCTID: 1239881000000109 – QOF
Primary Care Requirement of QOF	Cancer Care Review (QOF – CAN004)	Cancer care review (procedure) SCTID: 720006006

6. number for any oncological emergencies. For GWH this is:

Acute Oncology/CUP Team	Jo O'Connell	5213/7396	gwh.aosteam@nhs.net

   You may find the UKONS Triage Tool useful in identifying symptoms and triaging accordingly.
7. For patients who DNA repeatedly, the safetynetting protocol should be followed and should be contacted 3 times using differing methods before a task sent to cancer champion and followed up. If after this time a cancer review is assessed as inappropriate – the patient can as a last resort be exempted from 12-month QOF for that year. However, they may need

support in the future so setting a 6-month follow-up can be useful. An example of exemption may be someone with a diagnosis of skin cancer, this may not need the level of engagement of a full CCR. People who lack capacity should still be offered a review, with additional adjustments in place such as attending with a carer/relative or visit to a care setting to carry out the CCR.

Version 7		
Date	Signatory	Organisaton
May-22	Dr Karen Sandhu	Swindon Macmillan GP
May-22	Cherry Jones	Swindon Cancer Projects Co-ordinator
April-22	Dr Caroline Annesley	Macmillan GP - Wiltshire
April-22	Dr Lynne Macready	Wiltshire Macmillan GP
April-22	Terry James	BSW CCG – Cancer Commissioning Manager
April-22	Andrew Jennings	BSW CCG – Senior Commissioning Manager
May-22	Dr Kabir Ahluwalia	TVCA
April-22	Shelley Orton	Macmillan – Strategic Partnership Manager Swindon

What should be covered during a CCR?

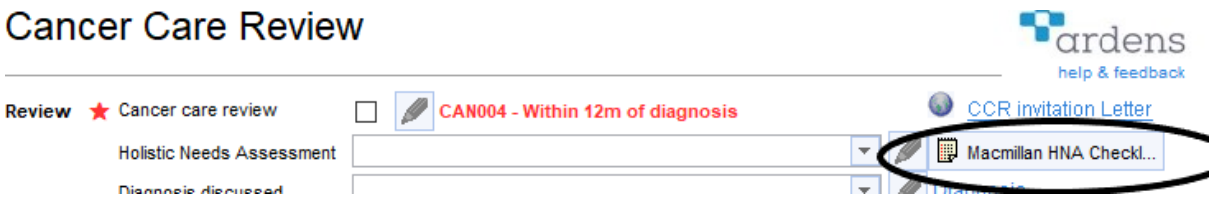
Macmillan have given some guidance about what as a minimum should be covered during a CCR

1. A patient should understand what their diagnosis and prognosis is by the time they have been discharged from secondary care. This may not always be the case, therefore you should ascertain their understanding and provide information around the diagnosis and prognosis.
2. An end of treatment summary (EOTS) may have been sent from secondary care, although they may not yet have finished treatment. It is import they understand how to manage any symptoms that arise from the cancer or the treatment.
3. Anyone receiving treatment for cancer is entitled to free prescriptions, in addition it is important that existing medications are known and whether any changes have been instigated by secondary care. Signpost to the medical exemption certificate they need to complete.
4. It is important that the needs of the patient (and any carer) are known and recorded, and that these needs are adequately signposted to local and national services. There is an extensive national library of resource links within the resource section of the Ardens template in SystemOne (Appendix 1).
5. Promotion of physical activity is essential in secondary prevention of disease and to empower people to live a better quality of life. Lifestyle questions, advice and motivational goal setting all help in giving back some control to the patient after a cancer diagnosis. There is a link to Lifestyle and Vitals within the Ardens template to record this. In addition there is an online Macmillan iHOPE course available

How should I record the 3 month discussion or full CCR?

You should always use the inbuilt templates in SystemOne implemented in surgeries across Swindon (appendix . These enable a structured approach and provides prompts to the clinician about what to include. The QOF red starred indicator should always be checked to gain the QOF points associated with the CCR. Templates can be accessed a number of ways but the quickest is by using the AUTOCONSULT tab, then CONDITIONS then CANCER and you will see the CANCER CARE REVIEW full menu. When selected, all sub-menus are visible along with the diagnosis, resources and notes tabs.

Please note the HNA flag and sub-menu which should be used at both the 3-month discussion and 12-month CCR (below)



Signposting to cancer related services in Swindon

As a directive from Macmillan and best practice in helping your patients to self-manage, signposting locally and nationally is essential at CCRs.

There are several services operating within Swindon that provide both generic advice and guidance and targeted therapies within the locality. The table below show the main services operating that are useful to people with a diagnosis of cancer, which patients can self-refer to.

Service	Offering	Referral
Swindon Live Well Live Well Swindon	This service is run by Swindon Borough Council and aims to address non-medical health and wellbeing (also known as Social Prescribing). The team has a Cancer Champion who is promoting cancer screening uptake and can signpost to a number of services such as: • Stop Smoking • Physical Activity • Weight Management • Connecting communities • Management of long-term health • Therapy groups	Self-refer via: For more information and to connect with us, please contact Live Well on 01793 465513 or email: **livewell@swindon.gov.uk**
Swindon LIFT Psychology	This service offers talking therapies, online self-help and advice in order to improve mental health issues such as anxiety and depression. They also offer more targeted and group therapies by registering with them.	You can self-refer to this service **Contact details:** **Phone:** 01793 836836

		Email: awp.lift-psychology@nhs.net or simply visit their website by searching 'Swindon LIFT'
Swindon WeHearYou (WHY)	Psychology therapies for people with cancer and their families.	Available Jan-23
GWH Macmillan Personalised Care Team	Consisting of specialist nurses, a physiotherapist, an occupational therapist and volunteer 'buddies' who focus on health and wellbeing. Enabling self-management and achieve a better quality of life after diagnosis. Running regular online and face-to-face sessions which empowering patients to take back some control and improve long-term health. The sessions are topic focussed (such as managing fatigue) and a list of 2022/23 virtual workshops is included here. Additionally, they offer face to face group sessions that enable self-care after a cancer diagnosis – referred to as the Macmillan HOPE course. Full details of the team and their offering can be found here. Accessing personal training sessions and short-term gym membership may also be possible through this team.	you can self-refer by emailing the team on mailto:gwh.macmillanpctreferrals@nhs.net and they will contact you to discuss your specific needs. Alternatively, their telephone number is: 01793 607819.
Swindon Podiatry	For patients having issues with their feet after a cancer diagnosis, there is an agreement that podiatry will see them.	Access via the normal 'orange arrow' via system one.
Prospect Hospice	For anyone with a life limiting diagnosis that means a deterioration and end of life care within a year. A Clinical Nurse Specialist is assigned to each PCN and new patients can be referred for therapies, support and medication management/palliative care.	Use the 'orange arrow' within system one or complete the online form here: Referrals - Prospect Hospice (prospect-hospice.net)

Macmillan Financial Helpline	The average impact to someone after a cancer diagnosis now stands at approximately £1000 (2022) and help can be sought via the helpline 8-8pm 7 days a week.	Self referral: Financial help - Macmillan Cancer Support.

What is available to enable my patient to self-manage?

We have in Swindon access to a Macmillan Personalised Care Team, who consist of a team lead, specialist nurses, occupational therapist and physiotherapist.

Services they can offer to your patient:

Cancer buddy service whilst in GWH (for people who may be isoloated and not have support whilst at appointments at GWH)

Access to a topic focussed session related to cancer (see sessions here)

Prehap/Rehab

Macmillan 'Take Control and HOPE' courses

Signposting and referral to specialist teams and services (such as Psychologist)

Supporting movement – 4KYourway, Personal Training sessions and Gym Membership (Link Centre)

Self-referral or from Primary Care via: mailto:gwh.macmillanpctreferrals@nhs.net

01793 607819

What resources are available for my practice?

There are a number of resources available that support a clinician when running a CCR clinic or appointment. Click on each of the resources below to access;

Signposting to local services	In-document
Macmillan Learning & Communications Hub	External link – requires registration (free)
Standard Operating Procedure	In-document
A4 Poster Advertising CCRs (Patient Focus)	Appendix
UKONS Cancer triage tool	External link
Macmillan Quality Improvement Toolkit	External link
10 Top Tips for Conducting a CCR	External link
10 Top Tips for Social Prescribing	External link
Patient information Leaflet (Swindon)	Appendix
Patient Information Leaflet (Wilts)	Appendix
Macmillan Cancer Care Plan	External Link (also accessible via S1 template)
Concerns Checklist	External Link

AccuRX Florey Crib Sheet	Appendix
Suggested Training Pathway for Nurses	In-document
Macmillan Primary Care Prospectus	External Link
Macmillan Competency Framework	In-document

Verbal Prompts for booking teams

Some feedback has been received about staff who may feel unsure about contacting patients to book them in for their CCR. The feedback relates to the language used when talking to someone who's recently had a cancer diagnosis. The below prompts go some way in helping people who are not clinically trained to give clear messages about CCRs.

Before contacting any patient to book them into a CCR, you must ensure they have had a discussion with a secondary care team. This is usually evident in the letter that comes back from GWH and is indicative that the patient is fully aware of their diagnosis/prognosis.

On contacting your patient you must carry out the usual demographics check after you have introduced yourself. You may then wish to start your conversation something like this:

"The reason for my call today is because we have received a letter from the hospital about your recent cancer diagnosis and wanted to invite you into the surgery for a Cancer Care Review. The purpose of the appointment is to check in with you and have a chat about your health and wellbeing after your diagnosis"

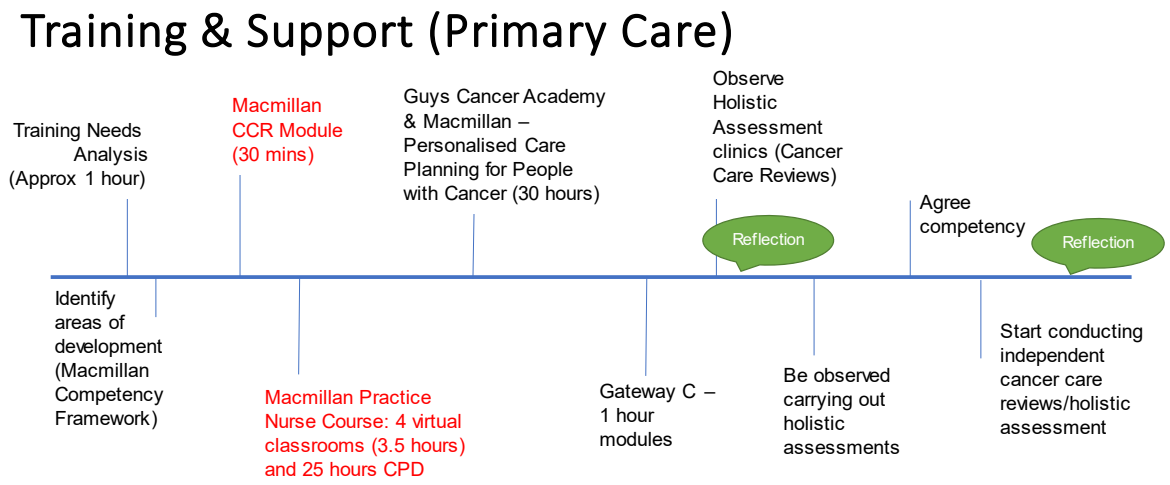
You may wish to emphasise that the appointment provides an opportunity to talk about all aspects of health and any concerns they may have (these do not have to be medical concerns, they may be physical, practical, social, financial or related to mood and mental wellness).

"the nurse/doctor who you will see will be able to provide a list of services that can help you move forward with your recovery whilst, or after you are having treatment"

You may wish to establish at this point any challenges that your patient may have at the appointment such as hearing/sight impairment, language barriers or memory issues. They may also benefit from being accompanied by someone they trust at the appointment. You will need to share with them a concerns checklist ahead of the appointment, so establishing whether an easy read version or another language would be better suited to that patient. Please make the patient aware that the purpose of the concerns checklist is to communicate all areas of concern to the clinician and provides an opportunity to openly discuss those things (including any that they feel embarrassed to bring up). If the patient is able to ably use a smart device then sending the AccuRX Florey questionnaire would be better as this codes responses back to their records.

Suggested training and pathways

There has been an evaluation by Macmillan (2018) which suggested that Practice Nurses and Social Prescribers are able to conduct CCRs after some initial training. The toolkits and templates that exist currently support all aspects that need to be covered in the CCR and working methodically through the templates ensure nothing gets omitted. However, a basic level of knowledge is needed in order to support people with a diagnosis of cancer within primary care. Macmillan have a number of courses available for people wishing to upskill and the modules can be completed alongside a suggested pathway for development as shown below.



For training support please contact Julie.cracknell3@nhs.net

Although the pathway is shown in a linear manner, the observational elements can be done alongside the training. An initial self-assessment is needed using the Macmillan Person Centred Care Competency Framework. This document covers all aspects of care with the levels stratified by AfC bandings to help clinicians relate to the level they should be working to (e.g. for pain management at a band 6 equivalent there will be a level of expectation that differs to a support worker).

After the self-assessment there will be areas that may need strengthening, where directed training can be applied. As a minimum, the expectation will be attendance at the Macmillan Practice Nurse course and the Macmillan CCR module, free to access. Registration is via the Macmillan Learning & Communications Hub.

Additional study can be undertaken and a suggested module would be the Guys Cancer Academy, Personalised Care Planning module.

For secondary care training pathways (GWH) please contact karen.brown@nhs.net who can direct you to the teams best suited to your training needs.

Evaluating your patient interaction

Any service that is undertaken in healthcare should be done using best practise and evidenced. Therefore we ask that you look at your CCR service provision and collect feedback. By doing this you can continually improve what you offer to patients and subsequently make service improvements that are patient-led.

We have created an evaluation form for you to give to your patients so they can offer feedback and suggestions for improvements at a granular level.

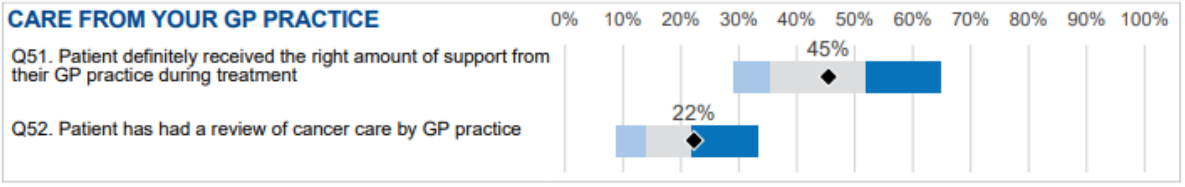
Please do share any feedback gained from these evaluation forms by sending your output to Julie.cracknell3@nhs.net

We also encourage anonymised case studies where you feel service/interaction can be learned from and shared across the BSW ICB geography.

The benefits of service evaluation:

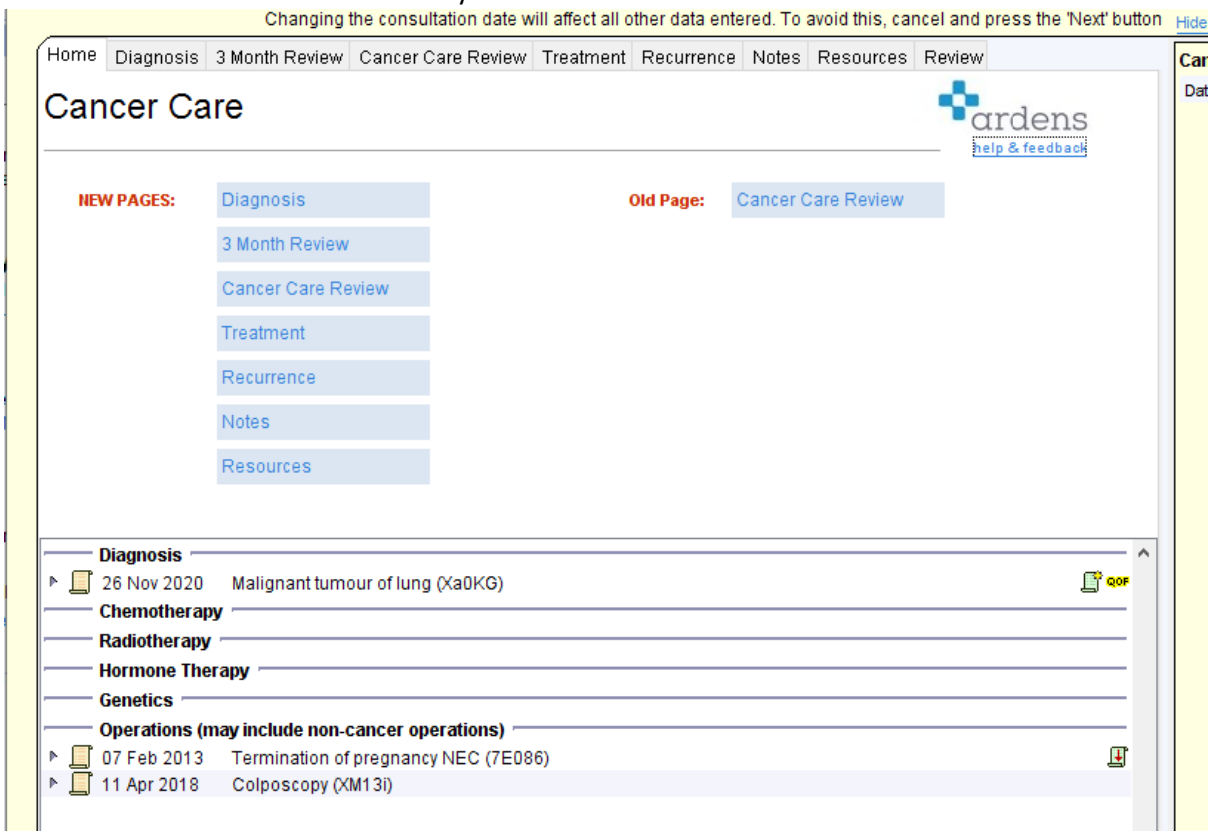
- Meeting patient needs
- Promotion of self-management and signposting
- Better quality of life
- Reducing repeat GP contacts
- Continuous service improvements, demonstrable to CQC

Post diagnosis support in Swindon needs to improve as per the last National Cancer Patient Experience Survey (2021) and that every contact counts.

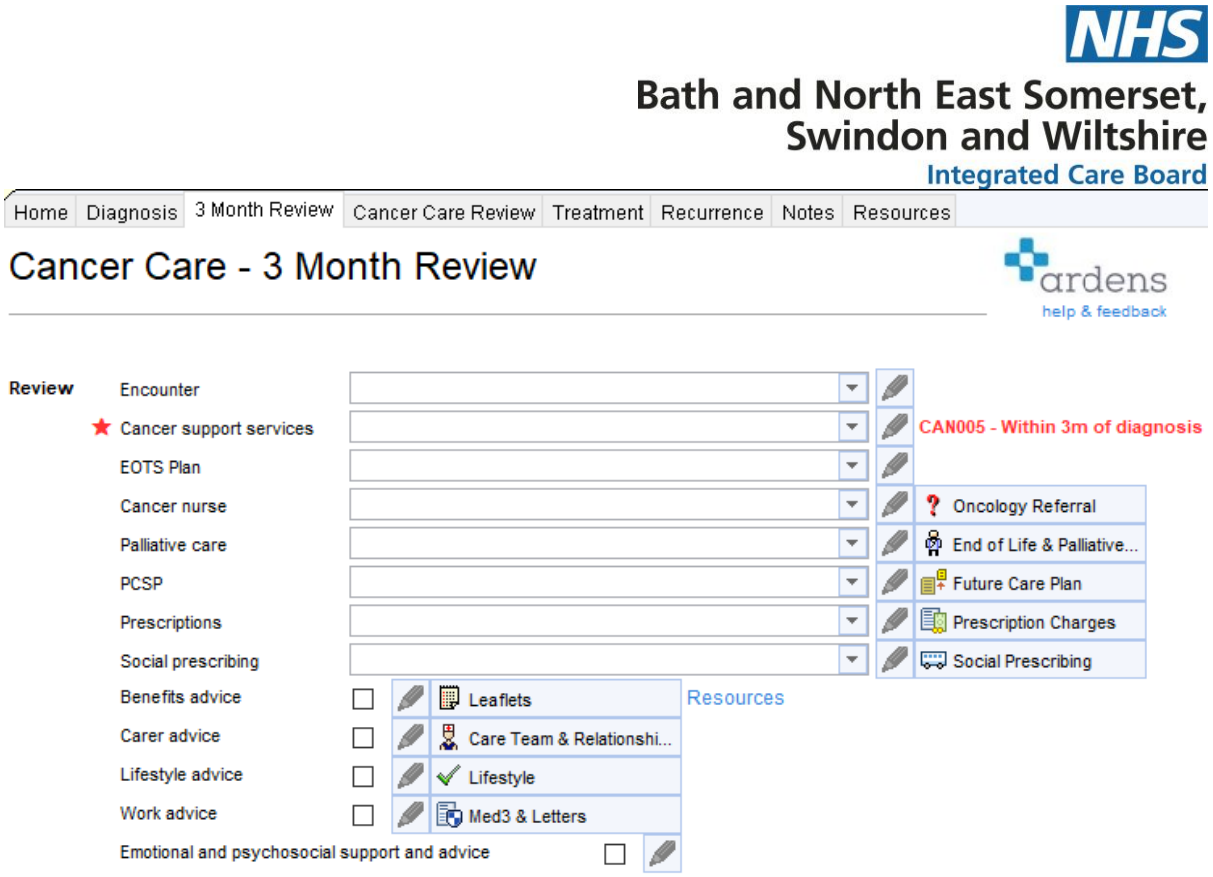


Appendices

1. The Cancer Care Full Menu within SystemOne



2. The 3 month review template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Home
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Cancer Care Review
Treatment
Recurrence
Notes
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Cancer Care - 3 Month Review
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Review
Encounter
Cancer support services
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EOTS Plan
Cancer nurse
Oncology Referral
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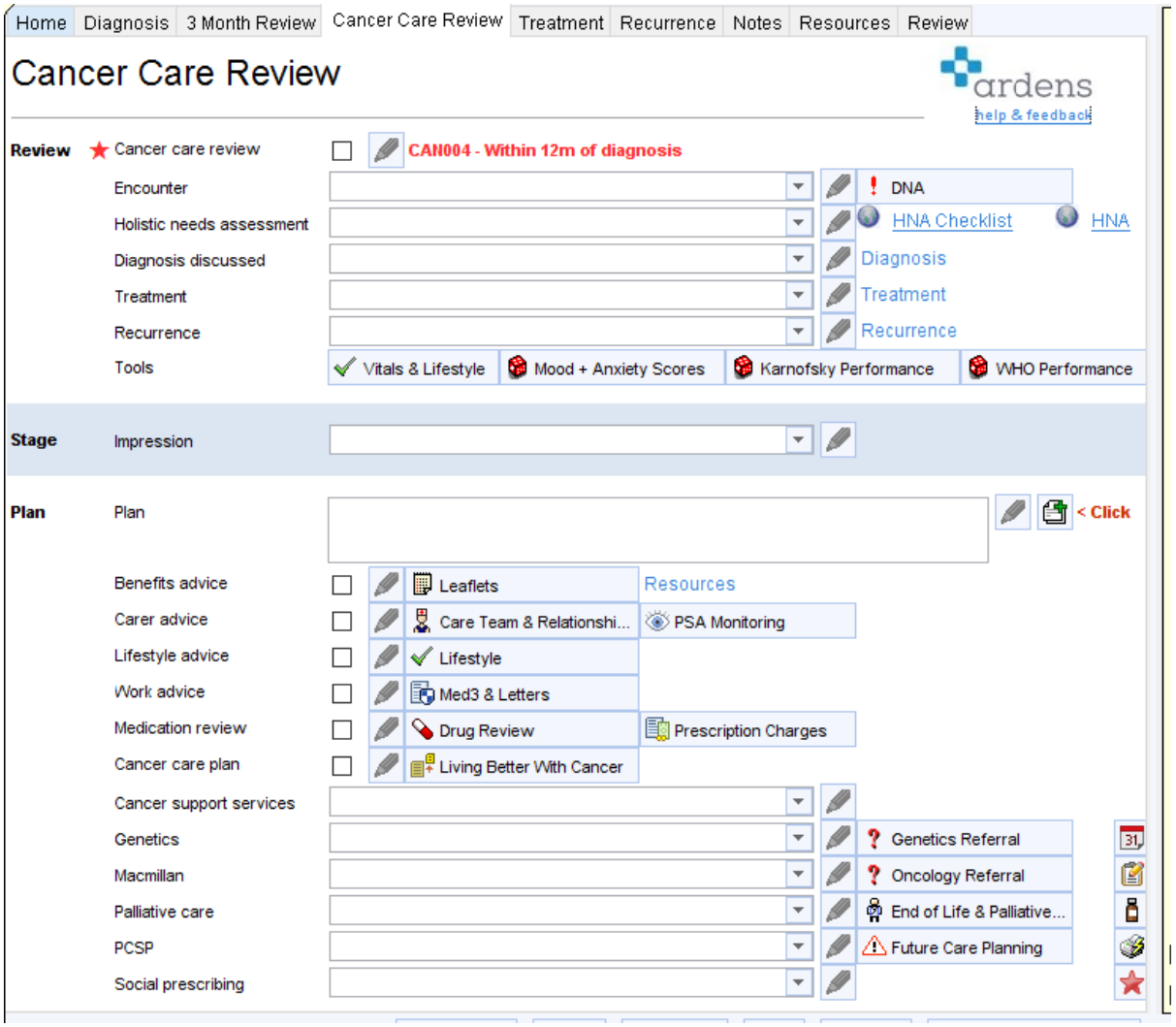
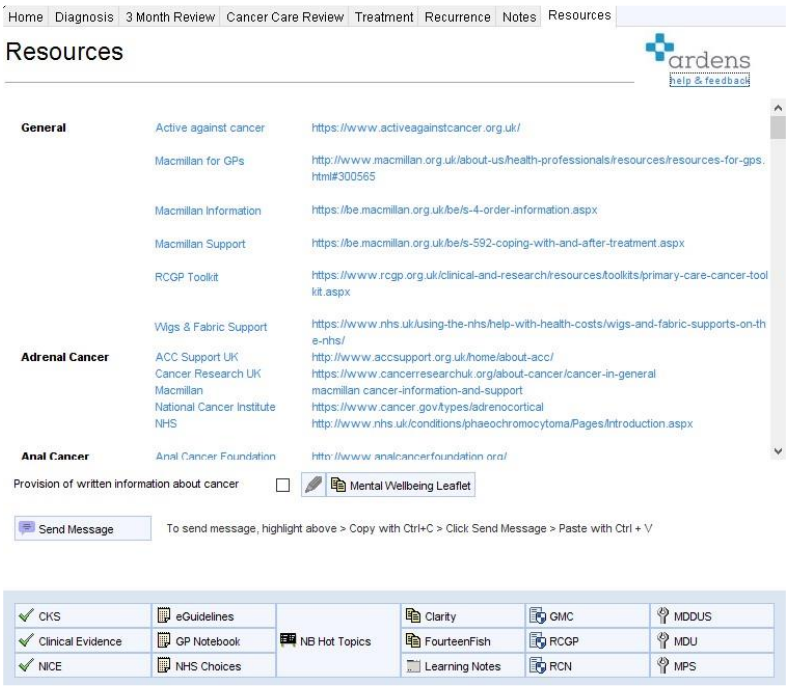
End of Life & Palliative...
PCSP
Future Care Plan
Prescriptions
Prescription Charges
Social prescribing
Social Prescribing
Benefits advice
Leaflets
Resources
Carer advice
Care Team & Relationshi...
Lifestyle advice
Lifestyle
Work advice
Med3 & Letters
Emotional and psychosocial support and advice

3. The 12 month Cancer Care Review template



4.The resources tab

Resources



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4. GWH Personalised Care Team Virtual workshop planner 2023	2023%20Draft%20virtual%20program_.d
5. About GWH Personalised Care Team 2023	About Macmillan Personalised Care Te
6. Macmillan Take Control (HOPE Course)	Introducing%20Macmillan%20take%20(
7. UKONS Triage Tool (for onco emergencies)	UKONS Traige tool.pdf
8. Patient facing poster	A4 Poster -Patient focus CCRs.pdf
9. AccuRX Crib Sheet	AccuRX%20Florey%20Crib%20Sheet.doc
10. Macmillan Person Centred Care Competency Framework	Person Centred Care Competency Fr
11. Macmillan Practice Nurse Course Flyer	Practice Nurse Flyer 2023 V4.pdf
12. CCR Evaluation form	Evaluation%20Form.docx