

Live Well with Cancer – Patient Pathway

Access – Via GP suspected cancer pathway or consultant upgrade

Via GP – Are any non-medical sources of support they may need at this time – eg financial, peer, psychological support etc

Consultant Upgrade

Potential GAP – Capacity & Demand. Insufficient CCC/CNS capacity to manage demand effectively

Potential GAP - Do patients go straight for tests and miss the HNA/PCSP stage

Potential GAP – Variation of information recorded / shared. Do ALL Patients receive copy of letters to GP

Initial booking appointment with Cancer Care Co-ordinator/CNS:

Q – Are they routinely offered an HNA – does that feel like a person-centred conversation?
 (Timing of this will be dependent on the pathway/tumour group as not all will be offered an HNA early in the pathway)
 Q – Is this turned into a PCSP if not what change or intervention needs to take place
 Q – How are ideas and actions followed up – eg What referrals are made at this point i.e. MCISS/VCSE/Psychological services/Social Prescribing - *who actions the referrals? Could be a barrier?*
 Q – Do these actions/ referrals promote changes to daily routines and takes part in proactive healing in order to reduce readmissions and promote long-term wellbeing.

Potential GAP – Process is not consistent for all tumour groups?

Moving through treatment phase

Q – Are they receiving a treatment summary at the end of each episode of treatment – does it adequately cover side effects, late effects etc sufficiently?
 Q – Do they receive another person-centred conversation via a HNA to check in on changes in circumstance and what they would like help with
 Q – If appropriate, was PSFU explained to the patient? And were non clinical needs discussed to ensure it was appropriate for the patient?

Potential GAP – Is Process consistent? Is formal process in place – or is summary completed ad hoc / details not shared

Potential GAP – Is Events Process consistent is a formal process in place

Health and wellbeing events / living with and beyond cancer

Q - Are H&WB Events offered across all tumour groups or are they mostly generic? If so is the offer of attending an event recorded?
 Q - Do Trusts know about the Cancer Care Map and provide updates on what is available?
 Q - How are events evaluated? Is there a mechanism for patients to feedback how useful it was?
 Q – Is Referral of patients on to other services predominantly via the MCISS centre or do CNS/CCC use Elemental to refer into Social Prescribing

Potential GAP - ?Late effect services capacity ?Psych support capacity ?Are pathways clear

Potential GAPS – ?Can GP's refer into late effects easily after 12 months post treatment and can patients self-refer?

Late effects – Are patients educated enough? Is this routinely enquired about whilst still under CNS care, or is it only up to 12m. *Effects include Chemotherapy effects (pain, nausea, fatigue etc) and radiotherapy effects (joint pain, sexual function etc).*
 Are referrals to other specialties for late effects assessment/treatment made routinely for physiotherapy for radiotherapy injury, lymphoedema etc / do CNSs manage or /and advise on menopausal symptoms.
 Is advise provided to GPs to prescribe risk reduction medication and to predict percentage risk of recurrence to both GP and patients
 Are psychological late effects considered routinely

Discharge to Primary Care – The patient should have a cancer care review at the time of a patient's diagnosis (within 3 months), after a patient has received acute treatment (within 12 months)

Q – Are these being routinely offered if so, are they informed by any previous HNAs or PCSPs?
 Q – Are they enabling a holistic conversation about what matters most to the person?
 Q – Does the practitioner feel well informed about opportunities and sources of support and help available in the community, and do they have time and skill to support people to access these?
 Q – Are there good relationships with Social Prescribing Link Workers/acute care CCCs so that the person can access support from them, and/or the practitioner can call on their knowledge to navigate their patient to non-medical sources of support?

Potential GAP – Data collection – can we access numbers of CCR's – how is quality assessed?

Follow up care - The health system fosters engagement between the patient and clinician in order to enable the patient to address symptoms and maintain good health.

Q – Does the person feel like there is someone there who can help them?
 Q – Is access back into support or reassessment made clear and readily available

Discharge: What next? Are there ongoing opportunities to access physical activity offer/social activities etc. Is return back into secondary care clear if needed?