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Welcome to the 2016 edition of our newsletter dedicated to the annual Macmillan primary care conference. The conference is hosted by our GP Advisers and Medical Communities of Influence team, and as always we had some inspirational speakers and hopefully lots of practical ideas to be taken back to the localities.

It’s been a challenging time for general practice, facing so many demands at a time when the needs of people with cancer are growing. Primary care teams will continue to play an increasing – and changing – role in supporting people with cancer alongside the management of other long-term conditions. Already we are seeing a step-change in how cancer care will be delivered in Scotland, following the dismantling of the Quality and Outcomes Framework, with other nations likely to follow in 2017. Keeping cancer high on the agenda during these transitions could not be more important.

The Macmillan primary care community, working closely with secondary care colleagues, continues to be at the forefront of developments across the UK. Building on the work started in 2014 by Professor Peter Vedsted from Denmark, we heard from his colleague Professor Frede Olesen as well as Macmillan GP Matthias Hohmann on how the Danish model has influenced earlier diagnosis of cancer across parts of the UK, particularly Greater Manchester. There is great potential for the primary care community to continue highlighting good practice and influencing its spread across the UK.

As always, we are hugely grateful to the people affected by cancer who join us and remind us why we are all here. Our dinner speaker, Greig Trout (pictured below), described his ‘anti-bucket list’ called ‘101 things to do when you survive’, which seeks to inspire people to feel positive about their future following a cancer diagnosis. Greig shared his very personal story of experiencing cancer both as a child and an adult, and how he had overcome the psychological effects of the diagnosis, something he felt no-one had warned him about. Greig’s talk resulted in a well-deserved standing ovation - you can find out more at www.whenyousurvive.com.

We look forward to seeing you in 2017!

Lorraine Sloan
Medical Communities of Influence Lead

Rosie Loftus and Cathy Burton
Joint National GP Advisers
Reflected from Macmillan’s First Clinical Fellow

For junior doctor Berkin Hack the last 12 months as Macmillan’s first clinical fellow have been something of a journey of self-discovery, he says.

The aim of the one-year National Medical Director’s Clinical Fellowship Scheme is to fast track and support trainee doctors who show the potential to develop as future medical leaders. Fellows are assigned to a national healthcare organisation, giving them the chance to work with senior leaders and gain new skills and experience.

Berkin, who trained in Brighton and has had a long-standing interest in cancer, says he has learnt an enormous amount in the last year about how to achieve sustainable change. “What Macmillan does really well is create networks and relationships and use those to get small things done but on a large scale, to make big differences.”

Part of his reason for applying for the clinical fellowship in the first place was that he felt powerless as a junior doctor to make the changes needed and didn’t have the skills to navigate the system.

The last year has given him an invaluable insight into how that can be done. “I’m more aware of how a complex system works and also as a doctor you have a set of skills and a unique position which really allows you to see where change needs to occur.”

He hopes to return to clinical work at the end of his fellowship, strengthened by what he has learnt. Like the NHS Macmillan is a large and complex organisation “but it achieves a huge amount with relatively little compared to the NHS. I think it’s a matter of taking the principles that I’ve learnt from Macmillan and extrapolating them to the NHS.”

During his time at Macmillan he has been involved in an impressive array of projects. Many have involved cross sector working between secondary and primary care, tapping into both the organisation’s expertise and his own experience as a frontline clinician.

One of Berkin’s biggest achievements has been to launch a UK-wide student network to engage medical students more fully in Macmillan’s work. “The aim is to involve students in different things from volunteering and fund-raising to creating educational resources,” he explains. “The individual groups will be semi-autonomous and Macmillan is working through how to support them in a UK-wide network. The long-term vision is to have groups of most of the medical schools across the UK who will work both together and independently.”

This in turn will help Macmillan to develop closer links with the 54,000 members of the junior doctor community as well as engaging individual junior doctors more closely. One example is radiology registrar Helen Cliffe who was introduced to Macmillan’s work last year and was a speaker at a workshop this year (see page 12).

The network was launched in Brighton recently with Glasgow to follow shortly. In addition a summer event has since been held to bring together the two groups and to take the network forward.

He knows he is now approaching “crunch time” for many projects he’d like to complete before handing over to his clinical fellow successor in September.

Initiatives he’s been involved with include a 10 Top Tips on clinical management of cancer for junior doctors, advice and signposting on cancer detection and management, a scheme to support and fund local cancer projects which are aligned to Macmillan’s priorities and a study into acute medicine trainees’ perceptions around the management of cancer patients in emergency care. He is also working with Macmillan’s Expert Reference Group on older people to support a programme to improve care for people with cancer.

He is also looking forward to returning to the NHS. “I had become very disillusioned with how the service worked but over time I have crave the close patient contact side more and more - though I’d like to balance that with my other interests.”

But the central focus must always be the patient. “As a frontline clinician there’s nothing more powerful than being able to talk to patients and understand what they want and then use your skills to do something about it – whether that’s through research, policy or practice.”
Oldham Macmillan GP Matthias Hohmann says it is a huge honour and privilege to have become the second winner of the David Millar award – and a complete surprise.

Matthias, who is Macmillan Clinical Director with Oldham CCG and joint primary care lead for Greater Manchester’s Cancer Vanguard diagnostics workstream, says he didn’t even know he had been shortlisted till days before the award and winning it was completely unexpected.

“I feel very honoured. I’ve always said that becoming a Macmillan GP was the best career decision I’ve ever made. I feel privileged to be part of the Macmillan community.”

The award is made in honour of former Macmillan GP and GP adviser David Millar who died in 2014. In choosing Matthias as this year’s winner the judging panel noted how he had used his clinical leadership to influence widespread change in the area. They singled out his willingness to focus on challenging areas such as culture shift and his ability to use levers in the system to embed sustainable change.

They also highlighted his innovative work across boundaries in Greater Manchester, including his important role in integrating a vague symptoms service, other cancer referrals pathways and direct access in an innovative one-stop multi-diagnostic centre.

He had also pressed forward with Macmillan priorities such as survivorship, one-to-one support and treatment summaries.

“Matthias like many of our Macmillan GPs goes above and beyond expectations of his role, working many more hours than he is contracted to do,” said Macmillan GPA Sinead Clarke in her nomination.

Intriguingly, the inspiration for much of this recent work came from a keynote speech at a previous Macmillan primary care conference in 2014. At that event Danish research director Peter Vedsted described how Denmark had tackled the problems of late cancer diagnosis by completely overhauling their cancer pathways, including the introduction of a vague symptoms clinic to help patients without a clear diagnosis.

The proposed new pathways in Oldham and the North East Sector of Greater Manchester are very closely modelled on the Danish system, Matthias says.

“There’s a very strong case for both the vague symptoms pathway and primary diagnostics of other pathways to be brought together in a single multi-diagnostic centre,” he says. “It’s a symbiotic relationship where one element makes the other more sustainable and vice-versa.” He hopes that by next year a number of other cancer pathways will also be brought within the multi-diagnostic clinic.

One of the distinguishing features is that the new service will give as much attention to the majority of patients who are found not to have cancer as those that do, he says.

“These patients take time out of work and will be worried they might have something serious. There is a psychological and emotional impact and we owe it to them that they get answers and reassurance quickly.” It will also be an opportunity to offer them good public health advice.

Meanwhile those confirmed to have cancer are fast-tracked to the appropriate specialist team for staging and treatment planning. Where appropriate patients will have access to palliative chemotherapy or radiotherapy much earlier than would normally be the case.

This offers real benefits both for those who do have cancer and those who do not. “Patients will achieve earlier cancer diagnosis and an earlier start to cancer treatment, which should mean that outcomes and survival are better. For the 90% and more who don’t have cancer but who are investigated there will be reassurance and clarity much more quickly.”

Just as importantly, this model can easily be replicated. “It’s a blueprint for many different diagnostic pathways,” says Matthias, “and would be easily replicated in Greater Manchester and outside – and it’s not very costly.”
Tania Anastasiadis  
Tower Hamlets CCG  
Tania established and chairs Tower Hamlets CCG Cancer Board, helping to shape its cancer strategy. She has worked with local authorities to develop a SOLACE pilot site and provides commissioning advice linked to social prescribing, and has actively raised awareness of the financial impact of cancer.

Debbie Hartley  
NHS Bury CCG  
As Macmillan cancer lead for end of life care Debbie (pictured with Jane Maher) has introduced a range of training events and other improvements. She helped to extend Dying Matters courses to secondary care and was also influential in introducing a quality premium to identify and register the 1% who require palliative care.

Lucy Martin  
Dudley CCG  
Lucy now sits on the end of life strategy board for Dudley and has been influential in supporting the local Macmillan Specialist Palliative Care at Home project. She also led on the WISHES Breast Cancer Survivorship Project and has provided regular education for practice nurses.

Helen McCall  
Great Yarmouth & Waveney CCG  
Helen has liaised with the CCG and Macmillan to run a well-attended GP Update cancer training session for local GPs and nurse practitioners. She has worked across boundaries to develop training sessions for pharmacists and has chaired several multi-stakeholder boards, including the palliative care board.

Clare Scarlett  
North Tyneside CCG  
In 2014 Clare initiated a project to reduce the inequalities that prevent people with a learning disability accessing NHS cancer screening programmes. She was also behind a pilot to increase screening uptake among women with learning disabilities.

Neil Smith  
NHS Blackburn with Darwen CCG and NHS East Lancashire CCG  
Neil has worked across boundaries to develop a cancer network and measurably improve local cancer services. Innovations include a new seven day-a-week service for acutely unwell patients receiving chemotherapy, patient advocates and a self-management programme for low-risk breast cancer survivors.

PICTURES AT AN EXHIBITION

Delegates are pictured in the bustling exhibition area that was open for business throughout the conference. In addition to offering a wealth of specialist information the area was, as ever, a popular forum for meeting, greeting and networking.

Among organisations represented at the exhibition were EMIS Health, the UK leader in connected healthcare software, digital healthcare company INPS Marketing, and the National Council for Palliative Care. Another stand was devoted to the current National Cancer Diagnosis Audit.

Macmillan was also fully represented with separate stands for, among others, the Macmillan Online Community, the Health and Social Care Team, Be.Macmillan, the Cancer Information Development Team and the specialist will writing and legacies service.
Many patients with stable prostate cancer are now being followed up by their local practices rather than in outpatients, thanks to an innovative Croydon-based project.

The scheme, involving Croydon CCG, the Transforming Cancer Services Team for London and a Macmillan GP, and funded by Prostate Cancer UK, identified 205 patients who were suitable for primary care follow-up. Since the conclusion of the project that number has now risen to 527.

An evaluation of the economic benefits shows that over five years the primary care pathway would be 57% cheaper than its outpatient equivalent. It has also been popular with patients and clinicians.

Macmillan GP Jaimin Patel said one of the keys to success was the funding of a practice nurse, sessional GP and project manager to help kick-start the project and to provide support to those practices taking part. The project team were also able to make use of an existing local enhanced service for prostate cancer patients that had had poor taken-up.

Nevertheless they encountered initial concerns among many practices that they were not equipped to manage cancer patients in this way...
and they did not have the time to identify who would be suitable.

The team were able to reassure staff that their management would be similar to other long-term conditions in the community. In addition they visited many surgeries to help them identify the patients they would need to see. “It was really just a matter of resources,” explains Jaimin. “We took the time to go through their list and identify those who would be suitable.”

In addition the team recommended e-modules on managing prostate cancer and an electronic template for GP systems that was as user friendly as possible.

As a result 57 out of 58 practices agreed to take part in the initiative. All patients involved in the scheme undergo a full holistic medical assessment as well as follow-up appointments to help spot any warning signs that might require a referral to secondary care.

The project has been successfully evaluated. It is hoped it will eventually be rolled out across London.

A three-year local incentive scheme to learn more about new diagnoses of cancer among Cumbria GPs has highlighted a number of areas for improvement and led to changes in practice, says Macmillan GP Davina Solomon.

Most of the area’s 82 practices used the RCGP audit tool in conjunction with significant event analyses between 2013 and 2015. In 2014, for example, 77 practices took part, analysing over 2,300 patient records and 530 SEAs.

The project was launched after Cumbria CCG adopted cancer as a priority in 2013. The resulting information has helped identify delays in diagnosis and also ensured that practice changes are based on hard data rather than anecdote, says Davina, who has been closely involved with the project since 2014.

For example, in her own practice in Eden, which is one of the most rural localities in England with large parts of the population employed in outdoor industries, the RCGP data for 2014 showed very high rates of melanoma.

This ties in with the fact that many of those working on farms don’t use sunscreen and tend not to visit their GPs. Davina and her colleagues are now investigating how to introduce health protection messages about sunscreen and check-ups to the local agricultural college.

In a similar manner each practice taking part in the scheme is receiving detailed feedback both on their own referral and diagnosis patterns as well as those for the whole area – and then receiving help and advice from Macmillan GPs on how to make improvements.

The SEA figures also identified area-wide problems in the management of haematuria, indicating that GPs may not always be recognising the symptoms. This has led some practices to produce new protocols – the challenge now is to pull this information together and ensure all practices follow suit, says Davina.

The project has made her question her own practice at times. “You ask yourself: If that patient had been referred the second time I saw them rather than the fourth, for instance, might that have made a difference?”

The LIS has now ended. The data from the project is still being sifted and evaluated but it has already helped inform several Macmillan GP projects. Davina has also been encouraged that some practices have decided to continue collecting data despite the fact they no longer have special funding.
Advance care planning – that is, finding out what people want at the end of their life and then recording and sharing that information – is everybody’s business, says Macmillan GP Clifford Jones. The trouble is that many health staff don’t feel equipped or confident enough to undertake these conversations.

That is why RCGP Wales, with support from a number of organisations including Macmillan, has launched a new multidisciplinary advance care planning training resource which is now available on their website and takes only a few hours to work through.

He hopes it will appeal especially to those “at the coalface” such as care home staff and general ward nurses. “Once people feel confident about it they’re more likely to initiate those conversations and know they need to record and share that information."

“Everybody should understand that there is a need to have these advance care planning discussions and everybody needs to be confident enough to be able to start them off,” says Clifford, who as chair of RCGP Wales’ End of Life Care Network was closely involved in putting together the resource.

Designed by a multidisciplinary team with input from an expert editorial group, the resource took 18 months to develop. It is aimed at all healthcare staff and includes sections on communication and legal issues as well as interviews with a range of professionals, patients and carers. It also has a built-in facilitation guide.

The sessions – which are held in the evening and last two hours to fit into people’s busy schedules – took place in June and July and were each attended by around 30 pharmacists and counter assistants.

Each session covered topics such as the current screening programmes, spotting alarm symptoms and how to approach difficult conversations around cancer. Helen produced a single sheet aide memoir on key symptoms and everyone received an information pack containing material from Macmillan and CRUK.

The sessions have proved popular and given participants greater confidence to deal with cancer issues, says Helen. “They feel inspired to do something about it because they can see the impact it can have.”

Most of those that took part have also appointed cancer champions within their pharmacy and many are planning in-house training sessions to spread the message to the rest of the team.

Research UK to pilot two cancer awareness training sessions for pharmacists in the Great Yarmouth and Waveney region. If successful the training could be extended to other areas in East Anglia.

At a time when GPs are under ever-greater pressure, it makes sense to look at alternative routes into the system and one obvious but often under-used channel is the high street pharmacy.

As Macmillan GP Helen McCall points out, many people, particularly in deprived areas, will consult their pharmacist rather than GP in the first instance. “Pharmacists are in a very good position to help. They know their patients well and can often offer ad hoc healthy advice.”

But how much do they know about the signs and symptoms of cancer? Helen and her Macmillan GP colleagues have now teamed up with Cancer Research UK to pilot two cancer awareness training sessions for pharmacists in the Great Yarmouth and Waveney region. If successful the training could be extended to other areas in East Anglia.

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RCGPWalestraining.co.uk/rcgp
Early diagnosis is critical to improved cancer survival rates. But when a patient presents at their surgery with vague but potentially serious symptoms the process of diagnosis can take much longer.

That is why Macmillan GP and Mid Nottinghamshire Cancer Programme Lead Thilan Bartholomeuz and his colleagues have been working with local trusts and CCGs to develop a vague symptoms cancer pathway that aims to establish a diagnosis within 28 days of being investigated.

Under the new arrangements patients with symptoms such as non-specific abdominal pain, unexplained weight loss, tiredness or appetite loss will be referred on to the pathway, which will simultaneously trigger a range of primary care investigations. Following this, patients will either be reassured, investigated for an alternative diagnosis or progress further down the pathway. Those progressing further will probably attend a multidisciplinary clinic made up of specialists from radiology, haematology, pulmonology, upper and lower GI and gynaecology. Initial MDT discussions could be held virtually.

“This formalises the whole approach and within a timeframe of just 28 days,” says Thilan. "Currently investigations can be very much GP-dependent," says Thilan. "This formalises the whole approach and within a timeframe of just 28 days.

He foresees significant benefits to both patients and the NHS. Early diagnosis is far less costly than late emergency diagnosis and reduces the pressure on secondary care. Most importantly, it improves the patient’s quality of life and survival chances.

The scheme will not attract any extra funding but Thilan is optimistic pathways could be up and running in both Nottingham City and Newark and Sherwood CCGs by the end of this year.
INTEGRATING CANCER – EMIS AND LONG-TERM CONDITIONS

Tower Hamlets is not only one of the most deprived boroughs in England, it has some of the poorest cancer survival rates. Those living with and beyond cancer have complex needs, often coupled with multiple co-morbitidies that may be poorly controlled.

Macmillan GP Tania Anastasiadis is working with colleagues to help improve this situation. Central to that is raising awareness among other GPs as well as commissioners that cancer is not just an acute disease – it is often a long-term condition.

‘Cancer can be a chronic disease but often it’s fairly poorly managed’

Tania Anastasiadis

The figures back this up. More than two thirds of patients living with cancer in Tower Hamlets have another long-term condition as well.

“We are trying to integrate cancer care reviews more into the long-term condition plans that we have,” Tania explains. “There are common clinical denominators across all these conditions. How do we make sure we recognise these, capture patients’ unmet needs and move towards more holistic care planning to meet these needs?”

Tower Hamlets’ Clinical Effectiveness Group has now produced a Long-Term Conditions EMIS smart template encompassing cancer-specific components. This user friendly template pulls in cancer patients automatically and prompts GPs to review and respond to all their unmet needs.

This process will also help to provide a fuller picture of cancer and co-morbidities. Last year’s figures, for instance, based on GP codings, indicated that 3,500 people in the borough had cancer. Tania believes this is may be an underestimate and hopes the new tool will help provide a more accurate picture.

An even greater challenge is changing mindsets to ensure professionals see the common denominators between cancer survivors and others with a chronic condition. That means offering holistic care, including looking at wider issues such as anxiety and depression, not simply disease-specific issues.

“You can’t necessarily fatal,” she says. “It can be chronic but often it’s fairly poorly managed with many patients’ needs being unmet.” She hopes that the “anti-tick box” EMIS template cancer page will help clinicians integrate cancer care components into their core business of holistic management of long-term conditions.

HOW A PAPER CLIP IS HELPING GPs’ DEATH CERTIFICATION

The legislation around death certification is complex and can catch doctors out if they’re not careful. That is why Macmillan produced its single-sheet 10 Top Tips for death certification earlier this year.

Now a couple of Macmillan GPs have taken that a step further by clipping the guidance to their practices’ Medical Certification of Confirmation of Death (MCCD) book.

Hong Tseung (pictured), who was also chair of the end of life sub-group that helped produce the guidance, said he wanted to make sure busy GPs were fully aware of the legislation when they were certifying a death.

The 10 Top Tips highlight a number of important areas that doctors may be unaware of, including the circumstances in which a GP can sign a death certificate even if they haven’t seen the body and the procedures to be followed when the deceased is subject to Deprivation of Liberty Safeguards (DoLS).

The innovation is already having an impact in his own practice in Widnes, says Hong. He has also contacted GPs across Merseyside and the North West to suggest they follow suit. Coincidentally, another Macmillan GPA Kavi Sharma has done the same thing in Sunderland. “It’s such a simple thing to do,” says Hong, “but it seems to be having an effect.”

The current Top Ten Tips apply to England only, but Macmillan hopes to produce similar guidance for Scotland, Wales and Northern Ireland in due course.
A pilot at St Helens and Knowsley NHS Trust to help diagnose patients with vague symptoms at an early stage is already showing results after its first year, said Oncology Consultant Ernie Marshall.

The study, which is being run in collaboration with primary care and the local CCG, showed that most of those presenting did not have cancer, he said. The most typical symptoms were some inflammatory process such as rheumatism, anaemia, weight loss and elderly people with frailty and/or co-morbidity.

The aim, said Ernie, was to direct most of these difficult-to-diagnose patients into defined pathways as soon as possible. The exercise had also met with a very good response from primary care and new links were being forged as a result.

He also reported on new work to ensure patients with cancer of an unknown primary, and therefore on no defined pathway, were being seen and diagnosed as quickly as possible. At the moment too many were being referred and presenting very late, which inevitably led to poorer outcomes.

It was vital to see these patients at an earlier stage so they could receive appropriate support and advice. But the critical question was: “How do you pull specialist advice forward and how do you pull the tests forward?”

Linked with this was a drive to ensure fewer patients were first diagnosed with cancer when they presented in A&E. The good news was that latest national figures indicated the proportion had dropped from 25% to around 20%.

Earlier Katie Mulroy (pictured) described how the Mid Cheshire Hospitals NHS Trust’s acute oncology team offered support to primary care colleagues through a mix of phone advice and home visits - though advice and links to consultants were much more in demand than home visits.

The result was improved communication between primary and secondary care with cancer patients with pressing but not emergency needs being able to be fast tracked to oncologist appointments within a week.

The team had now been operating for a year and in that time they had seen a general decline in referrals from secondary care and a corresponding increase from primary care, which in turn meant they were receiving referrals earlier than before.

The ongoing challenges the team faced included engagement with some practices as well as flagging up patients with risk factors in primary care. Seven-day working was also an issue – the team currently only operate from Monday to Friday.

Following the dismantling of the Quality and Outcomes Framework (QOF) in Scotland and the introduction of GP clusters, Macmillan GPAs Paul Baughan and Lorna Porteous have helped develop a new Macmillan quality toolkit to support busy practices that wish to include cancer within their cluster priorities.

The toolkit contains suggestions on how the quality of cancer care might be improved, helping practitioners explore:

- Supporting informed uptake into the national screening programmes
- Easier access to practice appointments
- The quality of cancer care reviews
- The longer term impact of cancer and cancer treatment
- Anticipatory Care Planning and information sharing for those living with cancer and those receiving palliative care.

With the future of QOF in doubt in the rest of the UK, workshop participants felt this model was well worth considering. The BMA’s General Practitioner Committee and the English government have already agreed to ‘explore’ a complete scrapping of QOF since an increasing number of GPs are working to local deals under CCG co-commissioning. An evaluation of one such scheme in Somerset found that dropping QOF had freed up GPs to offer patients more holistic, person-centred and co-ordinated care – without any reduction in quality.

The future of QOF in Wales and Northern Ireland remains unclear but the toolkit looks likely to gain momentum across the UK with the support of the Macmillan GP community.
PICTOR: EXPLORING RELATIONSHIPS IN PATIENT CARE

Providing optimal patient care usually involves good interpersonal relationships and effective collaborative working. But both can be difficult to describe and fully understand.

In this primarily practical workshop, Dr Jo Brooks introduced participants to the Pictor technique - a simple but effective way to help describe, reflect on and understand experiences of inter-professional working from different perspectives.

Pictor is a visual technique in which participants construct a representation of roles and relationships in a particular care situation. It has been successfully used in a number of research studies, including several funded by Macmillan. However, it also has considerable potential in applied settings.

Workshop participants were encouraged to create their own Pictor charts and then discuss these in their groups. The feedback was very positive with one describing the approach as “a new and interesting way to look at very familiar situations” and another saying that “it allows people to break down complex situations and think about roles – very useful”.

A number also indicated they would use it in their future work. “I am a GP and can see us using it ‘in-practice’,” said one participant. Another thought it was “an innovative way to understand how the patient sees their own journey compared to our view”.

More information:

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COMING TOGETHER TO SUPPORT BETTER END OF LIFE CARE

Most people spend more than 90% of the last year of their life in the community. Ensuring that primary healthcare teams are confident and competent to deliver high quality end of life care, using systems that are fit for purpose, is an ongoing challenge.

The workshop was designed to enable delegates to think about their day-to-day work with GP colleagues and consider how they are addressing the new guidance on end of life care, Five Priorities of Care and Ambitions for End of Life Care. It was also an opportunity to learn about Macmillan’s national work.

Delegates took part in a simulated GP practice meeting. Susanna Hill, Macmillan GPA, Devon, Cornwall and Isles of Scilly, presented a brief overview of the national picture.

Participants then discussed the end of life care challenges which included poor communication, lack of community nursing and adequate social care, time constraints, difficulty predicting death, problems with ‘Do not resuscitate’ forms, inadequate provision of anticipatory drugs and the challenges of communicating effectively with families and carers.

Participants then examined a number of case studies exploring current issues. The workshop also heard about Macmillan’s current projects, including advance care planning, ‘Building on the Best’ in acute trusts, specialist care at home and its 10 Top Tips for death certification.

Resources

End of life care commissioning toolkit

www.nhsiq.nhs.uk/8627.aspx

Actions for End of Life Care: 2014-16

bit.ly/1nTg3Q7

Care of dying adults in the last days of life: NICE guidelines

bit.ly/2arcIno

All resources apply to England. NICE guidelines apply to Wales as well.

ENHANCED SUPPORTIVE CARE

Enhanced Supportive Care (ESC) is a fresh approach to supporting people through cancer treatment. At its heart is better access to expertise in managing the adverse effects of cancer and cancer treatments.

And that’s good for both patients and cancer clinicians, Dr Richard Berman, from The Christie NHS Foundation Trust’s Supportive Care Team, told workshop participants. Timely supportive care, provided in a positive way, improves patient experience and outcomes, as well as reducing the need for hospital admission.

The Christie had rebranded and re-packaged existing palliative care services that support cancer patients to better suit the changing landscape of cancer care, he said. This would also promote earlier integration.

A successful pilot at the trust had demonstrated improvements in patient experience and potential cost efficiencies. As a result NHS England was now supporting the roll-out of ESC across 23 cancer centres.

Evidence from around the world shows that earlier involvement of supportive and palliative care in cancer care results in better outcomes for patients, including the potential to extend their survival, Richard said. It also overcomes the perception among public, patients and many health professionals that palliative care is only associated with care at the end of life.

Actions for End of Life Care: 2014-16
WHAT’S NEW IN BREAST CANCER AND RADIOLOGY?

Surgery is now minimal in the management of early breast cancer, said Mei-Lin Ah-See, breast oncologist at Mount Vernon Cancer Centre, London, in an overview of breast cancer, its diagnosis and newer treatments. The advent of deep inspiratory breath hold (DIBH) radiotherapy also means that the heart can be protected when treating left-sided breast cancer.

With systemic therapies, Mei-Lin (pictured) stressed that patients receiving Herceptin should have any cardiac symptoms assessed promptly and that gonadotrophin-releasing hormone analogues must be given very precisely at 28 days. It was important to be aware that the long-acting preparations are not licensed for breast cancer and may not fully suppress the ovaries. Meanwhile, high dose bisphosphonates are effective in post-menopausal patients for breast cancer and may not fully suppress the ovaries. Meanwhile, high dose bisphosphonates are effective in post-menopausal patients to prevent bone metastasis.

Giles Maskell, President of the Royal College of Radiologists, described PET-CT, an imaging technique that has recently become widespread in clinical practice in the UK. It is part of the “personalised medicine” paradigm, which is set to bring huge changes to cancer management in the future.

Serial PET-CT imaging soon after the start of therapy with certain novel chemotherapy agents can quickly and reliably determine which patients will benefit from a specific therapy. This allows expensive drugs, some of which have serious side-effects, to be continued only in those patients who will benefit from them.

Participants discussed the implications of the national drive to empower patients by giving them direct access to their test results. How, they asked, will patients understand the technical language in reports? Should there be a separate report written in layman’s terms? And how can we ensure that when the news is bad, patients receive proper support and explanation?

CANCER AND OLDER PEOPLE

Cancer is predominantly a disease of old age. Macmillan Consultant Adviser Richard Simcock told a workshop on older people and cancer. Nearly two thirds of cancers occur in people over 65 and one third in those over 75.

Yet at the moment people living in the UK who develop cancer in their 80s have the worst survival rates, he said. The reasons for this were complex but might be in part because many were less aware of the risks. This was underlined by the fact that 45% of those over 85 are first diagnosed with cancer in A&E.

There is also evidence that curative surgery rates decrease as people’s age increases – this was particularly noticeable with men who had bowel, lung or prostate cancer.

The new Cancer Strategy for England called for a comprehensive care pathway to be piloted for older people, including a comprehensive geriatric assessment. Richard suggested such an assessment should include a detailed exploration of carer responsibilities, the patient’s mental capacity and a careful weighing up of independence versus the risk of death.

The Macmillan Expert Reference Group on older people has developed a screening tool to assess who would most benefit from a comprehensive geriatric assessment.

IMPROVING ACCESS TO DIAGNOSTICS IN YOUR LOCALITY

The updated NICE guidance for suspected cancer together with existing Scottish guidance comes at a time of increased pressure on primary care during which many areas are struggling to meet cancer waiting targets. Even those with direct access to diagnostics will now be under greater pressure. So how can GPs meet the new challenge?

The workshop discussed diagnostic access variations within different regions and countries with the aim of sharing tips and best practice that could be applied to all areas, regardless of the level of access.

Macmillan GP Neil Smith and radiology registrar Helen Cliffe gave examples of ways to overcome these challenges, emphasising the importance of communication and clinician input between primary and secondary care. Neil introduced delegates to Macmillan’s new Top Tips for Implementing the NICE guidance.

He also identified the eight key components that, when considered together, will enable GPs to work alongside secondary care colleagues to successfully implement the NICE guidance in their area.

Both speakers emphasised the importance of building strong relationships with local providers. These relationships could enable GPs to use diagnostic access to a greater extent, particularly when referring because of clinical concern rather than a specific guideline recommendation.

Workshop groups were also presented with case studies as a way of exploring pathway and test-specific issues. Solutions included safety netting considerations such as implementing follow-up procedures after a ‘normal’ CT scan as well as consulting with secondary care colleagues and patients (where possible) when redesigning referral forms and pathways.