Training Needs Assessments for London: Highlight report for the Primary and Community Education Group (PCCEG)

Transforming Cancer Services Team for London

October 2017

Pan LondonTraining Needs Assessment

This report has been split into two sections:

Section 1: responses from Professional Cancer Awareness Measure (ProCAM) from GPs and primary care nurses

Section 2: responses from Living with and beyond cancer (LWBC) from GPs and primary care nurses

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Pan London Training Needs Assessment

Background

Cancer survival overall has been improving but this progress has not been uniform across all tumour sites. Some cancers remain difficult to detect and patients may present late not noticing symptoms until a cancer has spread. Also an increasingly aging population means that more people have multi-morbidity making it difficult for primary care practitioners to detect cancer. In London, cancer outcomes are variable and nearly 40% of CCGs have lower one year survival compared to the national average. Cancer is becoming a common disease and 1 in 2 people will get cancer sometime in their life. It is estimated that four million people will be living with and beyond cancer by 2030[1].

As 90% of patient contact in the NHS is through primary care[2], the importance of primary and community care professionals in both detecting and managing cancer is significant.

Introduction

In response, Training Needs Assessment (TNA) tools were produced to help the pan London Primary and Community Care Education Group (PCCEG) to:

- Engage and support primary and community care providers in the cancer agenda
- Assess knowledge and identify training needs across different disciplines within primary and community care.
- Gather evidence to inform future development of bespoke educational products and materials.
- Identify good practice in learning and teaching in living with and beyond cancer (LWBC) and early detection (ED)
- Inform the evidence for bespoke educational products, materials, share good practice in learning and teaching across the early detection and living with and beyond cancer pathways.
- Support providers to attract and retain a sustainable and confident workforce.

Links to the survey were sent to all practices, pharmacists and dentists across London by the regional Primary Care Commissioning Team and across West Essex by the local commissioning team. The surveys were also sent to Cancer Commissioners, Cancer Lead GPs, and Macmillan GPs across the TCST footprint.

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[1] Macmillan NCSI Toolkit

[2] http://www.cancerresearchuk.org/prod_consump/groups/cr_common/@nre/@hea/documents/generalcontent/primary-care-engagement.pdf

GPs, GP Trainers, GP Trainees, Registers, primary care nurses, practice nurses, general dental practitioners and community pharmacists were invited to take part in completing the surveys.

Methodology

The TNA survey tools were developed as a part of PCCEG's work programme for 2016/2017 as training needs gap analysis of London's primary and community care professionals have not, to date, been conducted. The development of the tools is supported by the pan London Early Detection & Awareness Group and the Living with and Beyond Cancer Board and led by the TCST.

Two distinct sets of surveys developed by the TCST aim to examine the attitudes and experiences of GPs, primary care nurses, dentists and community pharmacists.

- The Professional Cancer Awareness Measure (ProCAM TNA) covers early detection and awareness of signs and symptoms of cancer.
- The second set of surveys focuses on cancer survivorship and the longer term consequences of cancer treatment for people living with and beyond cancer (LWBC TNA).

Links to the survey were sent to all practices across London by the regional Primary Care Commissioning Team and across West Essex by the local commissioning team. The surveys were also sent to Cancer Commissioners, Cancer Lead GPs, and Macmillan GPs across the TCST footprint. Surveys were available online from April 2016 to October 2016. Links to the surveys were distributed to London-based GPs and primary care nurses via CCGs, GP newsletters, practice updates and reminders sent directly from the TCST and the Healthy London Partnership.

Questions for the surveys were developed in conjunction with GPs, primary care nurses, pharmacy colleagues, head and neck specialists and TCST senior leads from the Early Detection and Living with and Beyond Cancer workstreams. The ProCAM surveys followed the themes outlined in Cancer Research UK's Cancer Awareness Measures which is a set of validated questions designed to assess awareness of cancer among the general population[3] .

The aim of ProCAM was to assess:

- Knowledge of NHS cancer screening programmes
- Knowledge of potential cancer signs and symptoms
- Knowledge and current practice of available cancer risk assessment tools
- Perceived risk and severity of cancer
- Attitudes towards cancer and early detection
- Beliefs about their role in diagnosing cancer earlier.

Questions for the LWBC TNA was adapted, with permission, from a survey published by University of Cambridge and Oxford Brooks University designed to assess physician knowledge and attitudes regarding care of patients with cancer[4].

[3] http://www.cancerresearchuk.org/health-professional/prevention-and-awareness/the-cancer-awareness-measures-cam

[4] Caring for people living with, and beyond, cancer: an online survey of GPs in England
Fiona M Walter, Juliet A Usher-Smith, Suresh Yadlapalli, Eila Watson
Br J Gen Pract. 2015 Nov; 65(640): e761–e768. Published online 2015 Oct 26. doi: 10.3399/bjgp15X687409

LWBC surveys aim to assess clinician's understanding of:

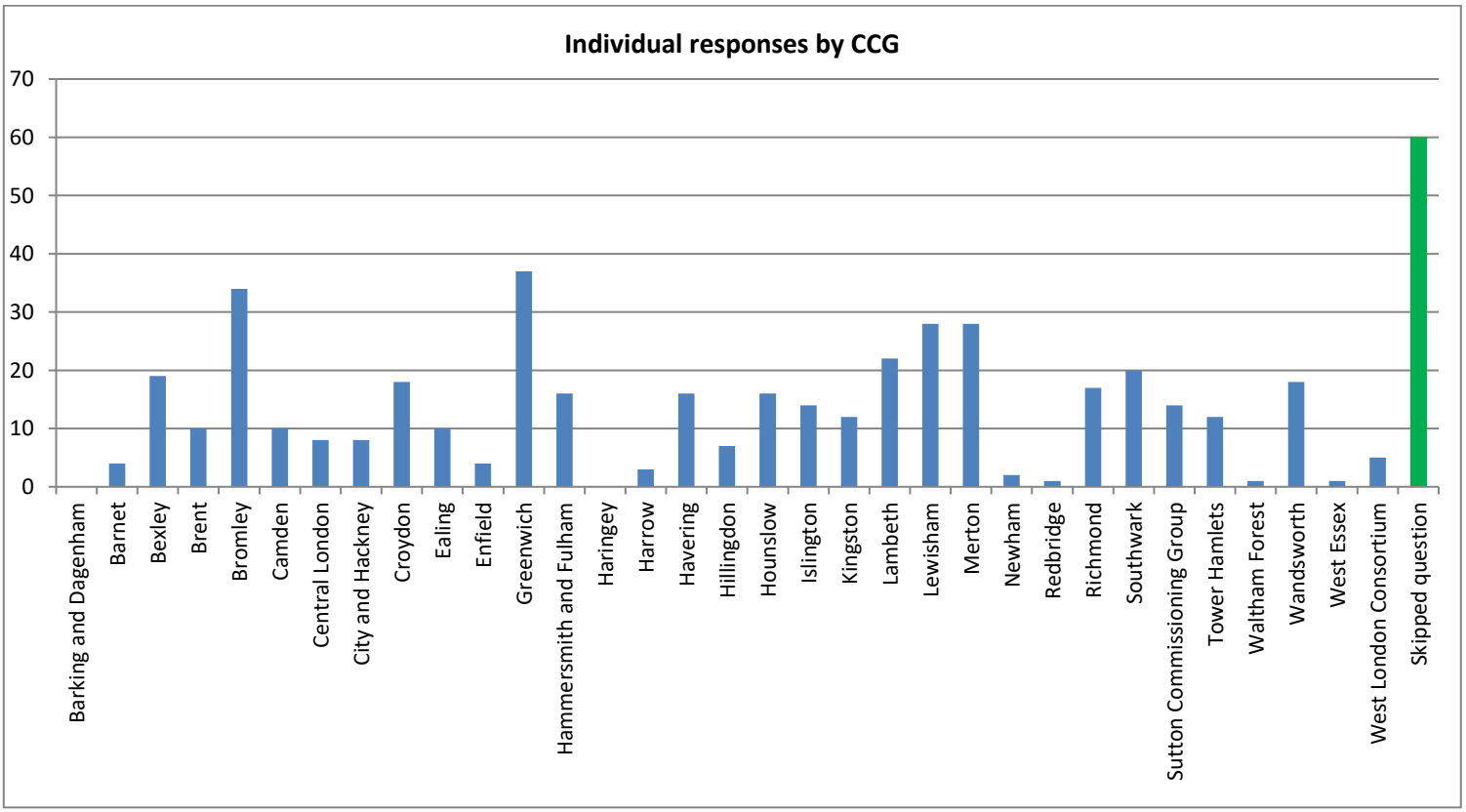
- The role of primary care in the management of patients after a cancer diagnosis
- Their understanding the consequences of cancer treatment
- The role of healthcare professionals in managing cancer as a long term condition where appropriate

Both surveys were designed to collect both quantitative and qualitative data with a mixture of multiple choice and free text comment boxes.

Summary of key findings

In total 665 people completed the surveys. The table below outlines the breakdown of responses across the surveys

ProCAM survey: Professional Cancer Awareness Measure for Primary Care Nurses	114
ProCAM survey: Professional Cancer Awareness Measure for GPs	223
ProCAM survey: Professional Cancer Awareness Measure for community pharmacists	61
Living with and beyond cancer TNA survey for Primary Care Nurses	50
Living with and beyond cancer TNA survey for GPs	88
Management of suspected oral cancer survey	129
Total	665



- Although GPs and nurses are aware of the three main NHS Screening programmes, confidence levels on advising patients on using FOBt bowel screening kits, for example, needs addressing through training opportunities.
- 100% nurse and 67% GP respondents are female.
- The majority of respondents were not Macmillan professionals or cancer leads for their CCGs or practices.
- Most respondents describe their practices as urban.
- There was almost an equal split between full-time, nearly-full time and part-time working patterns for both GPs and Nurses.
- 92% of GPs and 96% of nurses have personal experience of cancer through a diagnosis of a close family member such as a parent, sibling, partner/spouse or child.
- The majority of the responders to the surveys are from CCG areas in South London.
- No responses were gained from Outer North East London, outer north London or West Essex.

Scope

This paper outlines the key themes generated from GP and primary care nurse respondents.

TNAs for community pharmacists and general dental practitioners are not included in this report as the response rates are particularly low. The TCST have commissioned an academic researcher to analyse the data across all the professional disciplines.

The final results are being used to inform the development of an educational prospectus that is due to be launched in December 2017.

Section 1

Professional Cancer Awareness Measure for GPs and primary care nurses (ProCAM GP and ProCAM Nurse)

223 GP responses (rate of responses range from 223-186) and 114 nurse responses (response rate range from 114-99).

Knowledge of NHS cancer screening programmes, eligibility, local uptake/coverage
Bowel screening

The UK has a bowel cancer screening programme. The test checks for hidden blood in your poo (stool or faeces). This is called a faecal occult blood test (FOB test). People registered with a GP have a test every 2 years, between 60 and 74 years old. Flexi scope is a further test that is offered between 55 years and 60 years.

100% of GP and primary care nurse (n=223 GPs and 114 nurses) respondents were aware of the NHS Bowel screening programme and just over a half of the GPs (54%) were aware of the bowel scope test but 35% were not aware and 11% were unsure.

When asked at what age people are invited to take part in bowel screening programme and what age the programme finished, 64% of GPs and 68% nurses answered a starting eligibility age of 60 years and 22% of GPs and 30% nurses correctly answered 74 years as the completion age. However 20% of GPs and 27% of nurses didn't know the finishing age.

Just over half (54%) of GPs and 63% of nurses knew that they were able to order screening kits for patients however 26% of nurses were not confident in advising patients on how to use them.

Chart 1: Q3 (ProCAM Nurse)

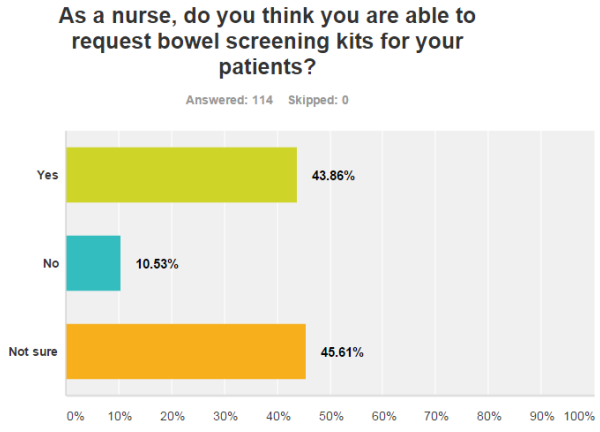
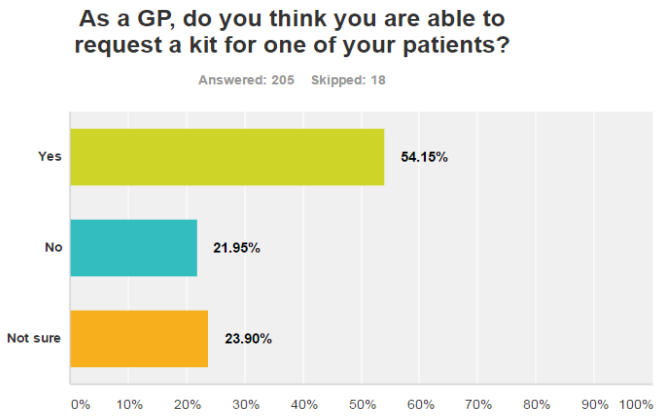


Chart 2: Q4 (ProCAM GP)



Cervical screening

The age range and frequency of cervical screening has changed for routine screening to 3 yearly from age 25 and 5 yearly from age 50 to 64. It was previously 3 yearly from 20 to 60 years old. Women on non-routine screening will be invited up to the age of 70 years (a change from current arrangement of 68 years).

All GPs and primary care nurses who responded to the survey were aware of the NHS cervical screening programme.

When asked what age women were invited to take part, 79% of primary care nurses, who typically conduct cervical screening, correctly indicated that women are invited for cervical screening at 25 years old. Conversely, 94% GPs specified the starting age for cervical screening is 25 years old. A quarter of GPs and 38% nurses correctly stated that it finishes at 64 years and just under half of GPs and over half of the nurses stated it ends at 65 years old.

When asked what options are available for patients after screening completion age, both GPs and nurses felt that patients could either self-refer or be referred by the GP. 43% of nurses and 18% of GPs didn't think they could request cervical screening to patients.

Chart 3:Q10 (ProCAM GP)

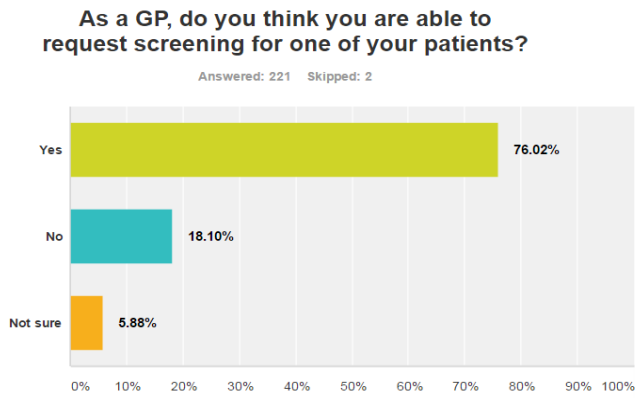
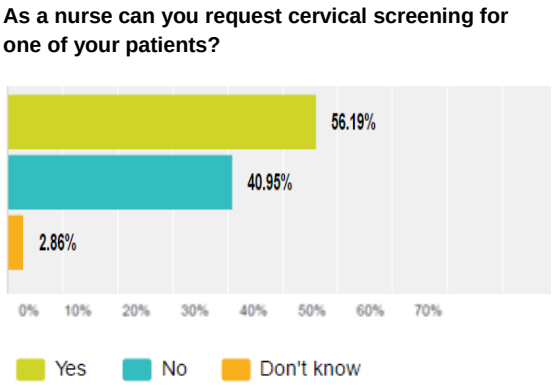


Chart4: Q3 (ProCAM Nurse)



Breast screening

The NHS Breast Screening Programme invites all women aged between 50 and 70 for screening every 3 years. You need to be registered with a GP to receive the invitations. In England, the screening programme is currently extending the age range to include women from 47 to 73 years old.

99.5% of GPs and all primary care nurses (n=220 GPs and 114 nurses) were aware of the NHS breast screening programme. Only 1 GP said they were not sure.

When asked the starting and ending age range women were invited to take part, 77% of GPs and 76% of nurses correctly stipulated that women are invited at 50 years of age. 55% of nurses thought breast screening finishes at 70 years but 13% stated 65 years and 5% didn't know. For GPs, 56% stated 70 years, 20% thought it was at 65 years and 10% didn't know.

GPs and nurses are able to request a screening test however 35% of GPs and a quarter of nurses thought they couldn't request screening for their patients, or they didn't know whether they could request screening.

Chart 4; Q14 (ProCAM GP)

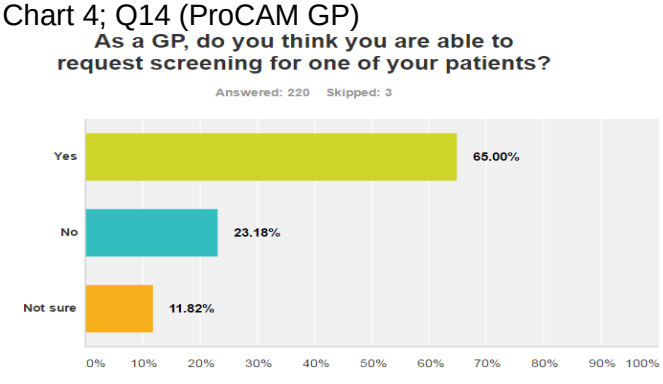
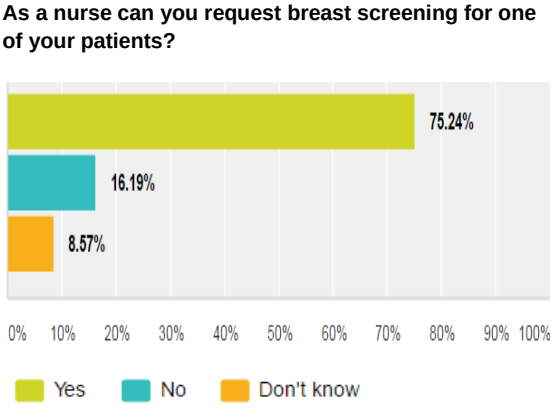


Chart 7: Q1 (ProCAM Nurse)



Collated free text responses for increasing all three NHS screening programmes

When asked if practices did anything to increase uptake of the screening programmes, the majority stated that they actively encourage uptake across all three screening programmes. Encouragement activities range from opportunistic face to face discussions with patients to recall systems, reminders to non-responders, posters in waiting rooms and information about screening programmes mailed to patients. Many of the practices contact those that did not turn up for screening appointments.

> "Cervical written reminders and verbal reminders discussion. Breast verbal. Bowel verbal" – practice nurse

> "Yes, we put up screening info and use TVs in waiting rooms to advertise. After recent meeting with cancer research discussed talking to non-participants of bowel screening" – practice nurse

> "Promotion by posters and verbally in appointments especially for vulnerable groups e.g. LD/Mental Health issues" – GP

> "no as I think the evidence is borderline in favour of breast screening and the info sent out is grossly biased towards screening" – GP

> "One of our GPs is the practice champion- she has a designated clerical assistant. We monitor our screening rates and write to non-attenders. All the clinicians opportunistically encourage non-responders to have smears. We have 3 nurses trained to take cervical smears and 4 female GPs [list-size 13,500] to ensure patients can get appointments quickly" - GP

Knowledge, education and training

When asked whether cancer had ever been part of a personal appraisal or educational/PDP, 76% of nurses (n=24) and 36% of GPs (n=121) said that cancer has not been a part of their personal development or appraisal.

Chart 8: Q7 (ProCAM Nurse)

Response from nurses

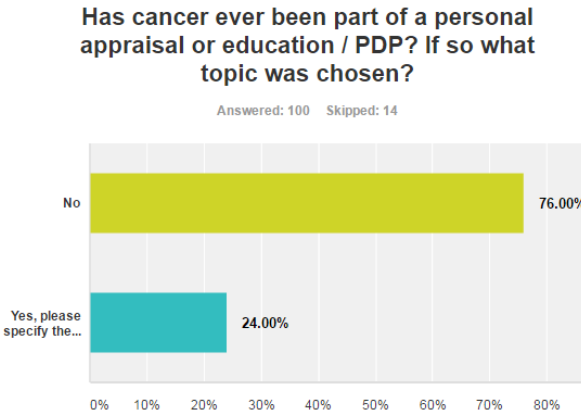
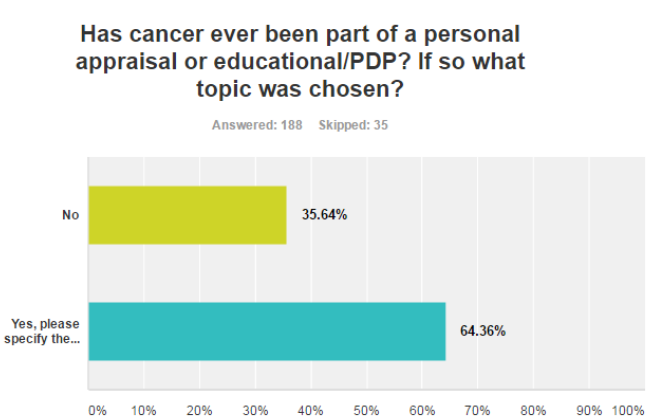


Chart 9: Q16 (ProCAM GP)

Response from GPs



Of those who said that cancer *was* part of their professional development, for GPs the most undertaken topic was around the two-week wait referrals (Urgent Suspected Cancer referrals), significant event analysis of cancer referrals and case reviews of cancer diagnoses.

"GI cancer. Had a clinical case review by the GMC and cancer diagnosis was one of the topics it was felt I needed more support in following a complaint, I am going to do a RCGP cancer audit with secondary care that were involved with the patient" – GP

Of the 24% of nurses that said they undertook PDP or appraisals in subjects related to cancer, the most common subjects were around signs and symptoms of breast and cervical cancers.

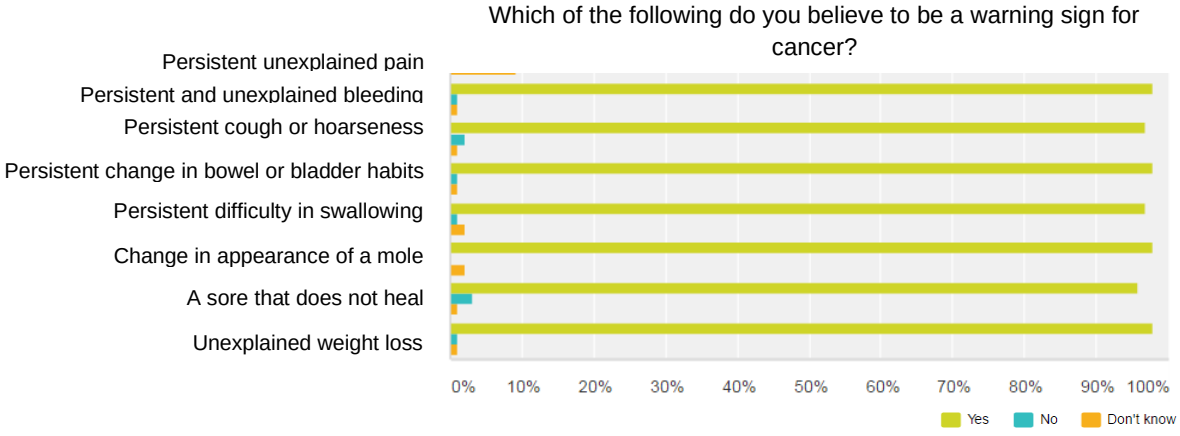
Responders were asked what specific cancer modules they have completed in the past three years. For GPs, the most common cancer module by tumour type was prostate cancer closely followed by breast. The least mentioned modules were around colorectal, 2ww referrals, and early diagnosis. The same question for nurses showed that modules about cervical cancer were mentioned the most. Only one respondent mentioned completing a course in red flags in primary care (relating to cancer symptoms). The top most common cancers for females are breast, lung and bowel and for males prostate, lung and bowel. With many lung and bowel cancers being diagnosed late this survey suggests a need with respect to training in these tumour sites.

A further question around accessing resources to obtain cancer information for healthcare professionals, 56% (n=100) of nurses and 39% GP (n=187) said they have not recently accessed resources. For those that said that they had, the most mentioned resources were NICE Guidance, Macmillan and BMJ (GPs) and screening leaflets, screening websites, and NHS Choices were most recently accessed by nurses.
84% of GPs (n=186) said they used a mixture of online learning materials such as BMJ Learning followed by the RCGP, Doctors.net and Pulse. For nurses, BMJ learning and RCN resources and nursing journals were most accessed.

Knowledge of signs and symptoms of cancer

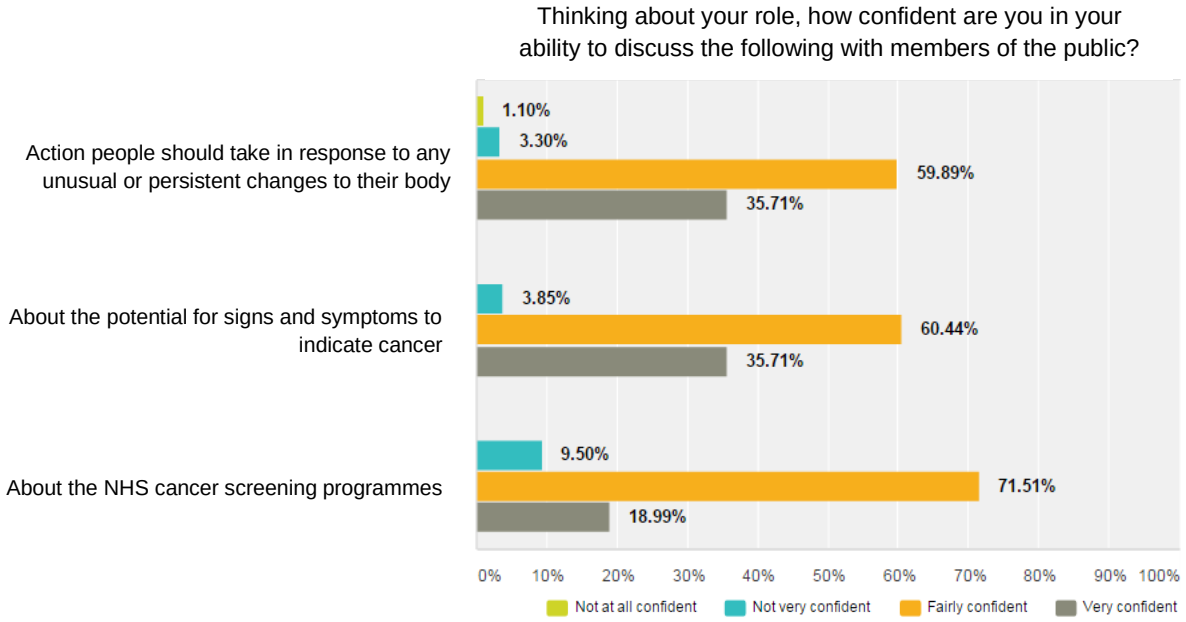
Primary care nurses were asked to outline what they believed to be or may not be a warning sign for cancer. The three common sign identified were unexplained bleeding, change in the appearance of a mole and unexplained weight loss (98%). Persistent unexplained pain was the least chosen sign for cancer (86%) and generated the most number of "don't know" at 9%.

Chart 10: Q19 (ProCAM Nurse)



GPs were asked about their confidence with respect to discussing cancer screening programmes, potential signs and symptoms that could indicate cancer, and what actions people should take regarding unusual changes to their bodies. The confidence levels outlined below reveal is an opportunity to enable clinicians to become very confident. See Chart 11 below.

Chart 11: Q26 (ProCAM GP)



Knowledge and current practice of available cancer risk assessment tools

The GPs were asked about their awareness and usage of cancer tools that are available to aid cancer referrals. These tools are: comparative cancer performance data (such as practice profiles), RCGP cancer audit tools, Significant Event Analysis (SEAs), Macmillan/GP update Cancer revalidation toolkit for GPs and cancer risk awareness tools such as QCancer.
The following chart outlines the responses regarding this question.

Chart 12: Q20a (ProCAM GP)

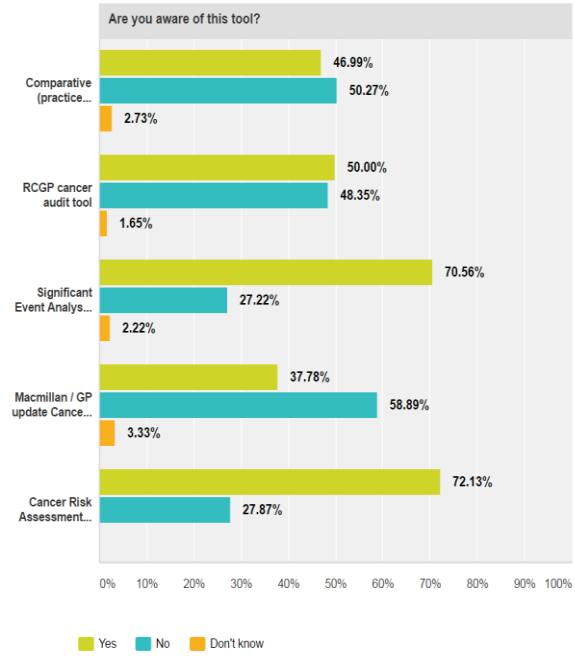
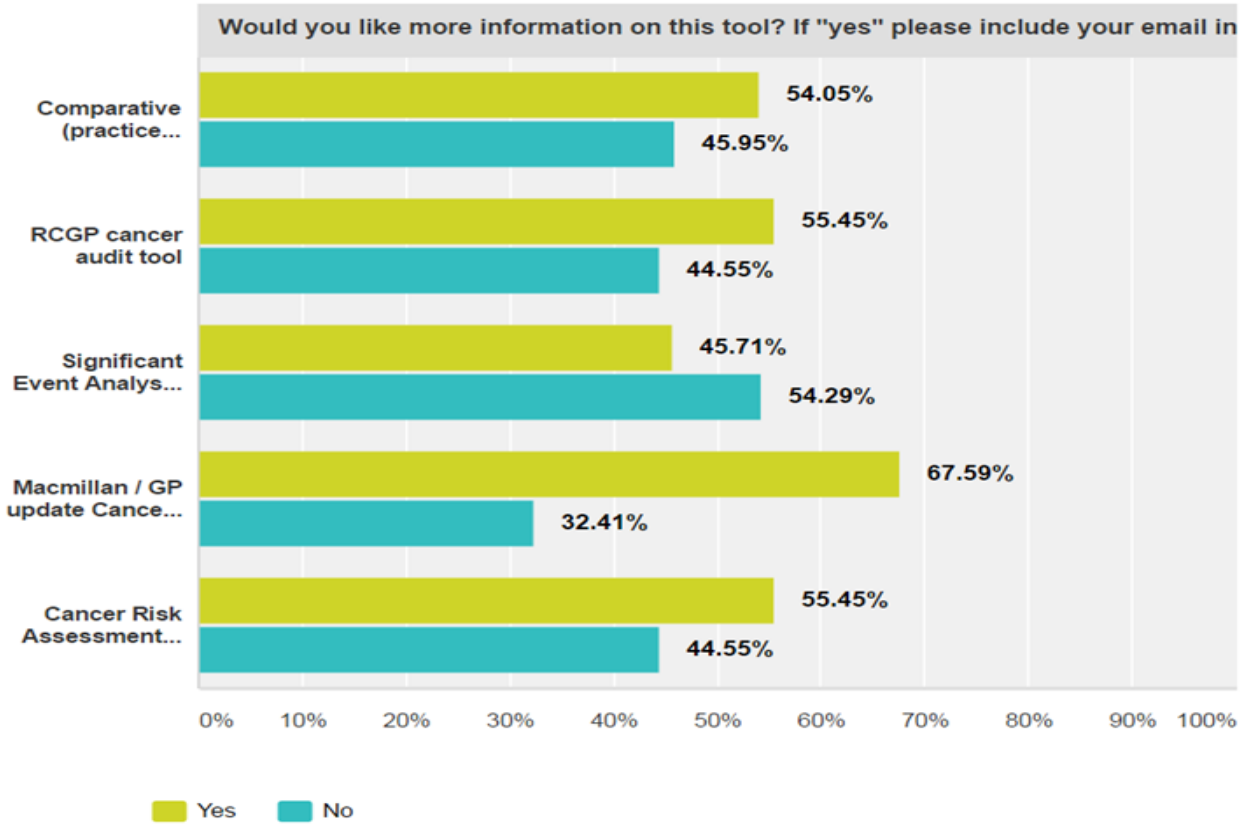


Chart 13: Q20b (ProCAM GP)

More than 50% of GPs would be interested in further information on the tools. The chart 14 below outlines the results of this question.

Chart14: Q20c (ProCAM GP)



Perceived risk and severity of cancer

Both surveys for GPs and nurses aim to assess an individual's perceived risk and beliefs around risk factors.

When asked about the perceived risk and severity of cancer "If I carried on with my current lifestyle I think my chances of developing cancer at some point in my life would be…." 44% of GPs and 42% of nurses stated their risk would be moderate. 27% of GPs and 38% of nurses said their risk would be small.

GPs who responded to the survey highlighted that compared to other men and women in their age group, their risk of developing cancer are about the same (43%) a little lower (29%) and a little higher (11%) compared to their nursing counterparts who outlined their risk is about the same (60%), a little lower (18%) and a little higher (13%).

Whilst there is high variation in survival between tumour sites 50% of people survive cancer for over ten years and survival is the last 40 years has doubled. The survey asked respondents on how much they agree to the following statement "if I develop cancer it is likely that I would die from the disease". 45% of GPs and 58% of nurses disagreed with the statement. 34% of GPs and 29% of nurses were unsure.

Attitudes towards cancer and early detection were also measured where respondents were asked to outline how much they agree to a series of statements. The results are outlined in the charts below.

Chart 15: Q26 (ProCAM GP)

Responses from GPs

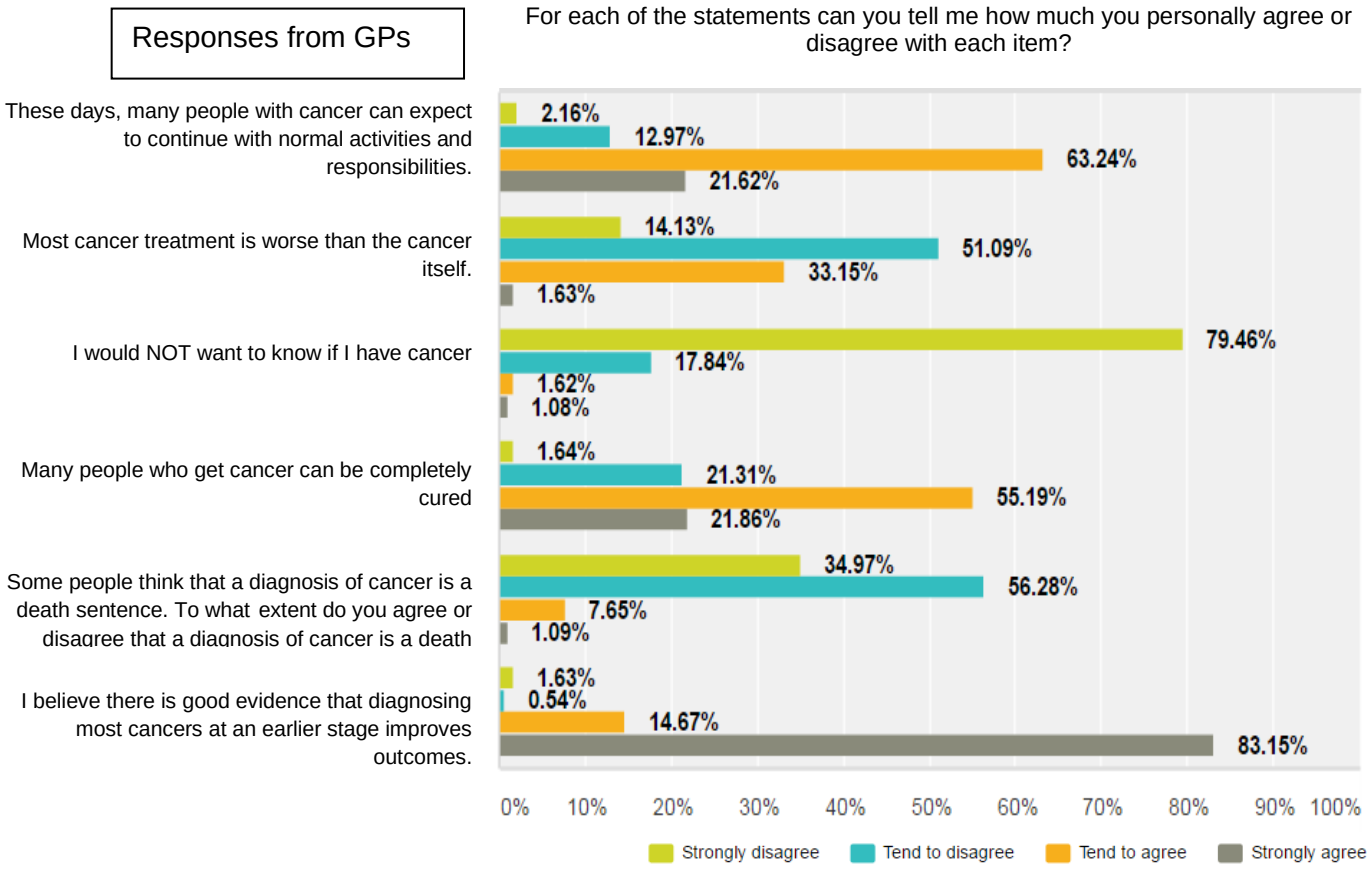
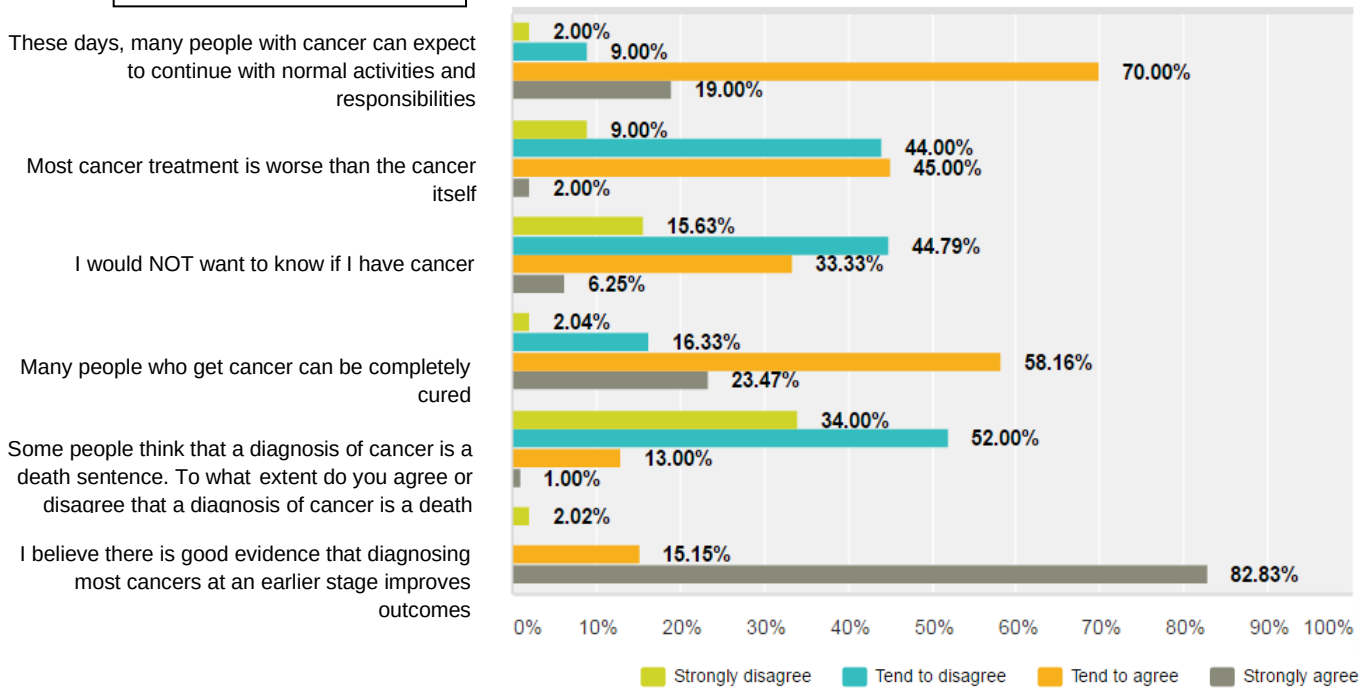


Chart 16: Q17 (ProCAM Nurse)

Responses from nurses



Beliefs about roles in detecting cancer earlier

95% of GPs and nurses either agreed or strongly agreed that prevention was part of their role however only 55% of GPs and 69% of nurses agreed that they could take more of an active role in cancer prevention.

Chart 17: Q16 (ProCAM Nurse)

Responses from nurses

Thinking about your role in primary care, please rate how much you agree or disagree with the following:

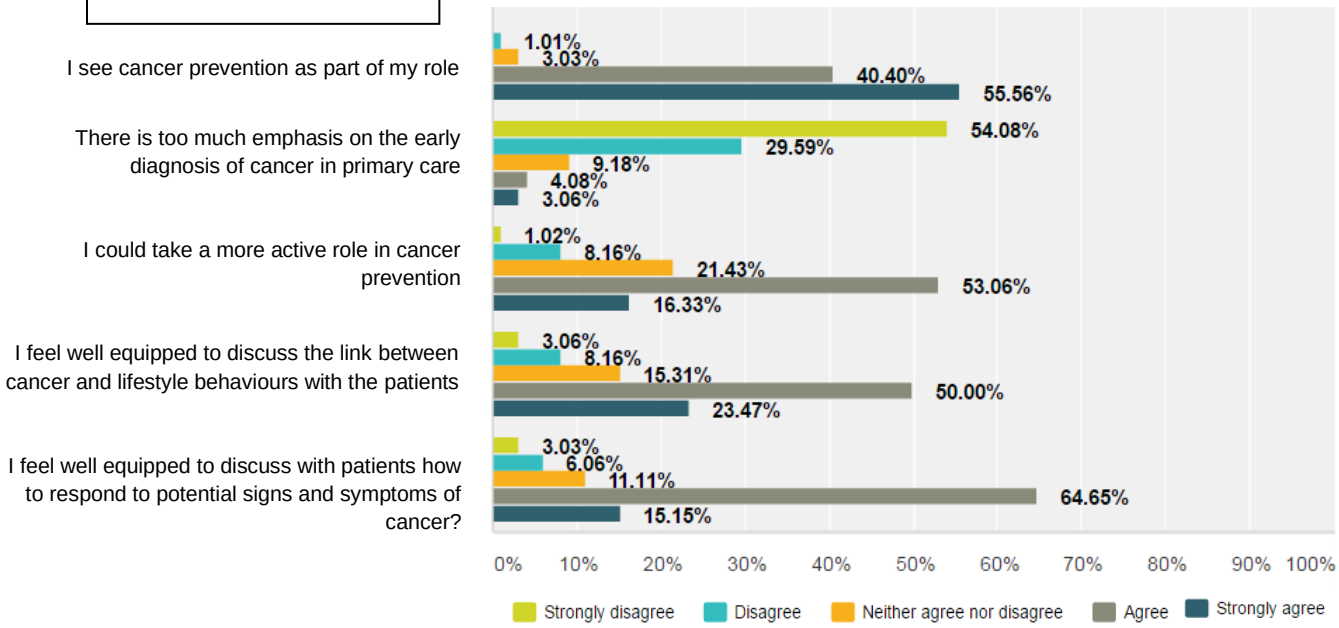
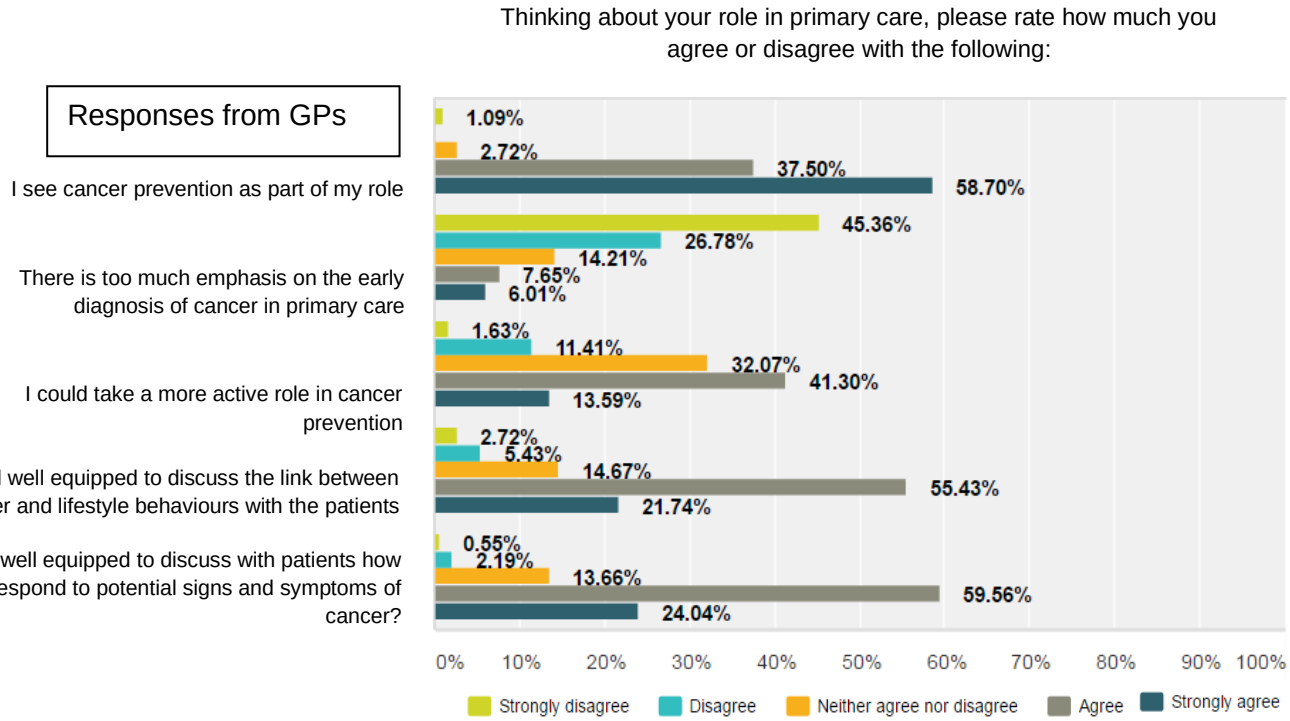
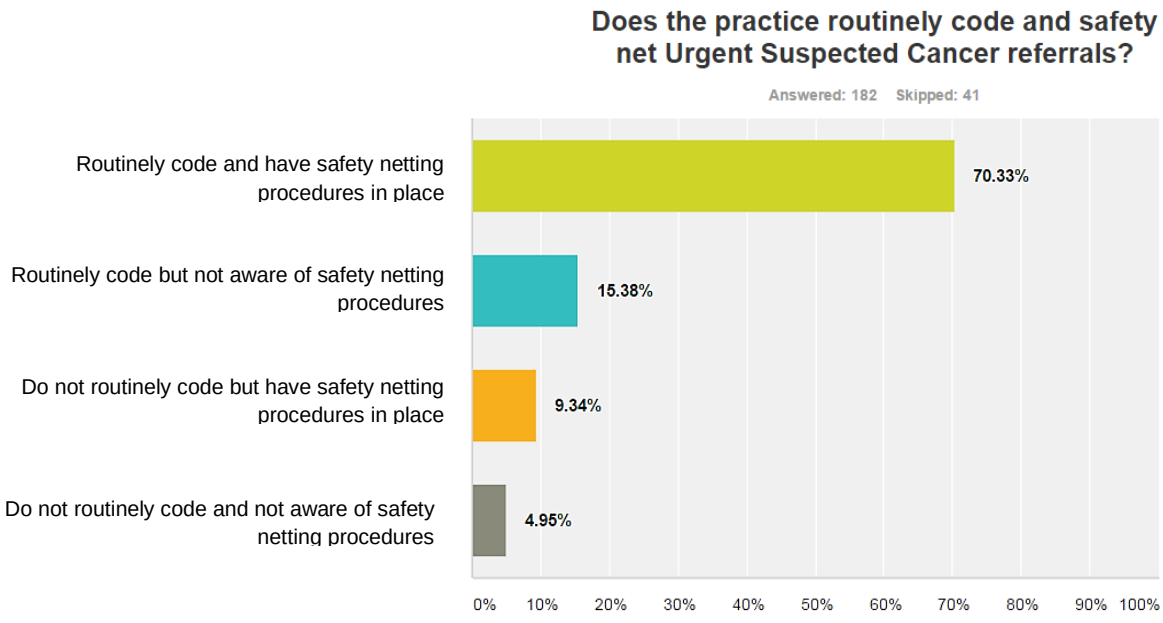


Chart 18:Q26 (ProCAM GP)



An additional question to GPs asked if their practice routinely codes and safety nets urgent suspected cancer referrals. Safety netting is a process where people at low risk, but not no risk of having cancer, are actively monitored in primary care to see if they risk of cancer changes or not. Safety netting excludes or confirms cancer and supports both the patient with initial suspicion of symptoms or those who are living with and beyond cancer.

Chart 19: Q36 (ProCAM GP)



Demographic breakdown of the respondents of the ProCAM TNA

- 336 total responses from nurses and GPs. See Table1 below for responses by Strategic Transformation Partnership area
- 99% of nurses and 69% of GP respondents are female.
- 48% of the GP respondents were cancer leads for their practice (n=20). 17% were Macmillan GPs (n=7).
- Most respondents describe their practices as urban.
- There was almost an equal split between full-time, nearly-full time and part-time working patterns for both GPs and Nurses.
- The majority of the responders to the survey are from CCG areas in South London.

Table1

STP	**ProCAM GP**	**ProCAM nurse**
West Essex	1	0
North East London	15	15
North Central London	20	7
South East London	66	38
South West London	46	25
North West London	40	14
Number of respondents that skipped question	40	15
Total	**185**	**99**

Section 2

Living with and beyond cancer training needs assessment for GPs and primary care nurses

As cancer treatments improve, the number of people living with and beyond cancer is increasing. Late onset and long-term side effects of cancer and its treatment have been defined as 'consequences of treatment'. They can be functional, physical or psychological problems and can occur months or years after completion of treatment. As many as 500,000 cancer survivors in the UK are considered to be experiencing consequences attributable to cancer treatment (Macmillan Cancer Support, 2013).

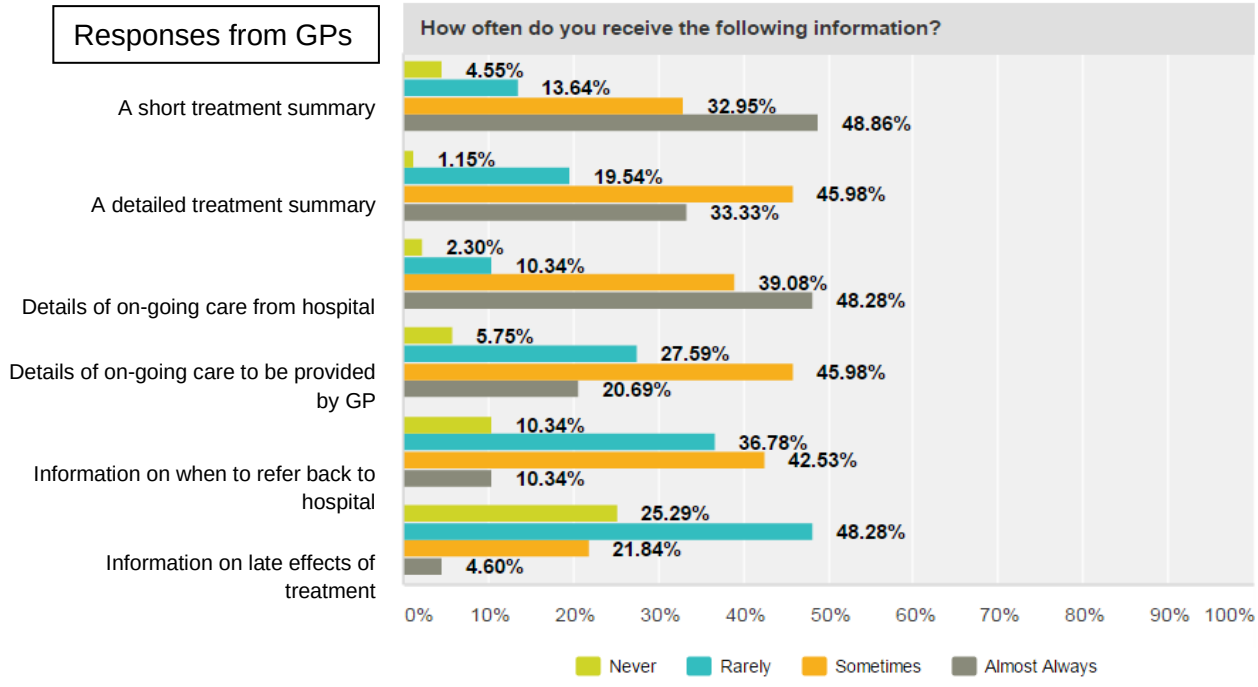
This survey was designed to investigate how primary care nurses and GPs follow-up care for people living with and beyond cancer and aims to examine the attitudes and experiences of primary care professionals about follow-up care and for people who have completed active treatment for any cancer. The survey, in particular, intends to identify learning needs in context to the service they currently provide and would likely to provide in the future as more services are being offered out of hospital.

88 GP responses (rate of responses range from 88-84) and 50 nurse responses (response rate range from 50-42).

Management of people who have recently completed active treatment

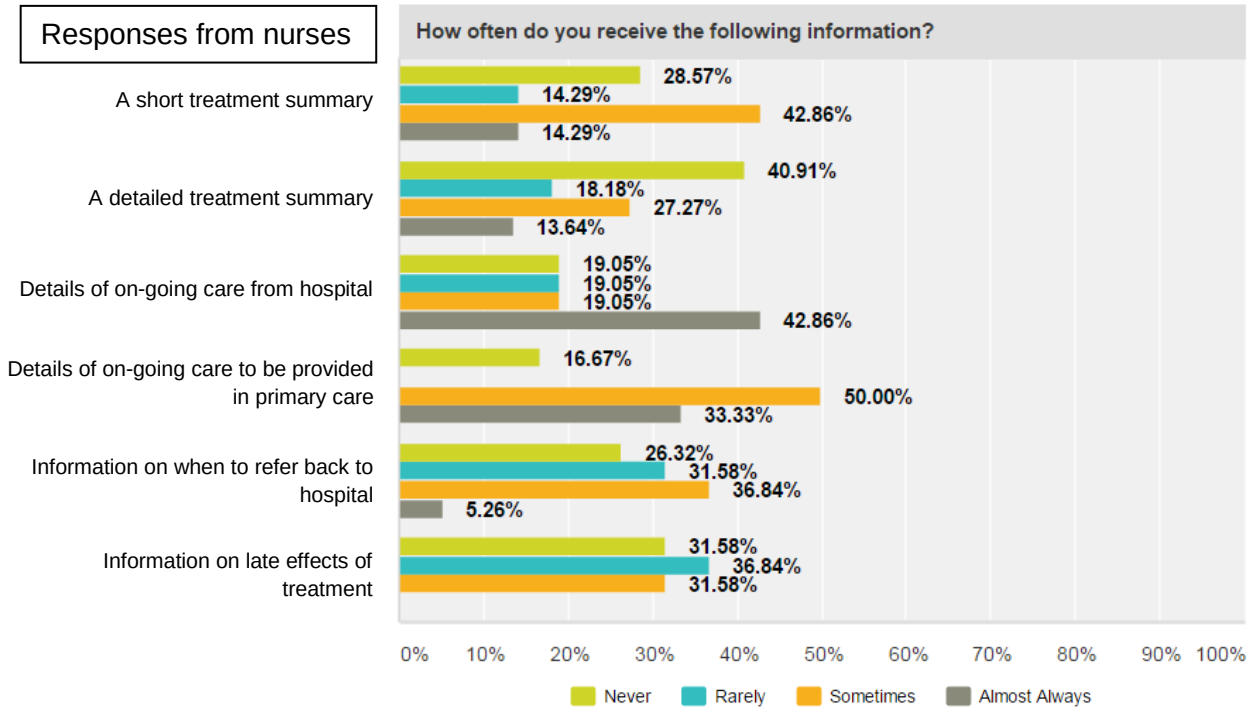
Regarding the information GPs and nurses receive from secondary care when patients have finished their first course of treatment; responders were asked what type of information they receive and how often. 48% of GPs (n=88) said they almost always receive a short treatment summary, with details of on-going care from hospital, however, 48% of GPs stated they rarely receive information on possible late effects and only 10% saying they receive information on when to refer patients back to the hospital. Treatment Summaries are sometimes called Discharge Summaries and it has been noted that confusion and clarity is needed to ensure the right document is identified as part of the delivery of the Recovery Package.

Chart 20: Q1 (LWBC GP)



The same question for nurses generated slightly different responses with only 14% of nurses stating that they almost always receive a short treatment summary from the hospital compared to 45% stated by GP. However, just as with the GPs, nurses state that they rarely (31%) or never (36%) receive information on late effects of treatment.

Chart 21: Q1 (LWBC Nurse)



48% of nurses (n=48) and 36% of GPs (n=87) felt they were sometimes clear about their role in providing on going care to patients of common cancers. 8% of GP and 9% of nurses stated that they were almost always clear. 12% of GP and 17% of nurses stated they were rarely clear about their role.

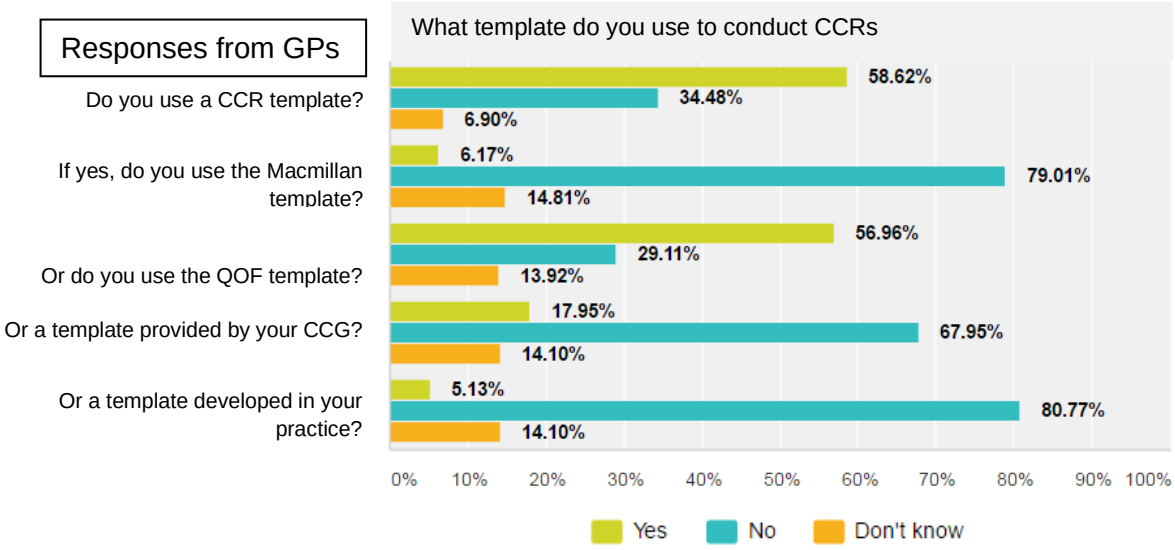
> "We sometimes get left out of the loop if a patient is transferred between teams. Not always clear what patient has been told re prognosis etc" – GP

Respondents were asked the provision of standardised Cancer Treatment Summaries and Survivorship Care Plans improve their ability to provide care for people who have recently completed their active cancer treatment. 80% of GP and72% of nurses either agreed or strongly agreed to the statement

> "As a GP, once I refer the patient and they are under the oncologist, I rarely see them, it's as though they are kept in a bubble within the oncology services. Once they are discharged (e.g. breast cancer post follow up period) they are then dumped on my lap with no clear instructions on when to stop for e.g. Tamoxifen and what the pathway is if a lump reappears. Refer back through 2ww or is there a back door for such patients?" – GP

GPs were asked how they usually conduct cancer care reviews (CCRs) and 93% (n=87) said they offer CCRs opportunistically via a specific appointment. 12% said patients are offered an appointment with a practice nurse. The chart below outlines the different templates used by the respondents when they conduct CCRs (n=87).

Chart 22: Q5 (LWBC GP)



90% of nurses (n=49) who responded to the question said they *did not* conduct CCRs and 2% were not sure. 8% (n=4) said they did conduct CCRs and did so opportunistically by offering an appointment with either the GP or practice nurse. The majority of the nurses (75%) used the QOF template compared to 25% who used the Macmillan template.

> "Sometimes in the form of phone calls at others either a home visit or an appointment" – practice nurse

> "All of the above - sometime the patient has an on-going relationship with the NP [nurse practitioner] rather than the GP and would prefer to continue seeing that person - reviews are often done over the phone post discharge" - practice nurse

75% of the nurse respondents either agreed or strongly agreed that that the CCR they offer is useful to the patient compare to 51% of GPs who agreed or strongly agreed. 38% of GPs were not sure.

> "Pts (patients) are bombarded with appointments and seen regularly during initial phase by hospital clinicians, often need more support post treatment" – practice nurse

> "It gives an opportunity to discuss what other services and support may be required" – practice nurse

Of the nurses that stated that they currently do not conduct CCRs, 49% said they would be willing to do so, 25% said they wouldn't and 21% were not sure. A face to face training session to help nurses to carry out cancer care reviews was viewed as the preferred method. Shadowing other clinicians who routinely carry out cancer care reviews was chosen as second choice method.

> "Not willing to do - I have enough on and feel this is GP work" – practice nurse

Recognising consequences of cancer treatment

Cancer treatment is a risk factor for cardiovascular disease in later life. In particular, radiotherapy to the left side of the chest and some chemotherapy commonly used for breast cancer, sarcoma and haematological cancers are known to increase the risk of the patient subsequently developing cardiovascular disease. Hormonal treatment, including the use of GnRH analogues for prostate cancer and aromatase inhibitors for breast cancer, is associated with an increased risk of bone fractures due to osteoporosis[5]. GPs and nurses were asked if they were aware of two major consequences of cancer treatment, namely diminished cardiovascular and bone health.

Chart 23: Q10 (LWBC GP)

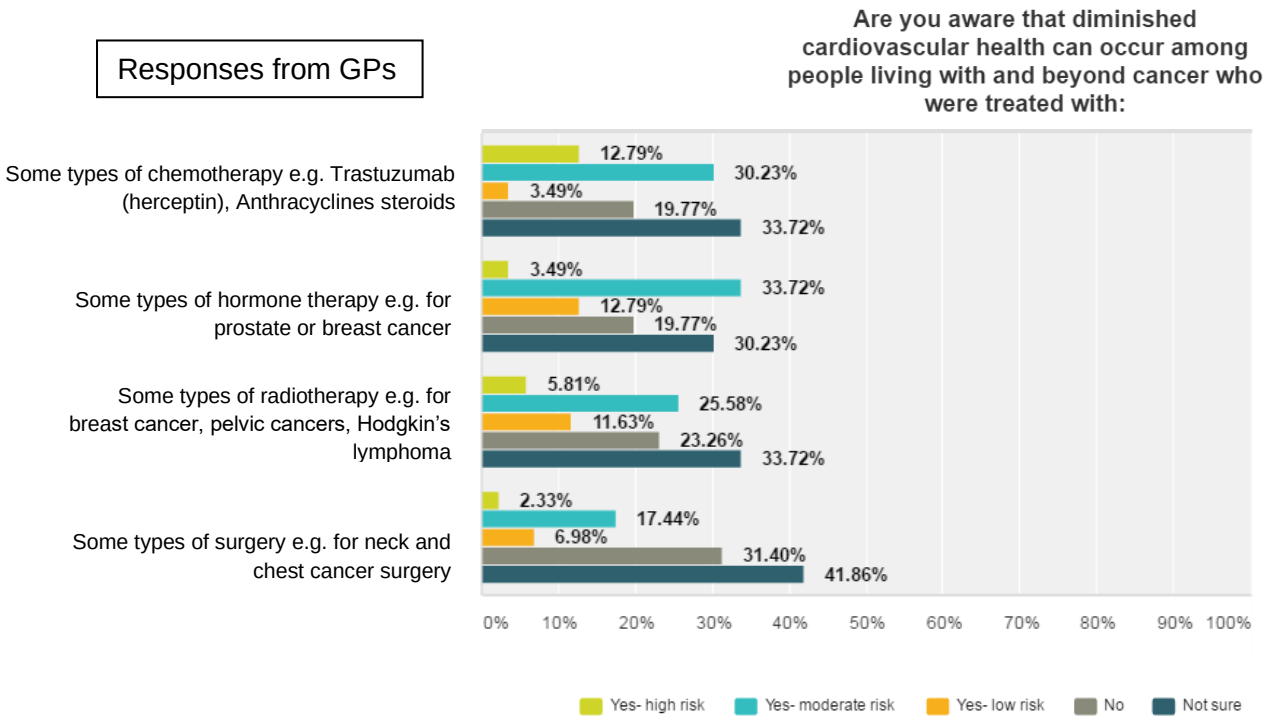
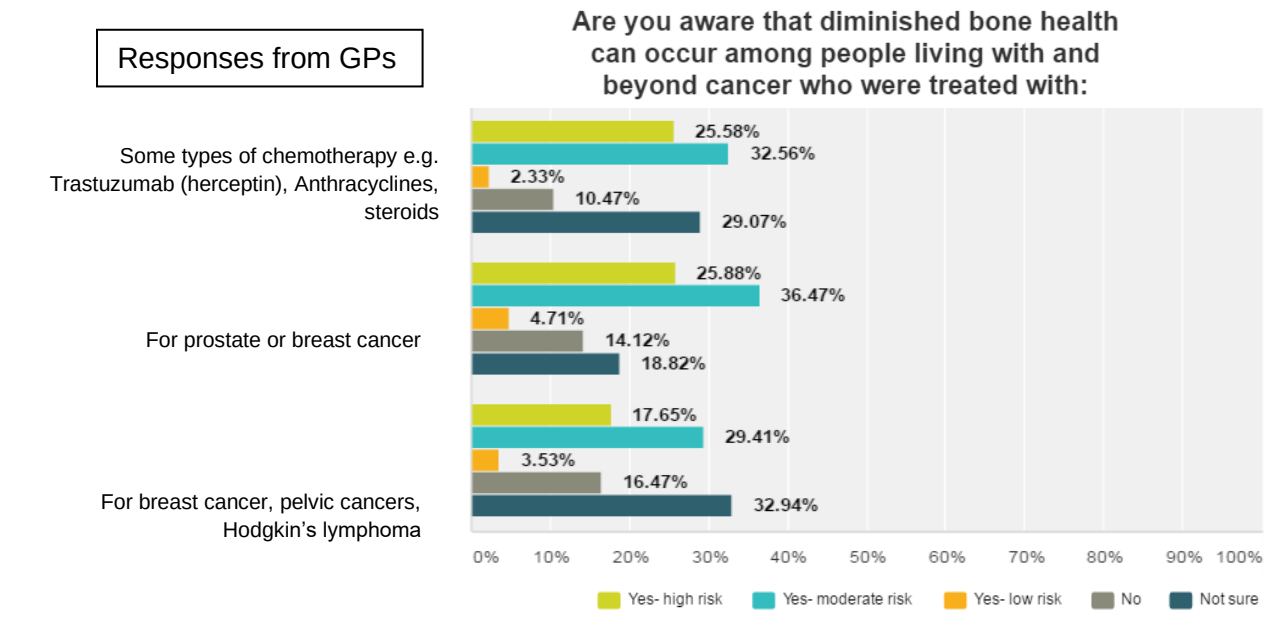


Chart 24: Q11 (LWBC GP)



[5] file:///I:/Downloads/Macmillan-Quick-summary-of-potential-late-effects%20(2).pdf

On the subject of managing patients in primary care and consequences of cancer treatment, GPs were asked to specify how commonly they provide specific types of care for people who have completed cancer treatment.

Chart 25: Q10 (LWBC Nurse)

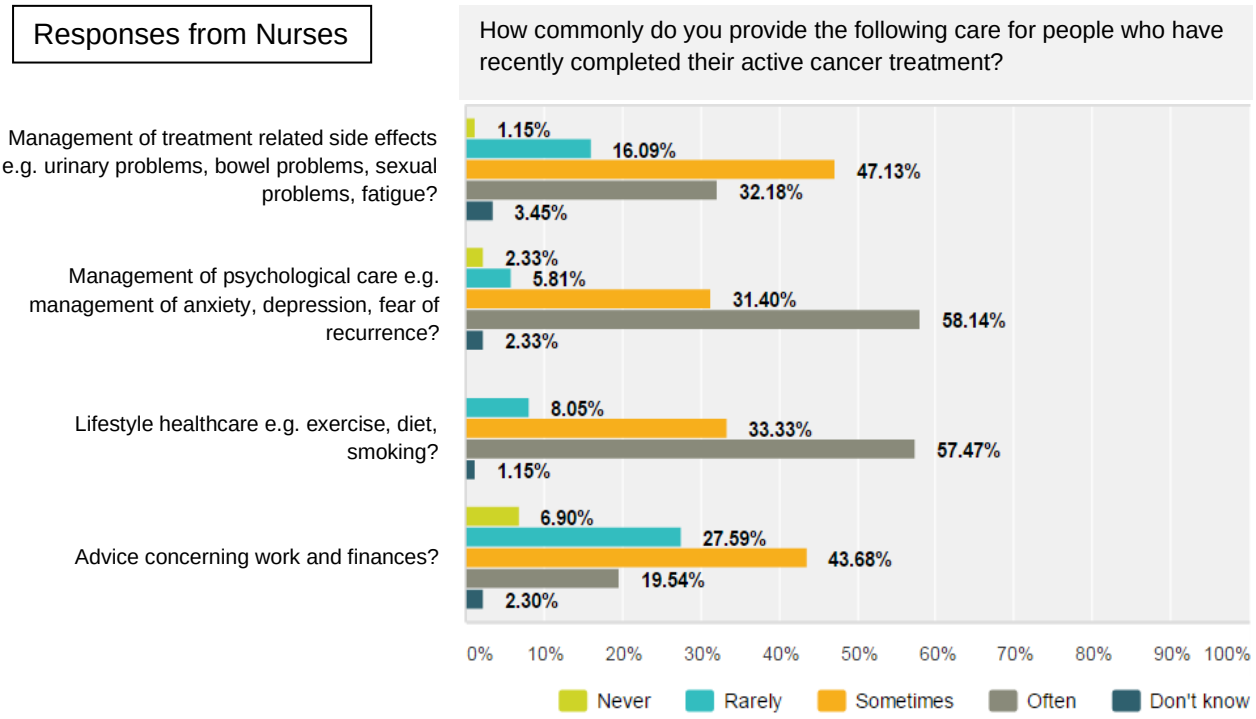
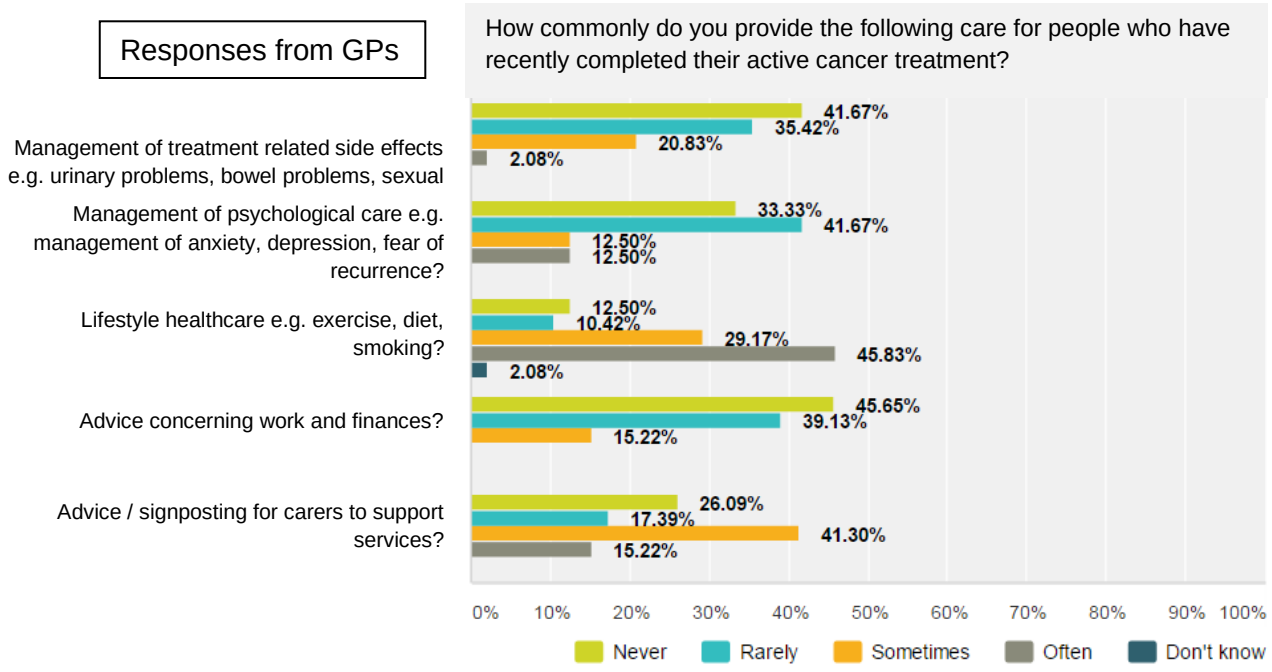


Chart 26: Q6 (LWBC GP)



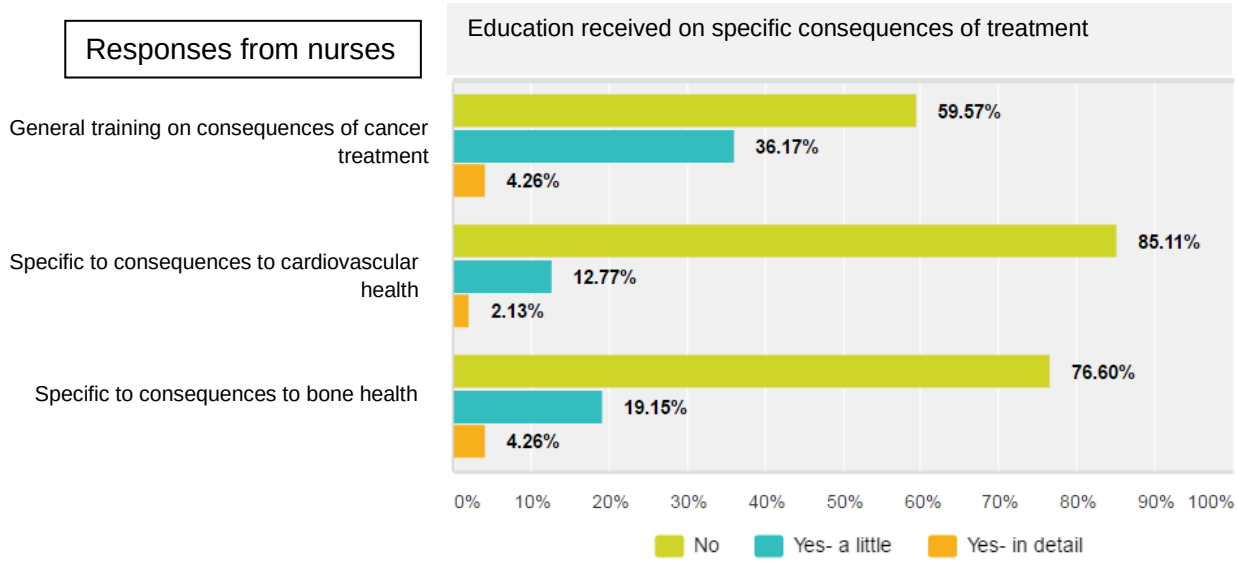
Both GPs and nurses, were then asked how confident they were on providing the above consequences of treatment and highlighted that they were least confident in providing advice concerning work and finance and were most confident on advising on lifestyle based healthcare.

Training and knowledge

Fewer than 6% of GPs and 4% of nurses had received general education on the consequences of cancer treatment that patients may develop over time. 41% of GPs and 36% nurses stated that they received a small amount of training.

Chart 27: Q22 (LWBC Nurse)

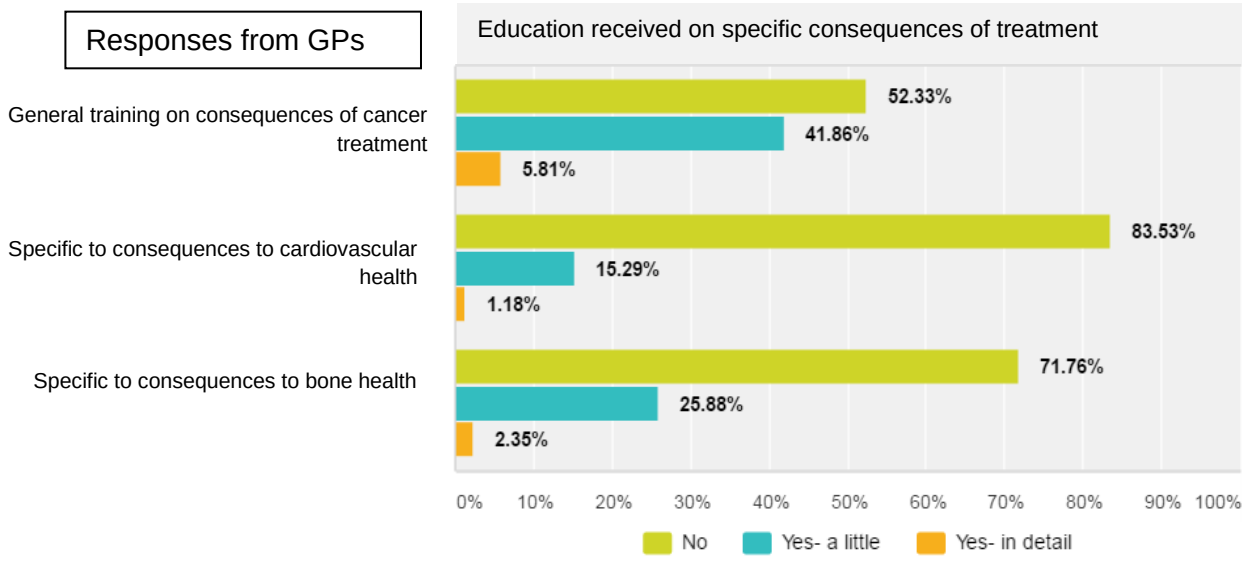
Responses from nurses



"I know nothing about cancer and many nurses don't, because it depends what area of nursing you go into when you qualify. There is a huge pull on putting over challenging demands on nurses by GPs and "assume" we know how to manage complex cases. A huge classroom based course would need to be implemented, not some e-learning module that everyone finds useless in the real world. There needs to be role play and you would need to teach us how to manage depression and anxiety, because again, no training available for that. We would also need counselling ourselves to manage the emotional aspect" – practice nurse

Chart 28: Q16 (LWBC GP)

Responses from GPs



When asked if they would like further training, the majority of respondents, both GPs and nurses said they would welcome the opportunity. The respondents were then asked to choose which sessions they would be interested in. 90% of nurses and 94% of GPs selected further training on the management of cardiovascular consequences of cancer treatment, 88% nurses and 93% GPs wanted management of bone consequences and 86% and 88% wanted management of side effects such as urinary and sexual problems and cancer related fatigue.

Chart 29: Q23 (LWBC Nurse)

Responses from nurses

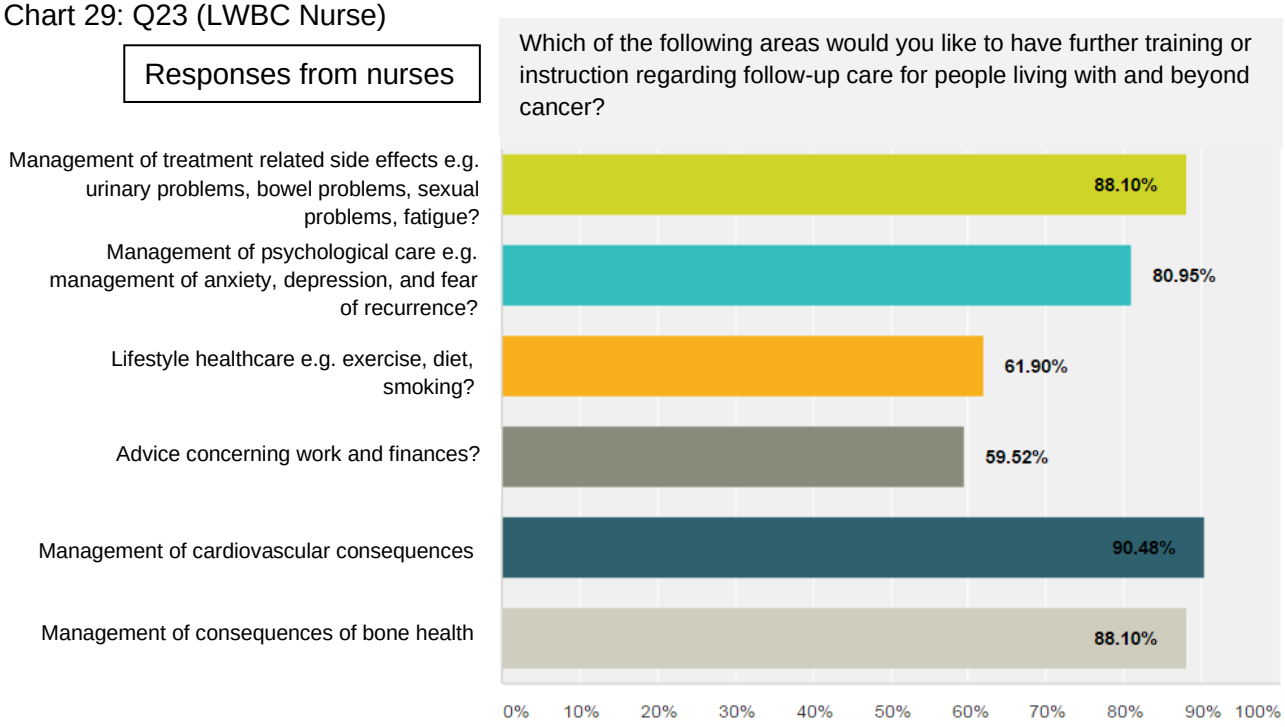
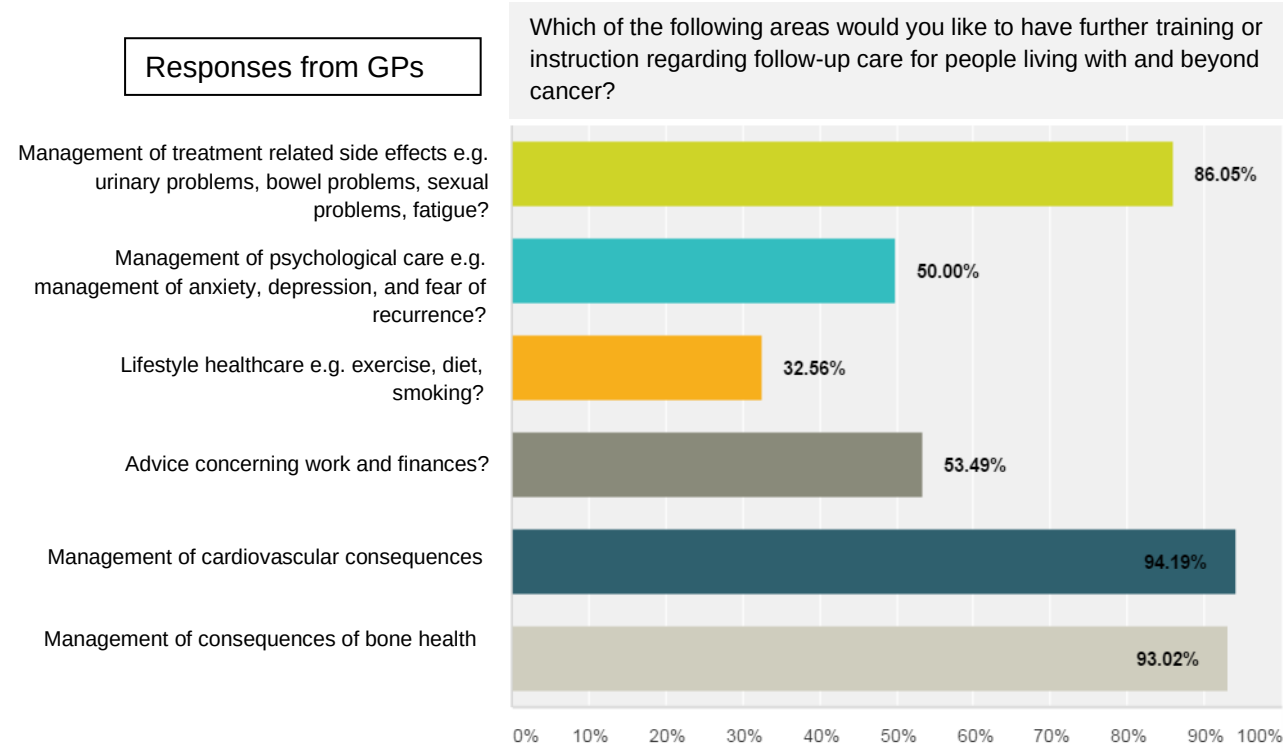


Chart 30: Q 18 (LWBC GP)

Responses from GPs



Demographic breakdown of the respondents of the LWBC TNA

- 138 responses received from GPs and nurses. See Table 2 below for breakdown of responses by Strategic Planning Group areas
- 100% nurse and 67 % GP respondents are female.
- The majority of respondents were not Macmillan professionals or cancer leads for their CCGs or practices.
- Most respondents describe their practices as urban.
- There was almost an equal split between full-time, nearly-full time and part-time working patterns for both GPs and Nurses.
- 92 % of GPs and 96% of nurses have personally experienced of cancer through a diagnosis of a close family member such as a parent, sibling, partner/spouse or child.
- The majority of the responders to the survey are from CCG areas in South London.

Table 2 – Geographical breakdown of respondents

STP	**LWBC GP**	**LWBC nurse**
West Essex	0	0
North East London	8	5
North Central London	8	3
South East London	31	21
South West London	23	13
North West London	16	6
Number of respondents that skipped question	2	2
Total	**86**	**48**

Limitations

- As the surveys collect data at a single period of time, it is difficult to measure changes in the population unless two or more surveys are done at different points in time. Such repetition will need to be discussed with CCG / Strategic Transformation Partnerships.

- The completion of the TNA surveys is primarily voluntary and in turn generated a low return rate, despite actions such as reminders and notification of extending survey deadlines. Non-response can introduce a bias in the survey results.[6] According to NHS Digital the total number of registered GPs is 7472 and 2864 primary care nurses in London. The TNAs were sent to all practices and 475 completed surveys were received. 223 GP responses (rate of responses range from 223-186) and 114 nurse responses (response rate range from 114-99) to the ProCAM (early detection) survey and 88 GP responses (rate of responses range from 88-84) and 50 nurse responses (response rate range from 50-42) for the LWBC survey.

Discussion

This report aimed to highlight the knowledge gaps of both GPs and primary care nurses. Although the response rates were much lower than anticipated, 227 for the GP ProCAM, 114 nurses for ProCAM, 88 for GP LWBC and 50 for nurse LWBC (see table 3), some of the results were not unexpected. For example, both GPs and nurses were in most cases were 100% aware of the three main NHS screening programmes. This could be due to the programmes being well established and promoted for several years (ProCAM GP Q1-Q15 and ProCAM Nurse Q1–Q6)

Table 3 shows number of responses across all the six TNA surveys

TITLE	MODIFIED ▾	RESPONSES
ProCAM: Professional Cancer Awareness Measure for Primary Care Nurses Created 03/16/2016	12/01/2016	114
ProCAM: Professional Cancer Awareness Measure for GPs Created 02/29/2016	12/01/2016	223
Living with and beyond cancer Training Needs Assessment for Primary Care Nurses Created 03/03/2016	12/01/2016	50
Living with and beyond cancer Training Needs Assessment for GPs Created 02/25/2016	12/01/2016	88
ProCAM: Professional Cancer Awareness Measure for Community Pharmacists Created 07/13/2016	12/01/2016	61
Management of suspected oral cancer Created 06/06/2016	11/24/2016	129

54% of GPs were aware of the newer flexible sigmoidoscopy (bowel scope screening) which was higher than expected as the flexi sigmoidoscopy programme has only commenced within a third of

[6] www.ons.gov.uk/ons/guide-method/...for-measuring.../accuracy-and-reliability.pdf

London CCGs and may not be rolled out to all GP practices. Nonetheless as almost half of respondents were not aware of the new scoping test this presents training opportunities.

In regards to primary care clinicians actively increasing screening levels (free text comment boxes), the majority of GPs and nurses seemed motivated to increase screening uptake across all three screening programme. They did this by either opportunistically promoting the programmes or actively recalling and chasing up non-attenders. It is noted that the Quality Outcomes Framework (QOF) incentivise practices to achieve high levels of uptake for cervical screening[7]. QOF incentives are not offered for increasing uptake of bowel or breast cancer screening.

A further point of interest was that a quarter of nurses were not confident in advising patients how to conduct the faecal occult blood test kits for bowel cancer screening. This may be due to the bowel screening programme being led by screening hubs rather than general practice but highlights a lost opportunity and training need

GPs were asked about their confidence levels in diagnosing cancer, their ability to discuss what actions patients should take regarding unusual changes to their bodies, awareness of the signs and symptoms that could indicate cancer and promoting NHS Cancer screening programmes to eligible patients. Although confidence levels are described as "fairly confident" there is an opportunity through training and education to enable clinicians to become very confident when faced with a potential cancer diagnosis.

GPs indicated that they have systems in place for recording and following through urgent suspected cancer referral. Nonetheless there would be value in ascertaining what system they are using since there are a number of codes and options within existing GP computer systems. 30% of practices either did not routinely code or were aware of whether safety netting procedures were in place. The National Cancer Strategy (2015) recommends establishment of safety netting processes and that training is in place to support implementation.

The NG12 NICE guidance identifies groups of patients at low, but real risk of having cancer, who will have investigations performed and followed up in primary care. For this set of patients there are reasons for robust safety netting to be in place since oversight remains with the practice. This report reflects research that also suggested variance in how GP teams implement safety netting[8] and there is current interest in developing robust methodology[9,10] There is therefore value in understanding how clinical and administrative staff work to enable the safety net to function, with potential to share better practice.

An existing project is seeking to improve GP safety netting systems. This project is supported by UCLH Cancer Collaborative, TCST and Macmillan[11] and has potential to inform good practice across London.

In the TNA survey, GPs outlined their interest in receiving further information on the various cancer tools that are available to support suspected cancer referrals such as cancer risk awareness tools, cancer significant event audit and comparative cancer performance data that outlines practice-level indicators such as cancer referral rates and screening uptakes. The Macmillan Cancer Update and followed jointly but the Cancer Risk Assessment tools and the RCSP Cancer audit tool were the items that GPs wanted further information on. It was noted that 54% of respondents said they did not want any further information on the Cancer Significant Event Audit. This could be due to the tool being well established and having been available for GPs to utilise for the past few years.

[7] http://www.nhsemployers.org/~/media/Employers/Documents/Primary%20care%20contracts/QOF/2016-17/2016-17%20QOF%20guidance%20documents.pdf
[8] https://www.bangor.ac.uk/nwcpcr/documents/ICBP3Ca-PRIposter.pdf
[9] http://www.bmj.com/content/355/bmj.i5515
[10] http://www.bmj.com/content/355/bmj.i5515/rr
[11] http://londoncancer.org/our-work/earlier-diagnosis/coding-safety-netting/cancer-safety-netting-toolkit/

The National Cancer Survivorship Initiative[12] highlighted the immediate and long term physical and psychological impact that cancer can have on those who have recovered. It states that many cancer survivors have unmet needs, particularly at the end of primary treatment whilst others are struggling with the consequences of treatment. The recommended 'Recovery package' model comprises four aspects: holistic needs assessments (HNA), health and wellbeing events (HWBE), Treatment Summaries (TS) and finally the cancer care review (CCR) in primary care. See 1 figure below.

Figure 1

The recovery package interventions have been included in London's acute commissioning intentions every year since 2012/13. Acute providers are expected to implement all interventions that relate to their services (HNA, TS, HWBE) in parallel so that patients receive a package of care without variation.

Survey results show that still less than half of the respondents were receiving a treatment summary from secondary care clinicians. Furthermore 48% of GPs stated they rarely receive information on possible late effects and only 10% saying they receive information on when to refer patients back to the hospital. It could be argued that without this vital information from secondary care, primary care clinician felt their unclear about their role in the onward management of patients living with and beyond a cancer diagnosis.

As with cervical screening, Cancer Care Reviews are governed by QOF and requires GPs to carry out a one-off cancer care review at a maximum of 6 months post cancer diagnosis. Practices can claim 11 QOF points against two indicators for cancer. Despite the incentive offered by QOF, the majority of GPs offered CCRs opportunistically rather than prescriptively and only 58% of respondents use a CCR template to record the CCR which may provide some insight into why only half of the GPs agreed that the CCRs are useful to patients.

Cancer treatment is a risk factor for cardiovascular and bone health however the awareness of these risk factors was notably low among the GP respondents. What has not specifically asked of the respondents was around their awareness that a cancer diagnosis could be a risk factor for a second primary cancer or a reoccurrence.

Finally, the TNA surveys highlighted that both GPs and primary care nurses welcomed training opportunities for both early detection of cancer, communication around signs and symptoms and understanding consequences of cancer treatment. More importantly, training must ensure confidence levels are increased in managing patients regardless of whether patients are at the start of the cancer pathway and under the care of hospital consultants or have finished treatment and are living beyond their cancer diagnosis.

[12] http://www.ncsi.org.uk/what-we-are-doing/the-recovery-package

Recommendations

- TCST to share results included in this report with the TCST's Train the Trainer's programmes, CEPNs, CCG Macmillan and Cancer Leads as a basis for developing local educational events.

- PCCEG to triangulate results with other research where possible:
    - Cambridge University and Oxford Brooks University (LWBC surveys)
    - CAM (public)
    - Talk Cancer evaluations
    - CRUK Facilitators pre and post evaluations of training events
    - Macmillan primary care nurse training session evaluations
    - Train the Trainer workshop evaluations

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- Ann Courtness, Macmillan Primary Care Nurse
- Gali Segal, Health Professional Engagement Facilitator, Cancer Research UK

Appendix A – D

Appendix A: ProCAM TNA questions for GP

ProCAM GP Sept16.pdf

Appendix B: ProCAM TNA questions for nurses

Procam Nurses PDF Sept16.pdf

Appendix C: LWBC TNA questions for GPs

LWBC TNA GPs.pdf

Appendix D: LWBC TNA questions for nurses

LWBC TNA Primary care nurses.pdf

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