

Core Principles to apply across the whole Pathway

The pathway will ensure that all staff will be compassionate in their approach and as a minimum make sure they always introduce themselves and explain their role to patients and those they have brought with them.

The amount of time taken between each step needs to be agreed between patient and health professional based on the individual situation.

Time needs to be taken by health professionals to understand the patients preferences, priorities and what is driving this view to accommodate the individuals requirements and support them to be in control of their care.

Included with written information sent to the patient is information on how they can start to make the most of their appointments clinicians, including information on what to expect at the next stage and help with planning the types of questions that they wish to ask.

An emphasis from the start of the pathway is planning to survive.

Information about discussions in secondary care will need to be very clear so that GP/Practice nurse can be facilitative and supportive do not give conflicting/confusing advice to patient. Clarity of role of secondary care, patient and GP practice in achieving the care plan needs to be clearly agreed and documented

There should be recognition of a person personal resilience reserves and support to build and maintain this throughout the pathway from the very start.

It is a positive outcome for the patient to not need formal support because they are self-managing effectively themselves.

Throughout the whole pathway the focus should in being able to access Health and Wellbeing advice and support whenever it is appropriate for the persons personal needs. This may include Exercise sessions, Healthy Eating talks, Stress Management Sessions and Health and Wellbeing Event

There should be access to specialist psychological/ mental health support for those who require it. A minimum level of self-management advice and guidance to help maintain good mental and physical health should be available to all. There should be help with early identification of needs for additional help, to support this self management ethos.

To support this approach a standard education approach for all health staff may need to be put in place to consider the patient as a whole person and encourage a true shared-decision making approach.

Where known late effects for a treatment option exists, this needs to be discussed early in the pathway. Action needs to be taken throughout the pathway and beyond to ensure the patient is doing as much as possible to minimise the long term impacts of treatment i.e. improving/maintaining bone density for Breast patients.

Should there be any significant event which changes the patient's care plan this is to be recorded in the patient held file and a copy of this information is shared with the GP within 48 hours of the event. This should aid the GP in being much more actively involved in supporting the patient throughout their cancer journey.

The health interventions need to be seen as part of a wider web of support that is available for and surrounds the patient and their family whilst they go through their cancer journey.

Presentation with signs/symptoms of cancer (ideally at GP Practice or through screening programme but may be A&E)

2WW referral made (or other appropriate pathway used) to access secondary care cancer services and diagnostics

Assessments and investigations undertaken and outcome of MDT communicated to patient, supporters (within 24hrs of information being available). This is followed up with written information sent to patient and GP.

Patient **not** diagnosed with Cancer and referred back to GP or onto specialist team to manage outcome of assessments. Opportunistic lifestyle advice and information given due "cancer scare".

A health professional meets with patient to discuss impact of diagnosis and potential treatment options including offering patient choice of where they wish to be treated. Written confirmation from discussions sent to patient copied to GP (within 48hrs after discussion with patient).

Secondary care to have pre-treatment discussion with patient which includes options around prehab and health and wellbeing opportunities for keeping well during treatment, self-management approaches.

Discussion and joint completion of Holistic Needs Assessment between health professional, patient (and if appropriate supporter) in Secondary Care. Information used to jointly agree treatment and wider care plan with patient. Outcomes of this information captured in writing and shared with patient copied to GP. Patient leaves with patient held file.

GP Practice to contact patient following receipt of diagnosis, outcome of Holistic Needs Assessment, treatment and wider care plan to offer support and discuss wider implications of general health as well as offering opportunistic lifestyle advice

Cancer Treatment undertaken

As patient is coming to the end of their treatment a review and repeat of the Holistic Needs Assessment process should be undertaken. Discussion of the next steps in the patient's pathway discussed and a shared decision making process undertaken to refine and update care plan and Treatment Summary document.

Based on this discussion a joint agreement of patient's risk stratification level is agreed. Information agreed and captured in patient held record and copy of information sent to GP. In order that patient and supporter is prepared for this appointment. Preparing for discharge information to be shared with patient with appointment letter and references parts of patient held record .

GP/Practice Nurse to contact patient following receipt of updated outcome of holistic needs assessment, Treatment Summary and care plan to offer support and discuss wider implications of general health as well as offering appropriate information and opportunistic lifestyle advice plus agree the regularity of cancer care reviews in the community. With a "normal" level of support being offered for 5 years

All patients offered access to Living Well Self-management courses, Exercise, Healthy Eating, Financial/ Practical/Occupational, Psychological and spiritual support, Stress-management, Management of Late Effects of Treatment – conventional/complementary, More intensive Self-Management Courses for those with complex needs

Patients Risk stratified as High Risk of additional clinical complications or high likelihood of recurrence and/or effects from treatment and require high levels of specialist input will receive: Follow up appointments with appropriate diagnostic testing in secondary care as per NICE guidance. This should be the exception not the norm and only where it is clinically unsafe for discharge to occur.

Patients Risk stratified as being of low risk of clinical complications and appropriate remote monitoring of recurrence and/or effects from treatment but need further support in self-management of the impacts of cancer diagnosis will receive: Remote monitoring and HOT clinic access with knowledge of signs/symptoms to watch out for and how to seek help should they have concerns. Community Support from the Community Complex Case Team to achieve identified goals this may include additional health and wellbeing support through groups and/or access to 3rd sector groups/services

Patients Risk stratified as low risk of clinical complications and appropriate remote monitoring of recurrence and/or effects from treatment and able to self-manage without additional support will receive: Remote monitoring and HOT clinic access with knowledge of signs/symptoms to watch out for and how to seek help should they have concerns. Signposting to 3rd sector groups/services to improve self management

Patients identified as having a life limiting prognosis of less than 6 months will be directed to a separate palliative pathway to meet their needs

Cancer Care reviews carried out as per agreement with GP Practice and Patient using the process set out in the patient held file. Continuing a shared decision making approach, which ensures that the patient is activated and in control of their care. Reviews cease at the point where the patient and GP both feel there is no longer benefit to continuing this appointments and it is agreed that the patient can re-access support in primary care at any point in the future should things change.