Role of primary care in the management of cancer patients

DANNY BUCKLAND

The management of cancer patients has traditionally been a secondary care responsibility but increasing survival rates and new models of care mean that the role of primary care is evolving, and a restructuring of cancer services to provide more integrated care is now required.

The demarcation between primary care and specialist services was anchored down in 1948 with the landmark formation of the NHS but, as with most structures approaching their 70s, the joints are creaking. The revolution in cancer care, in terms of therapies and survival, has put further stress on the dividing lines, which can at times appear like they are delineated with barbed wire and sentry posts. The boundaries have softened over time, but maybe not as much as the landscape in which breast cancer survival rates rose from 37 per cent to 77 per cent and colon cancer from 18 per cent to 47 per cent in the first 60 years of the NHS. Overall, death rates from cancer in the UK have fallen by more than a fifth over the past 30 years and are expected to continue to fall further, by an estimated 17 per cent by 2030 (see Figure 1). The number of cancer survivors in the UK has been predicted to double from two million to four million within 20 years and the burden on primary care and the need for linked strategies will grow as patients experience physical, psychological, social and financial changes.

Restructuring services

Despite this, the borders between primary and secondary care, while not quite the scene of trench warfare, can be viewed as too rigid. Targeted drugs, advanced diagnostics and new models of care could influence greater fraternisation between disciplines, allowing GPs and pharmacists a greater role in delivering oncology services to enhance patient experience and outcomes.

A major report from the Lancet Oncology Commission, published last autumn, was clear that restructuring services can lead to earlier diagnoses and better outcomes while stabilising costs and delivering care closer to home. It argued strongly for a fresh approach, ceding some treatments from hospital settings to GP surgeries and community clinics.

The report of the Independent Cancer Task Force, Achieving World Class Cancer Outcomes 2015–2020, states that outcomes can be improved radically with an emphasis on early diagnosis. Its litany of service desires includes patient expecta-
tion, holistic support, individual compassion and prevention – all qualities that sit snugly in the GP wheelhouse.

It states: “Cancer survival in England has improved significantly over the last 15 years. More than half of people receiving a cancer diagnosis will now live 10 years or more. But our mortality rates are higher than they could be. In addition, unacceptable variability exists in access to and experience of care across different areas, subgroups of the population and cancer types. There is much we could do to improve patient experience and long-term quality of life, and to make our care more patient-centred.”

It adds, significantly: “Realising the potential will require a broad set of approaches, including more integrated pathways of care and increased investment.” Integration and investment are often the twin demons bedevilling progress and GPs are entitled to mount a Churchillian gambit of “give us the tools and we’ll finish the job” to push back against changes to working practices that come with inadequate resources.

**Integrated care**

The big question hovers: can a more flexible structure be assembled to deliver the best of care and synchronise with the Cancer Task Force wish list and the NHS Five Year Forward View thrust of creating 13 new vanguard hospitals, sweeping across a range of conditions characterised by “speedier early diagnosis and optimising combinations of cancer surgery, radiotherapy and chemotherapy”.

Simon Stevens, NHS chief executive, enthuses: “The era of go-it-alone individual hospitals is now being superseded by more integrated care partnerships – both within local areas, and across different parts of the country. The scale of the interest in these new vanguards from across the health service shows the NHS is up for radical reform.

“Our new approach to hospital partnerships will help sustain the viability of local hospitals, share clinical and management expertise across geographies, and drive efficiency beyond the walls of individual institutions.” The mood music is clearly ‘caring is sharing’.

The Lancet Oncology Commission report’s lead author, Professor Greg Rubin, a GP and professor of general practice and primary care at Durham University, believes the opportunities should be rigorously explored. He was part of a team of 36 experts covering primary care, oncology, public health and psychology who assessed evidence to construct a narrative for a revamped service.

“The purpose of the commission came from a growing body of evidence that a number of elements of cancer care could be provided as well as, if not better, in community settings compared to hospital settings,” he says. “There is increasing survival after cancer diagnosis and we are accumulating a population that has survived cancer and will need general all-round holistic care that GPs provide, covering the physical and psychological consequences of surviving for a length of time.”

Harnessing GP influence in prevention could switch on a potent power source for lifestyle changes and the uptake of screening to aid early diagnoses, he claims. “Having GPs involved in screening improves the participation rate, and better access to diagnostic tests together with access to decision support tools to better identify people who need testing are two important elements going forward,” adds Professor Rubin.

Any new model would not necessarily mean increased prescribing for GPs – a move that would encounter concern and resistance – but their talents would be used more for follow-ups and enduring care. “There is no much doubt that integrated care between GPs and oncologists means that patients can be safely and effectively followed up in the community. There is good evidence that this applies to breast and colorectal cancer and there is no reason that this shouldn’t apply in other cancers,” says Professor Rubin.

“Cutting across all stages of cancer, from prevention to end of life, the one thing that came through was that integrated care was the model to develop. There was evidence that better integration between specialist and primary care provides the prospect of a better quality of care for the patients as it would make the most of the particular skills of general practice and the best of the skills of specialists. There are many things that specialists do that are either unnecessary or they are not the best people to do it, and that may include the follow-up of relatively low-risk patients.

“It clearly needs to be underpinned with professional development programmes and must be organised so it is not a specialist coming and telling GPs what they should be doing. It is about GPs and oncologists learning together what their roles would be in a model of this sort, making the most of the expertise of both.”

![Figure 1. Cancer mortality projections: actual and projected number of deaths in the UK](image-url)
Models of care
Recalibrating oncology across primary and secondary care has had success in Canada, where a pioneering service in Winnipeg, Manitoba, has been delivering a shared care model for 12 years (see Figure 2). Its concept, now being replicated in other provinces, is to have oncologists to assess patients and devolve elements of their care to doctors working in community cancer programmes. The oncologist retains overall responsibility for treatment plans, but the care is delivered by a multidisciplinary team, including family physicians, pharmacists and nurses, who have been trained in oncology. Uniting Primary Care and Oncology (UPCON) began with 12 family practice surgeries and, with federal funding, has now grown to more than 50 dedicated clinics.5

An NHS England initiative introduced last October, backed by Cancer Research UK and Macmillan Cancer Support, is looking at ways to test innovative methods to stop the UK lagging behind other European countries on cancer outcomes caused by a failure to diagnose early.6 One strand of the Accelerate, Co-ordinate, Evaluate (ACE) programme latches onto the fact that 89 per cent of the population in England can walk to a community pharmacy within 20 minutes,7 to provide the basis of a pilot study in Doncaster CCG that allows community pharmacists to refer patients presenting with symptoms of lung cancer directly to a chest X-ray. The theory is that a pharmacy is a good place to connect with people who do not regularly consult their GPs.

Pharmacies could be a fertile zone for prevention given that four in 10 cancers could be prevented through lifestyle changes8 and that around 438 million visits are made to local pharmacies every year in the UK.9

However, weaponising the high street in the general battle for more effective delivery has its critics, particularly as its subclinical referrals can be damaging even if well intentioned. Initial concerns over the Doncaster trial came from both radiologists and GPs who felt that overreaction might create additional strain on capacity.

GP concerns
Shunting responsibilities to GPs surgeries may seem advantageous on a flow chart but Dr Andrew Green, chair of the BMA General Practitioner Council's Clinical and Prescribing Group and a GP in East Yorkshire, sees dangers in the key areas of workload, resourcing and increased prescribing duties.

“The message that doesn’t seem to be getting through to enthusiasts is that general practice is full. We are struggling to provide good-quality primary care and the idea that we can take on specialist roles not only without training but also the resourcing – and that means the money and the people – is frankly absurd,” he says. “If general practice shows too much willingness to take on specialist roles, we will end up not doing our main one, which is to provide good-quality primary care.

“I have a lot of concern about it because these are powerful drugs with great potential for benefit, but also with great potential for harm and they should be prescribed by doctors who are familiar with their use. I have no problems with the wish that patients should be treated close to home, but that treatment should be organised by and prescribed by specialists. There is no reason why they can’t have that care in the community with the oncology prescribing still done through the specialists who are familiar with it.

“We have to remember that, even under shared care arrangements, the doctor who signs the prescription is responsible for it and I would be concerned if GPs felt pressurised into signing prescriptions they weren’t familiar with.”

There is a clearer line of sight to the benefits from improved communication between general practice and hospitals to ensure cancer patients do not slip between organisational gaps, he feels. “I am quite happy looking after patients with malignancies because they are patients you can see quite often and get a really good relationship with. But I’m clear that what I should be providing for them is high-quality primary care and if I tried to take on the role of a specialist and that harmed their primary care then I’m afraid I’ve done no one any favours,” adds Dr Green.

Concern about “who prescribes what” is shared by Steve Williamson, consultant pharmacist, Cancer Services for Northumbria Healthcare NHS Foundation Trust, but he also believes greater collaboration will pay dividends as the UK faces a future with more cancer survivors with multiple oncology
needs. “These patients are having more lines of treatment and they are with us for longer. GPs having a role in monitoring patients and getting bloods done so they are available prechemotherapy would be practical and useful, particularly for patients who have to travel a distance to hospital,” he says. “We find that with patients on long-term meds, the oncologist will deal with their cancer and chemotherapy needs, but any other long-term issues will be referred back to the GPs, so there is an issue of whether GPs are aware of the medicines the patients are on.”

There are also commissioning barriers to GPs becoming more involved in prescribing in the shape of the NHS financial mechanisms, which are not set up for that type of flexibility, and new targeted therapies – which are doing so much to revolutionise care, outcomes and force medicine to consider fresh models of care – are mainly monoclonal antibody-based, still in their prescribing infancy and require close clinical attention.

A holistic approach
But there is a pressing need for GPs, pharmacists and oncologists to be on the same page, as new therapies such as cancer growth blockers interact with medicines prescribed for other conditions. For example, tyrosine kinase inhibitors, which disrupt enzyme signalling in cells, can be associated with serious drug-drug interactions and a drugs review is recommended for each patient.10

“Enhanced support, earlier collaboration with patients and the involvement of GPs needs to be introduced to drive a more holistic approach, rather than surgeons, oncologists, palliative care and GPs existing in silos,” adds Mr Williamson, who is also a Royal Pharmaceutical Society spokesman.

“GPs can be more involved and could be doing some of the repeat prescriptions and some of the monitoring. We are seeing that these long-term cancer patients can become very stable and eligible for three-month prescriptions, so the burden on the hospital service falls away because they don’t come in every month. At that point, it is not about managing the cancer, it is about the patient living their lives with cancer.

“Here it becomes important for the GP to have an understanding of the patient and to be able to reassure them that aches and pains, which can be scary, are a part of normal life rather than a reason to come into hospital. I have a lung cancer patient who has, unusually, been on treatment for five years and if she gets a new pain in the rib or a cough it doesn’t have to mean the disease is there and spreading – it is just part of life.

“Good communication between the hospital and the GP is essential and, if a GP has an understanding of the side-effects of the medicines, they can be more involved in ongoing care rather than saying ‘that’s a specialist cancer med, go and see your hospital doctor’.

“The key is making sure the GP is well informed and they know the stages, have access to information about the drugs and know what it means for the patient so they can build a good and effective relationship. But I believe prescribing will stay in hospitals with the monoclonal antibody therapies as there are some unusual immune reactions and we are still learning how to handle the toxicity with patients.”

Dr Catherine Millington-Sanders, the RCGP’s palliative and end of care lead, believes a road map to navigate the barriers that exist across the NHS is essential. The feedback from staff and patients can influence a streamlined service that runs without glitches and delays, she says.

“Primary care is the main port of call for patients. It therefore makes sense that we play a fundamental role in looking after patients living with and beyond cancer treatment,” she adds. “I think general practice and hospice services are a good example of where primary and specialist services are already well practised at co-producing care in the community. It is common practice for specialist palliative care nurses to be well known to practitioners and also to plan joint care. Well coordinated care in this fashion is known to be associated with improved patient and family satisfaction.

“I think the key here is for prescribing guidelines to be clear and for the professionals prescribing to be trained and familiar with the cancer treatments and any potential side-effects in order to do so safely.”

The case for service improvement
Macmillan Cancer Support, which has 200 GPs working at CCG level, has introduced a number of diagnostic tools to go alongside its campaign to smooth the edges of cancer treatment delivery.

“Unless primary and secondary care work together for the best benefits of patients we are never going to crack it because people will always fall down in the transition phases between us, where patients say they come back from hospital and feel abandoned,” says Dr Rosie Loftus, the charity’s joint chief medical officer. “What happens at the primary and secondary care interface is what we need to get right.”

She says the average GP will see a maximum of one new cancer diagnosis a month and, typically, have 30 to 40 cancer patients on their list. The big change has been those patients surviving longer and living with the side-effects and later effects of treatment.

“Cancer has been seen historically as very much a secondary care disease,” adds Dr Loftus. “We refer our patients, they get treated and we don’t necessarily know or keep in touch with what is going on. Patients may not realise their GP has anything to offer because they think they need to be going to hospital.”

Macmillan has been running educational courses for GPs to help them synchronise practice with modern day cancer demands and to cope with growing responsibilities.

The Lancet Oncology Commission was not an academic system stress test but an exercise in improving patient experience and saving lives, notes Professor Rubin. He concedes that claims that 5,000 lives could be saved by earlier diagnosis are “finger in the air” estimates, but adds that the case for service improvement is compelling. “There is no question that what we do as GPs is much more complex than it used to be and we have to think about how we do our jobs in different ways,” he says.

“I appreciate the pressures on time, but we, as GPs, have to stop thinking we
have to do everything. There are others who can do some of the more routine parts of our job while we should be concentrating on what we are trained for and are best at – and that is caring for the complex needs of our patients.

“The message is not one of saying ‘we get GPs to do loads more things so specialists don’t have to do them’, but that there are aspects of cancer care that primary care is at least as good at, and in many cases better at, than secondary care. Some things like symptomatic diagnosis can only begin in primary care, so there are opportunities for us. But it requires investment in primary care services to make this happen as well as good collaborations to generate an integrated care model.”

References
1. National Cancer Intelligence Network (www.ncin.org.uk) and Cancer Research UK (www.cancerresearchuk.org) figures.

Declaration of interests
See http://www.mjauk.org/author/bucklandd/

Danny Buckland is a freelance health journalist

POEMs

Behavioural interventions reduce inappropriate antibiotic prescribing for acute respiratory tract infections

Clinical question:
Do behavioural interventions reduce rates of inappropriate antibiotic prescribing for acute respiratory tract infections in primary care?

Bottom line:
Requiring clinicians to justify antibiotic prescribing in the permanent electronic health record and to undergo periodic peer comparisons of prescribing rates are both effective interventions for reducing inappropriate antibiotic prescribing for acute respiratory tract infections.

Helpful reminders and suggested treatment alternatives do not reduce inappropriate prescribing rates. Information alone rarely changes behaviour, but the desire to conform with our peers can be very persuasive. (LOE = 1b-)

Reference:

Study design: Randomised controlled trial (nonblinded).
Setting: Outpatient (primary care).

Synopsis:
These investigators invited 49 practices in Massachusetts and California (n = 243 clinicians) to receive various combinations of behavioural interventions aimed at reducing inappropriate antibiotic prescribing. The first intervention used automated alternative treatment suggestions when providers attempted to prescribe antibiotics for antibiotic-inappropriate diagnoses. A second intervention required providers to text an “antibiotic justification note” that became a permanent part of the medical record. The third intervention distributed periodic emails to participating providers labelling them as either a “top performer” or “not a top performer” by comparing their antibiotic prescribing behaviour with their peers. Practices were randomised to receive 0, 1, 2, or all 3 interventions for 18 months and no cases were lost to follow-up.

Not surprisingly, the control group significantly decreased inappropriate antibiotic prescribing rates (11 per cent absolute reduction) during the study period. Both the accountable justification and peer comparison interventions significantly decreased antibiotic prescribing rates compared with the control group (-7.0 and -5.2 per cent, respectively). However, the suggested alternative intervention did not significantly reduce antibiotic prescribing rates compared with control.