# Primary Care Needs Assessment tool: indicator review

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> ⓘ You are now reviewing the PCNA indicator(s) for: **Prevalence of cancer**

> ⓘ **Caution**: The information on this page is provided for testing purposes and may be subject to amendment. It may contain errors or not be fully reflective of consensus public health advice or relevant services, therefore should only be used with care.

**STEP A** # Strategic context

ⓘ Consider the national strategic context for prioritising improvement action in this area (in conjunction with your health board's IMTP and Regional Partnership Board's Area Plan):

- In Wales neoplasms are the leading cause (19%) of DALYs across all ages and the major cause (together with cardiovascular disease) of premature mortality in people aged 40+ (*Health and its determinants in Wales*; PHW 2018; [link](#)).

- The Welsh Cancer Intelligence and Surveillance Unit (WCISU; [link](#)) note that the most common (prevalent) cancer in 2016 was breast cancer; colorectal (bowel) cancers were the fourth most common.

- Prevalence estimates for those registered with GPs in Wales who are living with and surviving cancer will help plan longer-term care for cancer patients and their carers.

- The *Palliative and end of life care delivery plan* covers all aspects of palliative and end of life care; indicators for end of life care/ dying well are reported within Primary Care Measures.

▼ ⓘ Tell me about: DALYs

What are DALYs?

- Disability-adjusted life years (DALYs) are a combined measure of early deaths (i.e. premature mortality) and disability-weighted impact on quality of live from living with poor health.

- Because DALYs capture both what kills us and what makes us ill, they describe the overall 'burden of disease' (reported by risk or condition) more effectively than mortality or disability prevalence does alone.

▼ ⓘ Tell me about: prevalence

- Prevalence refers to a count of **new and pre-existing cases** (e.g. people living with and after a cancer diagnosis), within a defined population (e.g. patients registered with Welsh GPs) at a given time.

- Prevalence counts are usually expressed as a proportion, where the denominator is the population who are at risk or "eligible" to acquire the disease; this is used to gauge how common or rare a condition is within the population.

- A prevalence proportion may be measured at a single point in time (i.e. point prevalence) or over a period of time (i.e. period prevalence).

- Period prevalence may be calculated annually (e.g. at the mid-point or end of one year), over the course of a lifetime, or to report survival after X years following cancer diagnosis.

- To account for random variation, prevalence estimates are often given with a surrounding confidence interval; this describes the likely upper limit and lower limit of variation around the single (best-guess) estimate of proportion.

**STEP B** # Improvement actions for GP practice cluster members

ⓘ Consider which of the following actions could be taken forward:

▼ **Identify and record preferred place of death for those on palliative care registers**

- Direct enquiry and identification of preferences for end-of-life care is associated with patients achieving their preference for place of death; patients whose preferred place of death was unknown were more likely to be admitted to hospital for end-of-life care (BMJ Supportive & Palliative Care [2019;9:84-91](#)).

- MacMillan Cancer Support produce a *Top tips guide to supportive and palliative care meetings* [[link](#)]. The tips are relevant to maintaining a palliative care register and recording preferred place of death and cover: 1. Regularly remind your team why they have supportive and palliative care meetings; 2. Prepare for the meetings; 3. Identify patients for the supportive and palliative care register; 4. Prioritise patients according to need; 5. Run an effective meeting; 6. Significant event analysis; 7. Continuity and coordination of care; 8. Communicate; 9. Maintain your register; 10. Reinforce positivity whenever possible.

▼ **Ensure awareness and implementation of NICE guidance/ quality standards**

- *Improving supportive and palliative care for adults with cancer*. Cancer service guideline [[CSG4](#)] (Published date: March 2004) includes recommendations suitable for adoption by healthcare

professionals. This guideline covers best practice in developing and delivering cancer services for adults. It aims to ensure that that people with cancer, and their families and carers, are well informed, cared for and supported from before formal diagnosis onward.

- *End of life care for adults*. Quality standard [QS13] (Published date: November 2011; Last updated: March 2017) sets out 16 quality statements, any of which could form a focus for collective local improvement action. This quality standard covers care for adults (aged 18 and over) who are approaching the end of their life. This includes people who are likely to die within 12 months, people with advanced, progressive, incurable conditions and people with life-threatening acute conditions. It also covers support for their families and carers. It includes care provided by health and social care staff in all settings. It describes high-quality care in priority areas for improvement.

- *Care of dying adults in the last days of life*. Quality standard [QS144] Published date: March 2017) sets out four quality statements, any of which could form a focus for collective local improvement action. This quality standard covers the clinical care of adults (aged 18 and over) who are dying, during the last 2 to 3 days of life. It describes high-quality care in priority areas for improvement.

# STEP C Improvement actions for wider cluster members

ⓘ Consider which of the following actions could be taken forward:

▼ **Development of improvement actions required**

- No actions suitable for the wider cluster membership are identified in this release.

# STEP D What is happening in Wales?

ⓘ Consider whether shared learning/ local experience might guide your own implementation of the evidence:

▼ **Placeholder project description**

- *What problem was being addressed?* Placeholder.

- *What was done to address it?* Placeholder.

- *How does this evidence good practice?* Placeholder.

- *What key learning can be shared?* Placeholder.

- *Who did it or who can be contacted in the event of queries?* Placeholder.

ⓘ Have something to share? Please let us know [here](#).

# STEP E What do you know about community views on this?

ⓘ Consider any relevant citizen/ community voice information (e.g. from surveys, complaints, engagement events, or your health board's well-being or population needs assessments). Summarise this into the following box:

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# STEP F What assets or partnership opportunities can you identify?

ⓘ Consider any relevant local assets or potential partner organisations that might facilitate co-production. Summarise this into the following box:

Type here

# STEP G Do you need more data before making a decision?

ⓘ If relevant, consider any additional data (or information) requirements that might ensure a more informed decision on determining action. Summarise this into the following box:

*Type here*

**STEP H** **What is your provisional decision?**

ⓘ Having reviewed indicator data on local needs and considered evidence-informed quality improvement options, please record initial thoughts on proposed actions. You may also wish to record related thoughts around potential service models, capacity requirements, workforce development or financial considerations. Ideally, discuss these with both the wider cluster and with your local public health team ([LPHT](#)). Summarise your proposals for action into the following box:

*Type here*

ⓘ Now ⟨ PRINT ⟩ this page (e.g. to PDF) so you have a record of your entries (Steps E-H). You may then close the Print view browser window and return to the PCNA workbook to review another indicator.