Utilising MSRG data/evaluations for workforce development and integrated personalised care.

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How does this fit?

Why as a cancer alliance, are we working so closely with the MSRG?

The need to drive service delivery which is embedded in an evidence base.

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Improving access to CNS' and key workers.

- Patient engagement
- Workforce modelling and clarity
- CSU - business case

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Clinical Nurse Specialist

- Specialist site-specific knowledge
- Complex psycho-social care of patient
- Treatment- including multimodality, genomics, immunotherapy, personalised medicine
- Investigations/ tests / specific specialist knowledge relating to the pathway from diagnosis to discharge
- Assessment of complex specialist need
- Complex pathway management across boundaries and organisations
- Supporting complex treatment decisions
- Symptom and toxicity management
- Identification and management consequences of treatment
- Research, Education, Service development, Audit
- Clinical leadership

Shared (Clinical Nurse Specialist and Cancer Support Worker)

- Assessment and screening
- Collaborative care planning
- Promoting supported self-management
- Multi-agency | Multi-professional liaison
- Provision of information resources (online/printed)
- Referral to rehab services (e.g. Wesfit)

Cancer Support Worker

- Interventions to support behaviour change including: Health coaching, Goal setting, MECC*
- Identification and building links with local support services and agencies. Care navigation, signposting and referral to agencies
- Health and wellbeing advice:
  - Healthy eating
  - Exercise/physical activity
  - Stress management
  - Emotional wellbeing
  - (including: signposting to "stop smoking" / alcohol support services gyms / complementary therapists / befriending services / support groups)
- Practical support re: finance / benefits / travel insurance, transport, housing
- Carer support
- My Medical Record

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Cancer Nursing Across Boundaries.

Education strategy / workforce planning

Relationships / links with continuity of care

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Right by you – building on integration.

- Single point of access / care planning –in collaboration with multiple numbers of and professional teams.
- Not just about the individual and their cancer diagnosis.
- Support closer to home.
- Recognising the generalist / specialist nature of supportive care.
- Informing Cancer Care Reviews.
- Evidence base for the work.
- Strong PPI
- Accessing hard to reach communities.

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Patient activation.

- CREW study / HORIZONS data
- Expert advisory group
- Rapid review of interventions to support self management and gain insight into interventions from diagnosis.
- Literature review.
- Implementation
- Constituents of assessment

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Moving forward…

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- People have multiple and complex chronic conditions requiring a ‘whole’ person’ approach to care
- They need to be informed and engage in their own health and co-productive models of care
- Often faced with high levels of uncertainty and unpredictability about prognosis and outcomes
- Individuals will increasingly live with their cancer for longer periods of time, receiving multiple different cycles of treatment designed to ‘hold’ their cancer

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WORKFORCE - planning

- What is needed?
- What do teams look like?
- Universal, targeted and specialised care.
- What are the skills and capabilities required in cancer teams and where?
- What is the reality for patients – especially in relation to the non-medical workforce?
- Primary, Secondary and community care?
- Advanced and/or advancing practice.
- What evidence do we have to support our strategy?

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Thoughts?