NHS
Wessex
Cancer Alliance

Cancer Care Coordinators

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&

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AIMS

Part 1 - Introduction to the Cancer Care Coordinator Role

Part 2 – Introduction to Supervision and Training Package

Part 3 – Introduction to the Primary Care Drivers and Responsibilities for Cancer

The Care Coordinator Role

- Care Coordinators provide extra time, capacity and expertise to support patients in preparing for clinical conversations or in following up discussions with primary care professionals.
- They work closely with GPs and other primary care colleagues within a PCN to identify and manage a caseload of identified patients, making sure that appropriate support is made available to them and their carers (if appropriate), and ensuring that their changing needs are addressed.
- They focus on the delivery of personalised care to reflect local PCN priorities, health inequalities or at-risk groups of patients.

Cancer Care Coordinators

- Cancer Care Coordinators can be utilised across the cancer pathway from prevention to End of Life. Their role can help drive up screening numbers, tackle inequalities and support patients.
- Consistent employment of cancer care coordinators across all PCNs will also enable co-ordination across sectors as growing knowledge of this role will enable easy access to the primary care MDT.
- A cancer care coordinator can support the following:

Cancer Care Coordinators

- **Prevention:**
- Identify at risk populations through QoF Register: including obesity and smoking.
- Lead on advertising preventative advice within surgeries, social media and websites
- Signpost to services
- Coding
- **Screening:**
- Identify low screening rates, non-responders, low participation groups
- Make contact to provide information and support to encourage uptake

Cancer Care Coordinators

- **Safety Netting:**
- Arranging follow-up GP appointments, providing information and leaflets to patients.
- Follow up patient groups that may not attend appointments.
- Monitor completion of FiT
- Audit PCN Safety Netting process
- **Early Diagnosis**
- Promote use of digital tools to aid decision making and safety netting
- Monitor 2-week wait referral and escalate breaches.
- Care Navigation

Cancer Care Coordinators

- **Personalised Care**
- Coordinate care for anyone diagnosed with cancer in the practice signposting to internal and external services at any point in the pathway
- Prepare patients for cancer care reviews
- Help with maintaining palliative care register and coordinate gold standard framework meetings

Current Support & Guidance

- ARRS Toolkit
- Cancer Care Coordinator Button Cancer Care Coordinator - Welcome to Wessex Cancer Alliance
- Webinar Cancer Care Coordinators in Primary Care - Welcome to Wessex Cancer Alliance
- Community of Practice
- DES Support Pack

Contact Details

- For further 1:1 support or further discussion contact:

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Support and Training Offer for Cancer Care Coordinators

Supervision & training offer to start from April 2023

- Duration: 6 Months
- Training and training needs analysis open to all Cancer Care Coordinators currently in post.
- Supervision offer open to newly employed Cancer Care Coordinators (including those employed within the last 4 months)

Primary care supervisor

- PCN Manager, Team Leader, Practice Manager, Clinical employee for example GP, Nurse or AHP.

Commitment

- 3 virtual joint sessions of 30-60mins duration at Month 1,3 & 6.

Aim

- ensure we are working to the PCNs expectations of the role
- update and handover at the end of the supervision process.

Supervision Plan

Month 1

1 with CCC

- Introduction to toolkit ,E-lfh ACCEND Program, Competency Framework

1 with CCC and PCN supervisor

- Understand the PCN priorities and intended role of the CCC

1 training needs analysis with CCC

- Develop training plan

1 Virtual Group supervision

Month 2, 4 , 5

- 1 individual CCC
- 1 group CCC

Month 3

- 1 individual CCC
- 1 group CCC
- 1 with CCC and PCN Supervisor Review

Month 6

- 1 Individual CCC
- 1 Support workforce conference
- 1 CCC, PCN supervisor Handover and Evaluation Interview.

Training

Self Directed

- E-lfh ACCEND Program
- Macmillan Explore
- Macmillan Communication Skills
- Personalised Care Institute

Group

- Month 1 – Introduction to DES, QOF, Integrated care
- Month 2 – Prevention, Screening, Early Diagnosis
- Month 3 – Tacking Health Inequalities
- Month 4 – eHNA & Cancer Care Reviews. Support for Cancer patients
- Month 5 – Prehabilitation and rehabilitation of Cancer patients

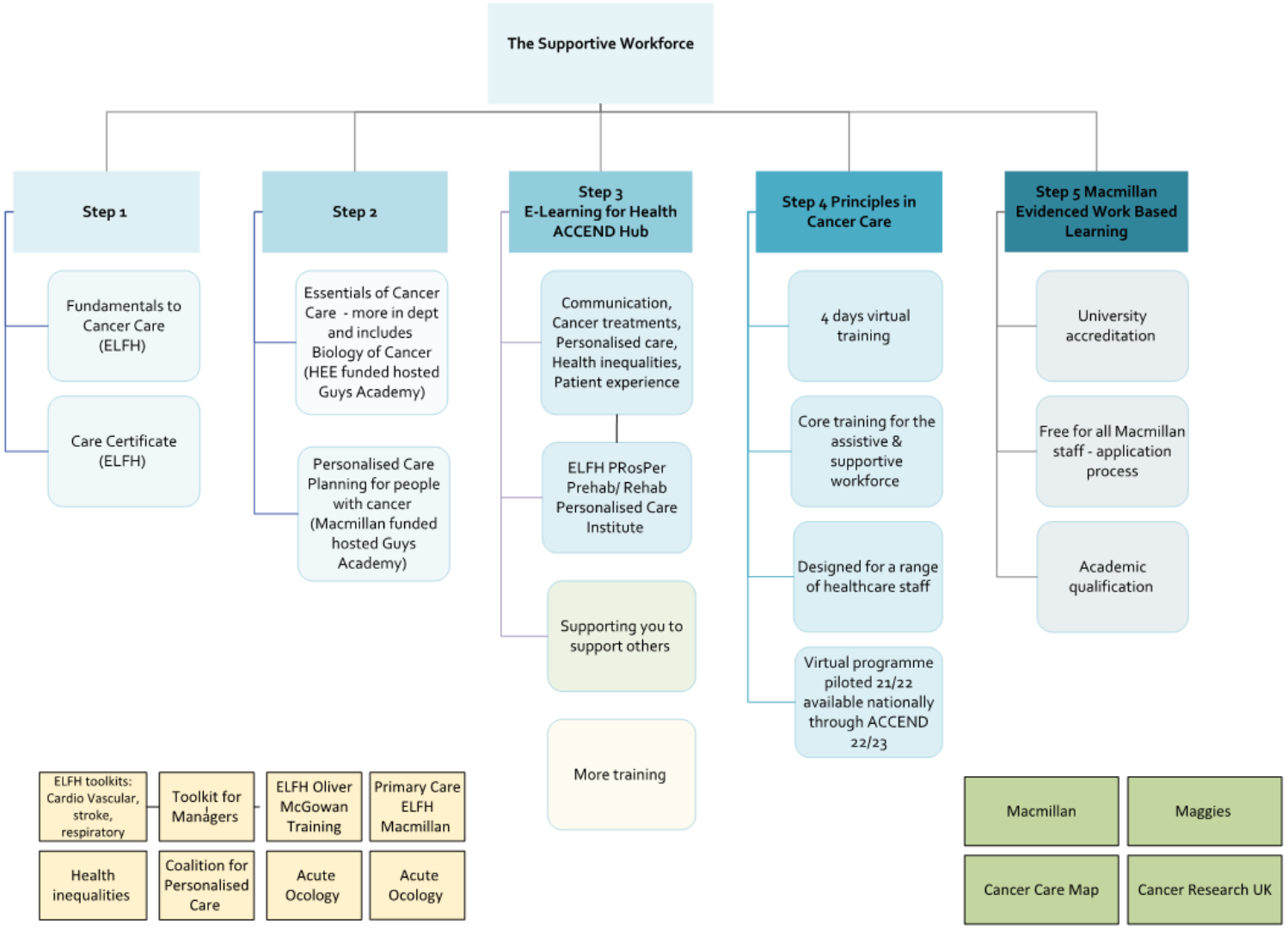
Month 6 Support & Assistive Workforce Conference

Open to: Cancer Care Coordinators, Care Navigators, Cancer Support Workers, Social prescribers, Therapy and Health Care Assistants

- Networking
- Integration
- Resilience
- Psychological support level 1 training
- Learning from others

Aspirant Cancer Career and Education Development Programme (ACCEND)

- Support workforce, Assistive Workfroce, AHPs and Nurse to Consultant Level Practice
- Capability Framework
- Career and Education Development Programme
- Learning Opportunities



Cancer Matters Wessex

Table 2. Supervision/Training Responsibilities	
Wessex Cancer Alliance Supervisor	Primary Care Network
• **Supporting Postholder** • **Collaboration with PCN to develop the role in line with PCN and population need** • **Training Needs Analysis** • **Signing off competencies** • **Providing Training/Links to training**	• Mandatory Training • Local Induction • Systems/IT training • Clinical day-to-day supervision • Follow on supervision after 6 months. • 1 year appraisal

Expectations: Cancer Care Coordinator

- To attend supervisions (individual and group)
- work towards the competencies
- Complete the training (Virtual/on-line/F2F)
- Join the community of Practice
- Attend 1 x F2F Conference/Training Day in September)
- Complete evaluation survey at the end

PCN Expectations

- Provide the training and supervision set in Table 2
- Release the Cancer care coordinator to complete training and education 1-2 hours per week
- Release CCC for supervisions and Virtual F2F training up to 5 days during the 6 month period.
- Attend 3 x joint sessions to set/review role and specifications
- Attend final interview to handover and evaluate role and

WCA Expectations

- Provide x 6 individual supervision sessions
- Provide x 6 group supervision sessions
- Provide x 2 Training Needs Analysis sessions
- Complete the Competency framework with postholder
- Ensure training available to support role
- Ensure role is aligned to GP Contract DES requirements/Primary Care responsibilities
- Flex and adapt to changing priorities and need of the PCN and population

Ongoing Support

- Training to continue with for the next 6 month explored at exit interview with CCC and PCN supervisor
- Community of Practice
- Continued development of the ARRS Cancer toolkit
- Annual cancer support workforce conference
- Further career development opportunities through the ACCEND program

Primary Care Cancer Priorities

- PCN DES
- IIF
- QOF
- Ardens & Ardens Manager
- Long Term Plan

PCN DES – Early Cancer Diagnosis

- Review referral Practice for suspected & recurrent cancers.
- Improve uptake in NHS Cervical & Bowel Screening programmes
- FIT Testing for Colorectal Cancer referrals.
- Teledermatology – adopt and embed the use of for skin cancer referrals.

PCN DES – Early Cancer Diagnosis

- Prostate Cancer - develop and implement a plan to increase the proactive and opportunistic assessment of patients for a potential cancer diagnosis
- Non-Specific Symptoms Pathway review - identifying opportunities and taking appropriate actions to increase referral activity.
- PCN DES Alliance Workbook : PCN-DES-Early-Diagnosis-Support-Pack-2022-23.docx (live.com)

PCN DES: Role Requirement and Responsibilities

- Additional Role Reimbursement Scheme

- Available from:

NHS England » Network Contract Directed Enhanced Service – Contract Specification 2021/22 – PCN Requirements and Entitlements (p90)

IIF

- CAN – 01 Indicator :Percentage of lowerGI two week wait (fast track) cancer referrals accompanied by a faecal immunochemical test result, with the result recorded either in the twenty-one days leading up to the referral, or in the fourteen days after the referral.

QoF

- CAN001. The contractor establishes and maintains a register of all cancer patients defined as a ‘register of patients with a diagnosis of cancer excluding nonmelanotic skin cancers diagnosed on or after 1 April 2003’
- CAN004 - Cancer care review within 12 months of diagnosis
- CAN005 - Support information within 3 months of diagnosis : Cancer Care coordinators can complete these.

The NHS Long Term Plan for Cancer states that “where appropriate every person diagnosed with cancer will have access to personalised care, including needs assessment, a care plan and health and wellbeing information and support.”

Personalised Care and Support Planning (based on holistic needs assessments) ensures people's physical, practical, emotional and social needs are identified and addressed at the earliest opportunity.

- **End of Treatment Summaries** provide both the person and their GP with valuable information, including a detailed summary of treatment completed, potential side effects, signs and symptoms of recurrence and contact details to address any concerns.

- **Primary Care Cancer Care Review** is a discussion between the person and their GP / primary care nurse about their cancer journey. This helps the person to discuss any concerns, and, if appropriate, to be referred to services or signposted to information and support that is available in their community and from charities.

- **Health and Wellbeing Information and Support** includes the provision of accessible information about emotional support, coping with side effects, financial advice, getting back to work and making healthy lifestyle choices. This support will be available before, during and after cancer treatment