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Cancer Alliance

Cancer Care Coordinators in Primary Care

Cancer Care Coordinator

Wessex Cancer Alliance are promoting the role of Cancer Care Coordinators, if you would like to discuss support and employment for this role or join our Community of Practice please contact Tamzen Hogben at: Tamzen.Hogben@nhs.net or Mary Edwards: mary.edwards8@nhs.net

Wessex Cancer Alliance

Cancer Care Coordinators:

- Support the delivery of cancer priorities of the Network Contract DES
- Support achievement of Quality Outcome Framework (Qof) Indicators
- Provide personalised care planning throughout the cancer pathway, as stated in NHS Long Term Plan

Wessex Cancer Alliance will support you as a PCN by providing:

- Job Description
- Competency Framework
- Insight into the potential utilisation of this role.

Wessex Cancer Alliance will support your Cancer Care Coordinators by providing:

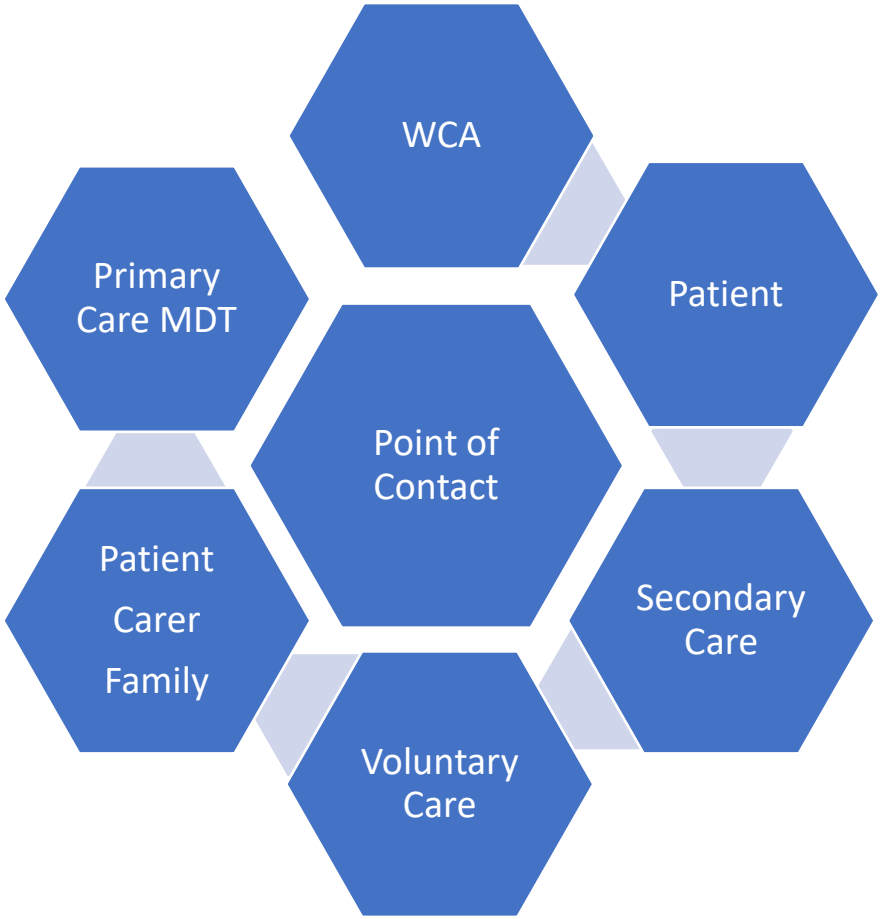
- Resource and Training Package
- Formal supervision and training
- Education and Training
- Tools to help patients
- Community of Practice

There are many points in the cancer patient pathway a Cancer Care Coordinator can be utilised:

Prevention	Screening	Safety Netting	Personalised Care

• Identify at risk populations Obesity, Smoking.
• Signpost to health and well-being services
• Coding
• Health promotion media within PCN
	• Identify:
	  • low screening rates,
	  • non-responders,
	  • low participation groups
	• Contact patients to provide information and support to encourage uptake of screening
		• Arranging follow-up appointments,
		• provide information and leaflets to patients.
		• Follow up patient groups that may not attend appointments.
		• Monitor completion of FiT with 2WW referrals
		• Monitor 2-week wait referral and clinic appointments and escalate breaches.
		• Champion decision support tools within the practices
			• Co-ordinate care for anyone diagnosed with cancer in the practice signposting to internal and external services at any point in the pathway
			• Support Holistic Needs Assessment prior to Cancer Care Review
			• Palliative care register and GSF Meetings

Why is this role so important to integrated care?



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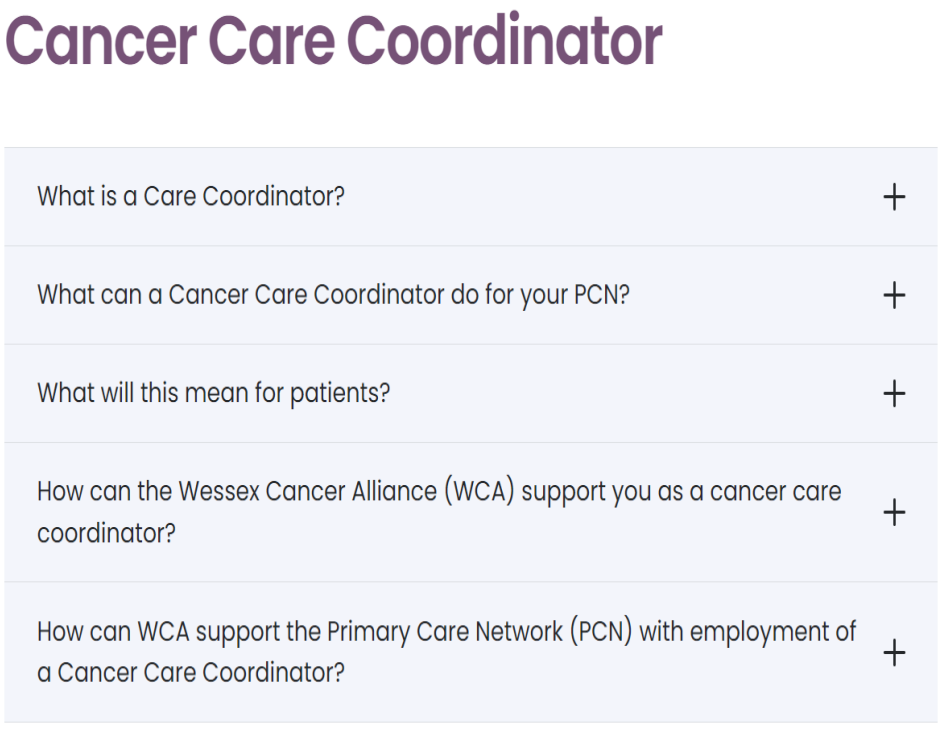
ARRS Toolkit Update: This is now live on the Wessex Cancer Alliance website: [Additional Roles Reimbursement Scheme - Welcome to Wessex Cancer Alliance]

This includes a ‘button’

for each role:

Once you click on the button it will take you to a page where there are 5 drop downs to enable quick access to information and support



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

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

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Pathway Navigator Pilot in Wessex

Jo Tibbles; Project Manager Workforce

Project Overview

Pathway Navigators

- Initial funding for 16 posts
- B4 role, 12 month fixed term, patient facing, non clinical*
- Sited between referral and diagnosis

Purpose of the role

- To improve patient experience
- To release capacity for clinical teams
- To improve performance in the pathway

Project Stages

- Job specs and job matching
- Recruitment and induction
- Learning and development
- Project measures
- Evaluation and business cases

New Funding

- Phase one 21/2: 14 posts
- Phase two 22/3: 7 posts
- Phase three 23/4: to include colorectal, gynae and sarcoma

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Project Progress

First steps

- Exploring/Engagement
- Sites agreed with trusts
- JDs created/job matching

Recruitment and retention

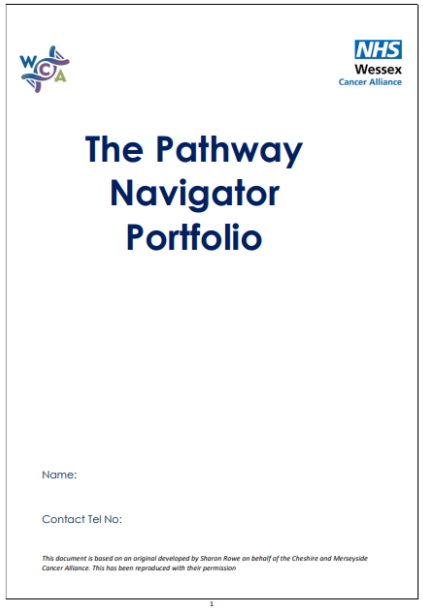
- Recruitment slow at first
- Some attrition
- 25 currently in post*
  - 4 existing, 21 new funding
- 4 planned and 4 in discussion

Breadth

- 6 Trusts
- 7 tumour sites
- 2 diagnostics

Training and Development

- Navigator Portfolio
- Training plan
- ACCEND



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Number of Pathway Navigators in post over time

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www.wessexcanceralliance.nhs.uk/pathway-navigators/

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Confirmed Locations of Pathway Navigators

www.wessexcanceralliance.nhs.uk/pathway-navigators/

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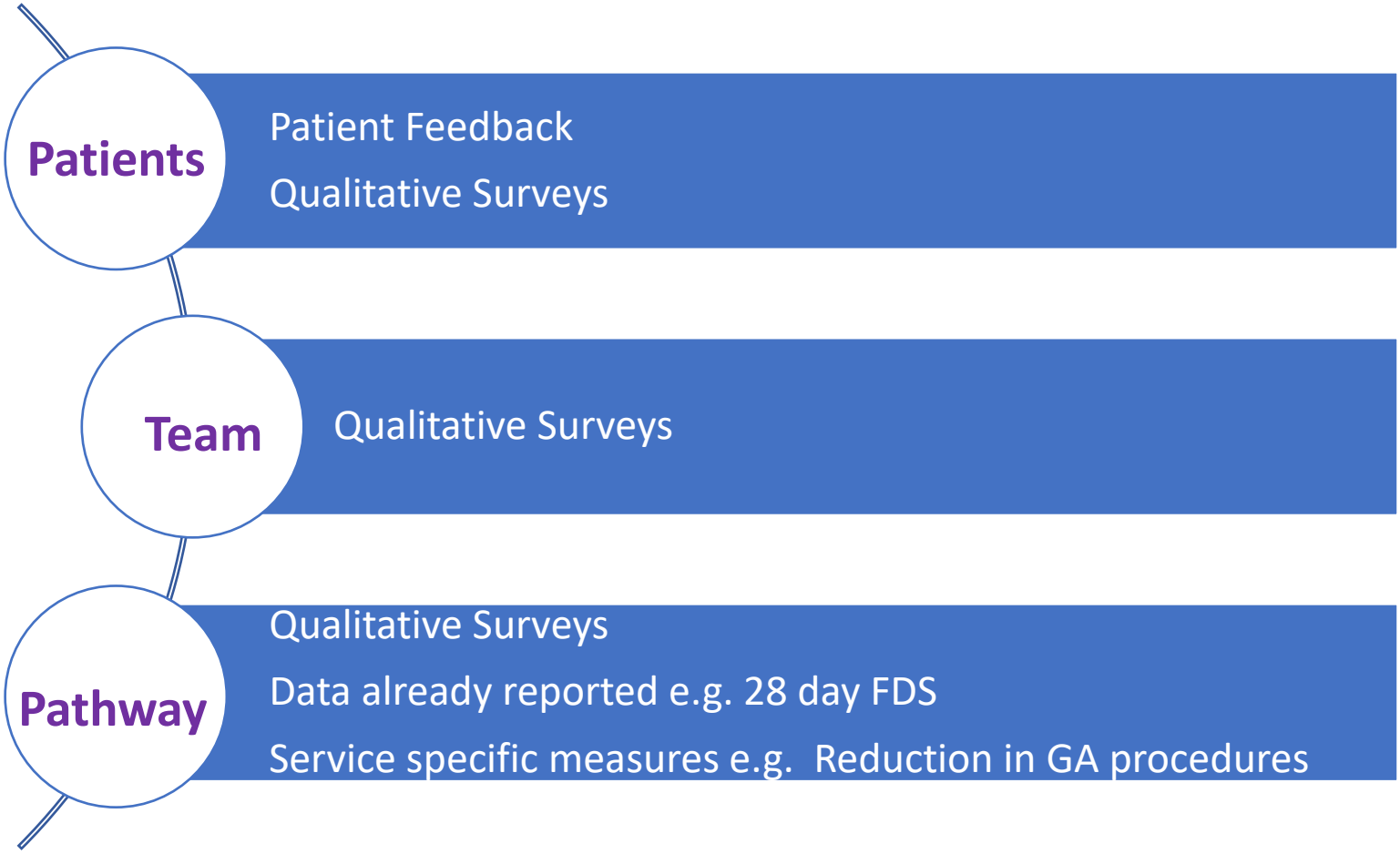
Measuring the Impact



Outcomes - patients

Navigators have become:

- ✓ Single point of contact
- ✓ Information providers
- ✓ Personalised care givers
- ✓ Supportive staff

Just wanted to tell you that I have had a few ladies that have sent their thanks to you since starting your new role. They have found your phone call really reassuring and helpful. They have named you in person.
Thanks and well done.

9. 1. Thinking about your Pathway Navigator did you feel supported and guided by them throughout your care? **Scale of 1 -10 with 1 being not supported and 10 being fully supported** (0 point)

4
Responses

9.25 Average Rating

"I supported a patient attending her CT app and then to a clinic app. She kindly gave me a thank you card and said she would not have had the CT scan if I had not been there with her" *Pathway Navigator*

"Patients are coming to clinic with better understanding of the investigations that can take place in the clinic" *team member*

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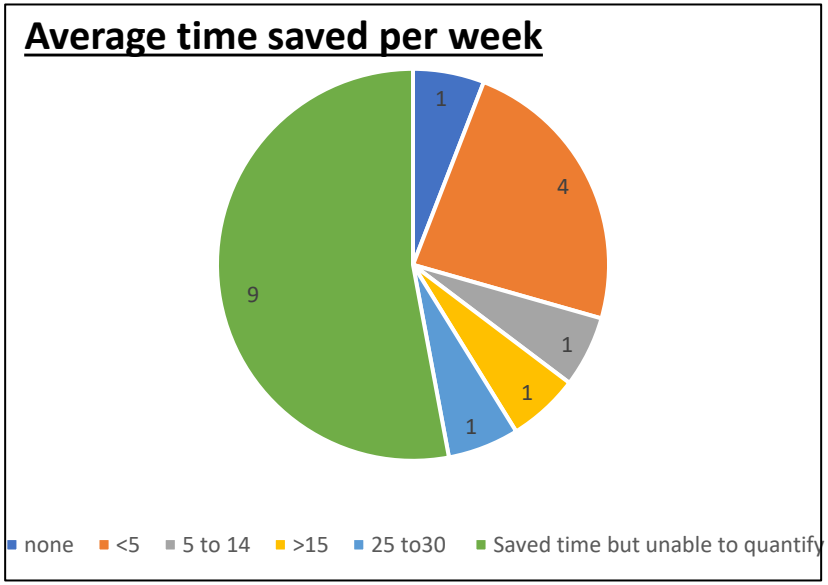
Outcomes - team

Some of the tasks picked up by navigators which have freed up time for other team members:

- Becoming point of contact for patients
- Completed safety checks/questionnaires
- Booking appointments
- Answering patient calls and responding or triaging
- Taken on e-referrals
- Tracking patients
- Helped chasing diagnostics
- Chasing investigations, results and correspondence
- Communicating with other teams
- Contacting patients
- Monitoring clinic spaces
- Taken on telephone clinics



"I have learnt fusion biopsies which will free up consultant time"

"Can focus on training and development of my team to try and improve retention"

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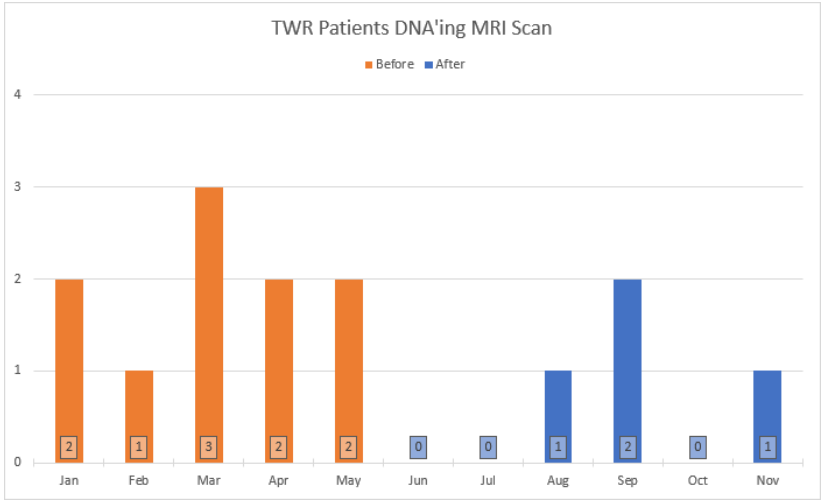
Outcomes – pathway

Faster Diagnosis Standard

- Time lag with data
- Referrals continue to rise across system
- Diagnostic capacity has not increased
- Quantitative impacts not clear at high level e.g. 2ww/28 day



Service Specific Measurements

- Looking in depth at each service to see if can demonstrate impact such as:
  - DNA rates
  - Reduction in breaches due to patient choice
  - Reduction in GA procedures
  - Looking at reductions at certain points in e.g. referral –first appointment

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Outcomes – pathway

Increasing Capacity

- ✓ PN identified that timeslot of CT colonoscopy could be reduced to pre pandemic level saving 15 minutes per appointment
- ✓ Support of PN in 2ww clinic has enabled extra 4 patients to be seen per week
- ✓ Temporarily suspended routine appointments to increase 2ww capacity

Improving Utilisation

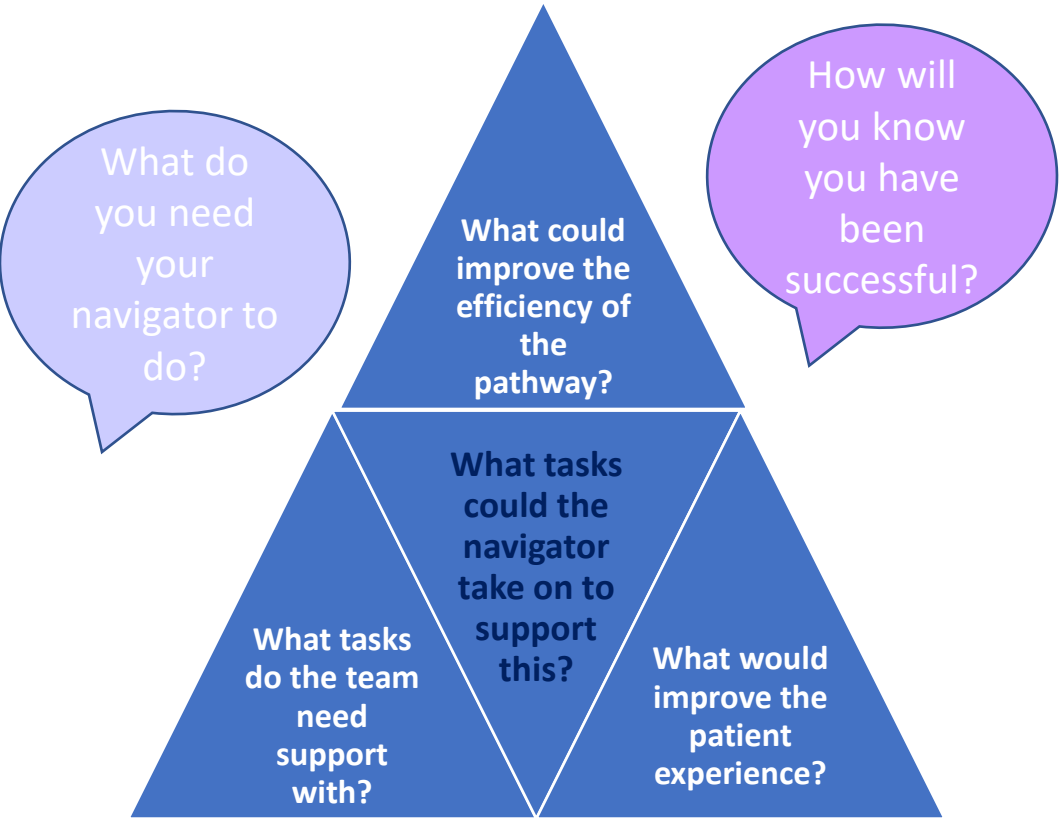
- ✓ 2ww MRI slot booked by PN means all are now being utilised
- ✓ Improved communication with patients to reduce DNA's
- ✓ supported in the downgrade process of 2ww referrals, minimising the amount of inappropriate referrals

Reducing length of pathway

✓Booking more CWTs within 7 days due to patient tracking and prioritisation
✓Improved turn around time for clinic letters
✓All scans now booked immediately after CNS triage
✓Introduced daily MRI review so patients are being discussed much sooner

Lessons Learnt

Clarity of Role “create a shared understanding”



Part of a Team “engage, involve and embed”

- Ensure all team members are **aware** of the new post and its purpose
- Allow staff the opportunity to **provide feedback**
- Consider the **practical** arrangements e.g. desk, phone line manager, dual sites
- Plan the **induction** so the PN can spend time with different team members

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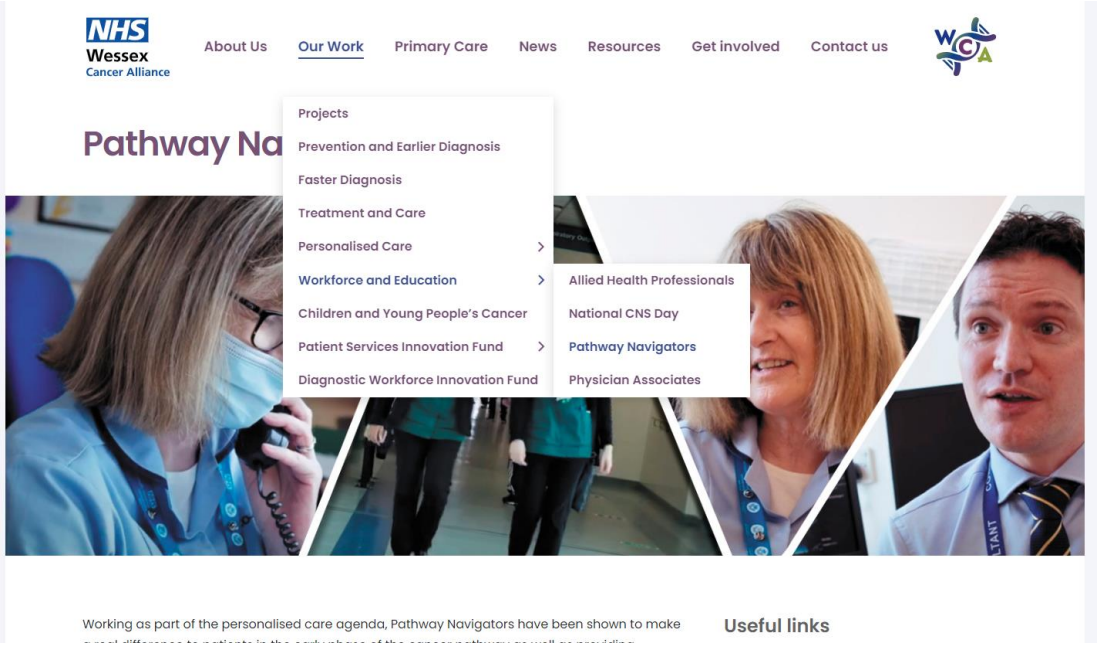
Next Steps

- ✓ Continued engagement with teams to embed posts
- ✓ Demonstrating value/business cases
- ✓ Pathway Navigator development programme

More Information

Contact: Josephine.tibbles@nhs.net

Website: www.wessexcanceralliance.nhs.uk/our-work/workforce-and-education/pathway-navigators



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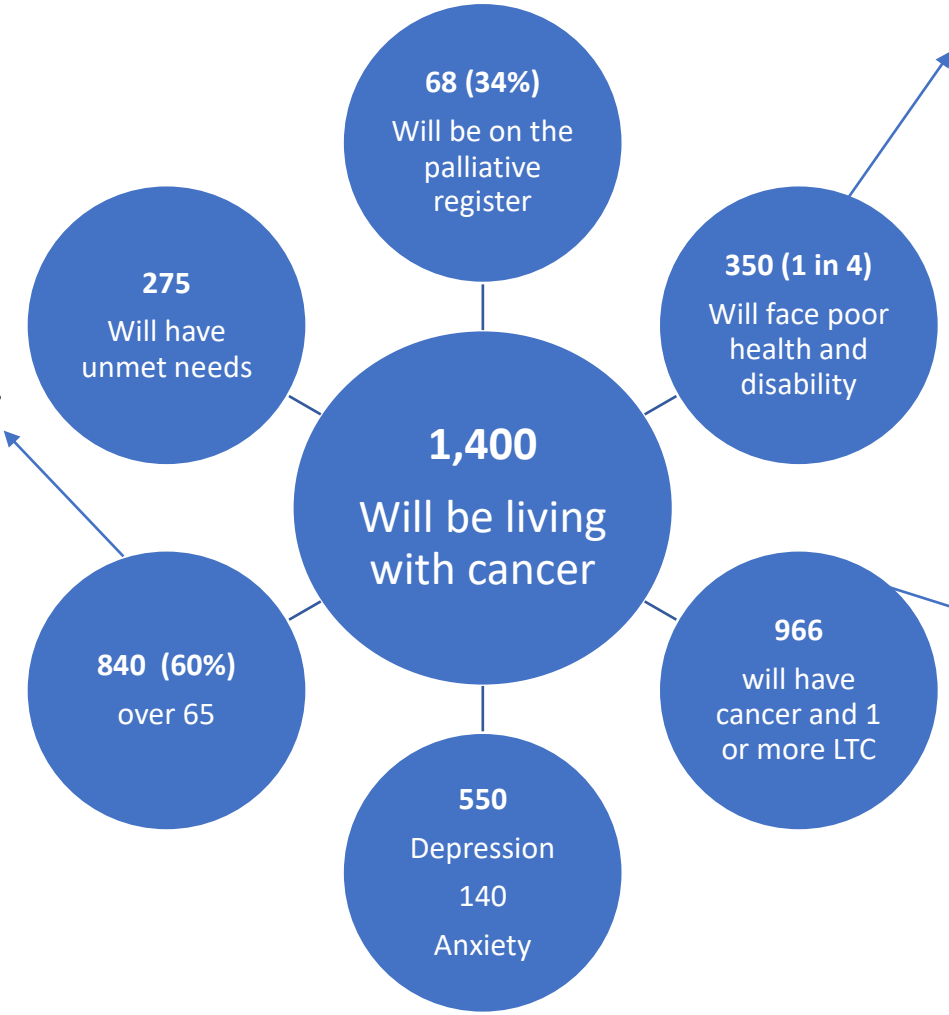
Primary Care Workforce

Evidence, projections, expectations & opportunities.

by

Mary Edwards

In a PCN of 40,000 Patients….



Poor health and disability…
245 chronic fatigue
245 sexual difficulties
168 mental health problems
140 living with moderate to severe pain
105 affected by urinary problems
63 experiencing gastrointestinal problems
46 experiencing lymphoedema

These problems may only emerge months after treatment and some can persist for at least 10 years (1)

1 or more LTC….
261 will have been prevented from working in their preferred occupation
242 will visit a GP or HCP more than 10 times a year
222 will find preforming ADLs very difficult

This is a great deal more than the general population or people with a diagnosis of cancer and no other LTC (2)

Over 50% of those aged over 80
will have moderate to severe functional disability affecting their QoL (3)

Frailty…
80-89 years: 30% at least are clinically frail
90 years and above: 60% at least are clinically frail (4)

What does this mean for referral, investigation, treatment and management for this group?

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Cancer projections & Primary care

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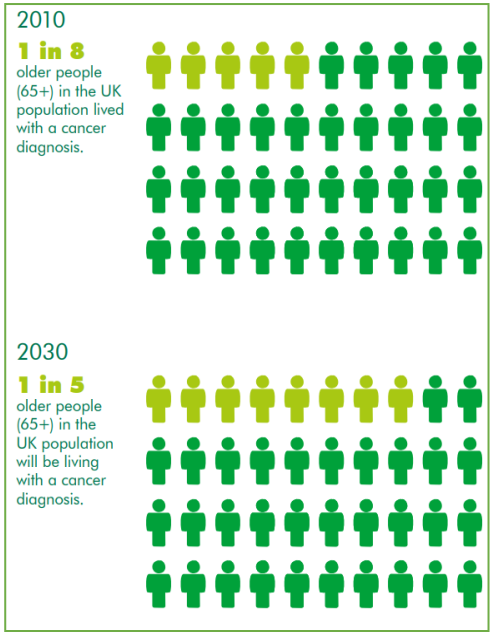
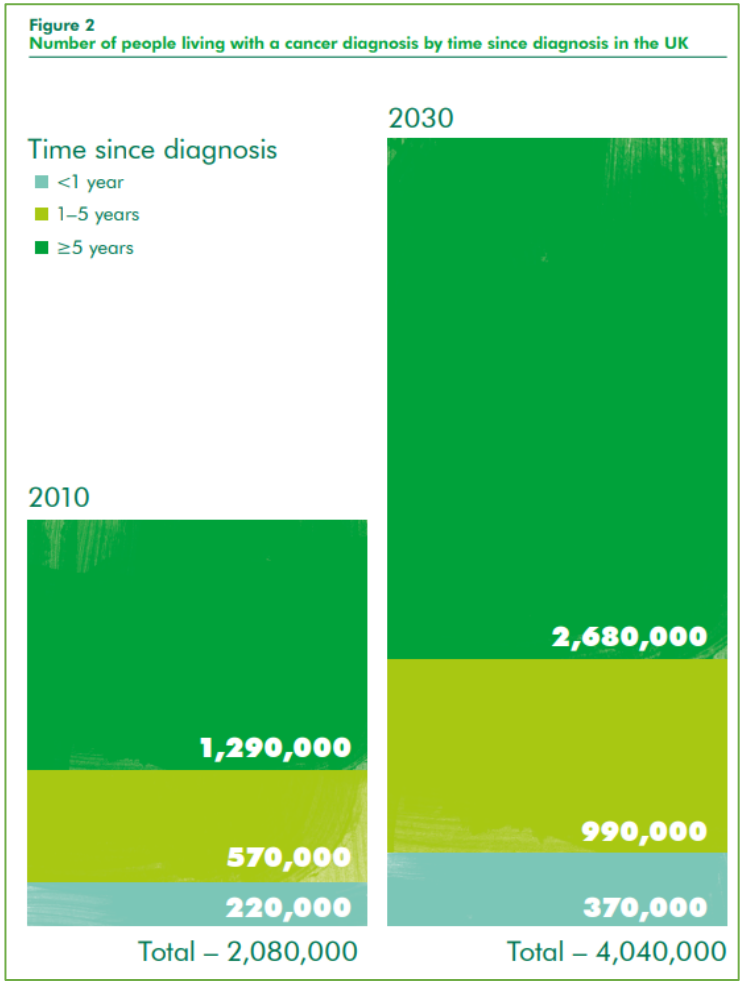
Older people will account for 73% of the total number of people with a cancer diagnosis

- **Complexity**
- **Frailty**
- **Multi-morbidity**





The largest growth will be in people living more than 5 years with cancer

- **Primary and Community care focus**

Cancer as a long term condition

- **Support**
- **Review +++**
- **Self-management**
- **Healthy behaviours**
- **Symptom management**
- **Late effects**

Palliative care responsibilities

- **Proactive**
- **Non-specialist**

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Primary Care Workforce Opportunities

UPSKILL

INNOVATE

RAISE PROFILE

Knowledge of cancer: signs, symptoms, consequences	All roles need a knowledge of risks, signs and symptoms of cancer, especially roles that are exposed to undiagnosed symptoms.	Advanced: Nurse/AHP FCP: AHP Enhanced: Practice Nurses
Cancer **part of** role and demographic	Those working with older people, frailty, enhanced health in care homes, palliative, mental health, home visiting service	Advanced: Nurse/AHP Enhanced: Nurse/AHP Support: Social Prescribers
Cancer **specific and specialist** role	Members of the team employed to manage cancer patients, complete cancer care reviews	Advanced – Nurse/AHP Enhanced AHP/Nurse Support- Cancer Care Coordinator

Enhanced & FCP Practice

Highly experienced, knowledgeable healthcare professionals.

‘Generalist with a specialist interest’

- Practice Nurse or AHP completing cancer care reviews
- Frailty Nurse or AHP
- Enhanced Health in Care Homes Nurse or AHP
- Palliative AHP or Nurse

‘Specialist in a generalist field’

WCA Proof of concept
Dual Roles/Secondments

- FCP Dietitian
- FCP OT
- FCP PT

ACP & FCP roles in Primary care

Pre-Diagnosis

- Signs and Symptoms
- Assessment
- Safety Netting
- Referrals

Managing suspected Cancer

- Discussion
- Care planning

Post Diagnosis

- Recurrence
- Managing symptoms
- Mental health
- Recognising late effects
- Acute oncological presentations
- Palliative and EOL

Cancer Advanced Clinical Practitioner

NHS Wessex Cancer Alliance

Clinical

- Has a range of advanced skills that can be utilised at any point of the cancer journey.- -
- The ability to manage complex and uncertain presentations that are cancer and non-cancer related.
- Will lead the further clinical management needed including referral to secondary care or to the GP within the PCN

Education

- Provides cancer education within the PCN
- Upskilling non-specialist roles from support to advanced level
- Education is delivered in relation to patient and population need, best practice and contractual obligations.

Leadership

- Acts as cancer lead
- Drives and promotes change within the PCN
- Promotes integrated care and develops relationships internally and externally across sectors

Research

- Up to date at a regional and national level
- Leads on cancer quality improvement within the PCN impacting on:

- early diagnosis
- personalised care
- Tackling health inequalities
- improving outcomes for cancer patients

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Conclusions

- There are a lot of opportunities to ‘make the most of’ established and emerging roles and teams in Primary care by raising their profile and assisting with upskilling this workforce.
- Cancer projections demonstrate the growing need for Primary care to develop a proactive MDT workforce skilled in managing cancer care especially alongside other conditions and in an older population.
- Rising complexity, multi-morbidity and risk of late effects support ‘ cancer specialist in a generalist field’ role which has been evident in other long-term conditions such as diabetes and respiratory diseases.

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Educating the Cancer Nursing Workforce

Helen Perry, WCA Project Lead

Background

- Patient Experience
- Holistic Care
- CNS Workforce

Personalised Education

Workbook	Practice based document
Structured study days with specialist teaching from the MDT	Allocated study days Virtual Classroom
University support & accreditation	Assignment – essay / academic poster / professional discussion / presentation (one for single module / 2 for double module)
250 study hours 500 study hours	- 10 ECT (credits at level 6 or 7) - 20 ECT (credits at level 6 or 7)

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CNS Core Qualities

- Communication
- Personalised care
- Psychological support
- Tumour site knowledge
- Leadership
- Research

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Academic Pathway

PART 1

Academic Award: PG Cert

- Personalised Care (10 ECTs)
- Psychological Support Module (10 ECTs)
- Research Module (10 ECTs)

PART 2

Academic Award: PG Dip

- Completed PG Cert (30 ECTs)
- Site Specific Module / Fundamentals of Cancer Care / Specialist Module (10 ECTs)
- Advanced Communication Skills (10 ECTs)
- Leadership Course / TAP Module (10 ECTs)

PART 3

Academic Award: Masters

- Completed PG Dip (60 ECTs)
- Dissertation (30ECTs)

Personalised Care Module

Patient choice	Shared decision making	Patient activation & supported self management
Social prescribing & community based support	Personalised care & support planning	Personal health budgets

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The Future