



Wessex
Cancer Alliance

Supportive Workforce Conference

27th February 2024

Hosted by Jo Tibbles and Mary Edwards
Wessex Cancer Alliance



Welcome



Please help yourself to refreshments and take a seat ready to start by 9.30



Agenda



- 9.00-9.30 – Arrive
- 9.30 – 9.40 Welcome and Aims for the day
- 9.40 – 10.30 - Introduction to supportive workforce roles in Wessex
- 10.30 – 11 30 – Pathway/Patient Perspectives
- 11.30 – 11.45 - Break
- 11.45 – 12.40 – Locality/Role Grouping
- 12.40-13.00 – ACCEND
- 13.00 -13.45- Lunch
- 13.45 -14.45 - Workshop 1
- 14.45 -14.55 – Break
- 14.55 –15.55 Workshop 2
- 15.55 – 16:00 Close session



Aims of the day



- To understand the breadth of roles in the supportive workforce,
- To network and identify ways to work together,
- To examine how different roles impact on the patient journey,
- To hear the patient voice and consider experiences of care,
- To share best practice,
- To identify different ways of working,
- To access a choice of CPD sessions



Role Ambassadors



**Cancer Support Worker/Cancer Care Coordinator
(secondary Care)**

Marion Rood – lead Cancer Support Worker and
CSW Team from University Hospitals Southampton

Samantha Cope - Macmillan Lymphoma Care
Coordinator, Queen Alexandra Hospital Portsmouth

(presentation on slides 20-32)



Role Ambassadors



Cancer Care Coordinator (Primary Care)

Mary Edwards – Project Manager WCA

(presentation on slide 33-39)



Role Ambassadors



Pathway Navigators (secondary Care)

Sanja Agic– Colorectal Pathway Navigator at University Hospitals Dorset

(presentation on slides 40-46)

Vicki Chestnutt – Gynae Pathway Navigator at Hampshire Hospitals



Role Ambassadors



MDT Coordinators (secondary Care)

Lucie O'Brien – Gynae MDT Coordinator at University Hospital Southampton

(presentation on slides 47 -50)



Pathway Mapping



What do our roles offer at different points in the pathway?

Patient Representatives:

- Geoffrey Smail
- Carla Whitbread



Pathway Mapping

1. Topic one

- Concerned about health/symptoms of cancer/reoccurrence of cancer
- Screening programmes
- Going for tests

2. Topic two

- Receiving a cancer diagnosis
- Starting and going through treatment
- Finishing treatment

3. Topic three

- Living well with cancer – including treatable non-curable
- Living with the consequences of cancer
- End of life

Post-It Notes

- Cancer Support Worker: **Green**
- Cancer Care Coordinator: **Pink**
- Pathway Navigator: **Blue**
- MDT Coordinator/other: **Orange**



11.30: morning break (15minutes)



Please go to your allocated table
number at 11.45



Locality/Role grouping



Facilitated table discussions

1. Write a short bio (5mins)
2. Share your bio with the group (10 mins)
3. Understand what different support roles do/how roles work together (30 minutes)
4. Discuss services to signpost to (10mins)



ACCEND



The Aspirant Cancer Career and Education Development programme (ACCEND)

Three elements:

1. Core Capabilities in Practice
2. Education Framework
3. Career Pathway

Key Facts:

- Cancer specific
- National approach
- From supportive to consultant level
- Increasing knowledge, skills and capability
- Providing access to the education and training required for each role
- Underpinned by four pillars of professional practice
- Career and development pathway for those aspiring to work in cancer care

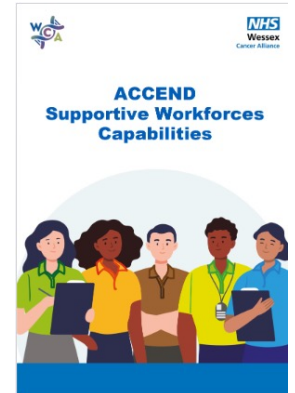


ACCEND for your role



- **Capabilities in Practice (CiPs) for the Supportive Workforce**

- Framework for all supportive roles
- Builds on the HEE Support worker competency document (no need to start again)
- Large document; Domains A-G, capabilities 1-24
- Personal development journey
- Helps build Knowledge, skills and competence for you and for your patients
- Available to download on our ACCEND webpage under the Supportive Workforce
 - [ACCEND Page](#)
 - [Capability Framework](#)





Training and Development



National ACCEND Learning Hub

- Log in with E-learning for health to access online resources to help you meet your capabilities
 - Foundations of cancer care
 - Essentials of cancer care
- Principles of Cancer Care Programme (PCCP) – limited places offered to us each year

Local Wessex and Wider Training Offer

- Development programme
 - Highlights access to a variety of courses that meet the ACCEND capabilities
 - WCA run a variety of courses each year (training needs always welcome)
 - Provide access to PCCP
 - Distribution list for supportive workforce (email Jo.tibbles@wca.uhs.nhs.uk to join)
 - List training and live events on our training [Education and Training - Welcome to Wessex Cancer Alliance](#)

Remember... training helps provide knowledge but not necessarily competence, also training is only one way of learning

Aspirant Cancer Career and Education Development (ACCEND) Toolkit





Practical Application/Next Steps



Getting started/Self assessment:

1. Download the [capability framework](#)
2. Identify where capabilities are not relevant to your role and mark them for later consideration
3. Find the capabilities where you know you feel strong and make some notes about any knowledge or skills you have in these areas
4. Identify the areas where you would like to develop your skills
5. Take what you have done to your next 1:1 or appraisal and ask your manager to sign you off in the areas you feel competent and to help you find ways to develop further

Top tips

- ✓ Take one section at a time (over 80 capabilities)
- ✓ Consider it as your ongoing development over 12+ months
- ✓ If you have already started working on the HEE or other competency document talk to us so we can help you transfer your work – you do not have to start again
- ✓ It is okay to ask for help 😊



Lunch



1pm – 1.45



Please return to the conference area
to find your workshop room



Workshops

13.45 -14.45: Workshop 1

14.45 -14.55: Break

14.55 –15.55: Workshop 2

- Workshops:

- 1) **Introduction to resilience** -
Dr Kate Jenkins Consultant
Clinical Psychologist
- 2) **Introduction to frailty and cancer** – Mary Edwards
WCA Project Manager
- 3) **Meeting people’s diverse needs** – Sue Newell and
Emma Leatherbarrow WCA
Inclusion and involvement
lead WCA & Equality and
Involvement Strategic Lead



Final Thoughts



- Summary of the Day
- Will be emailing out feedback forms
- CPD certificated will be issued
- Any questions

The role of Cancer Support Workers at PHU



Samantha Cowpe

Macmillan Lymphoma Support Worker

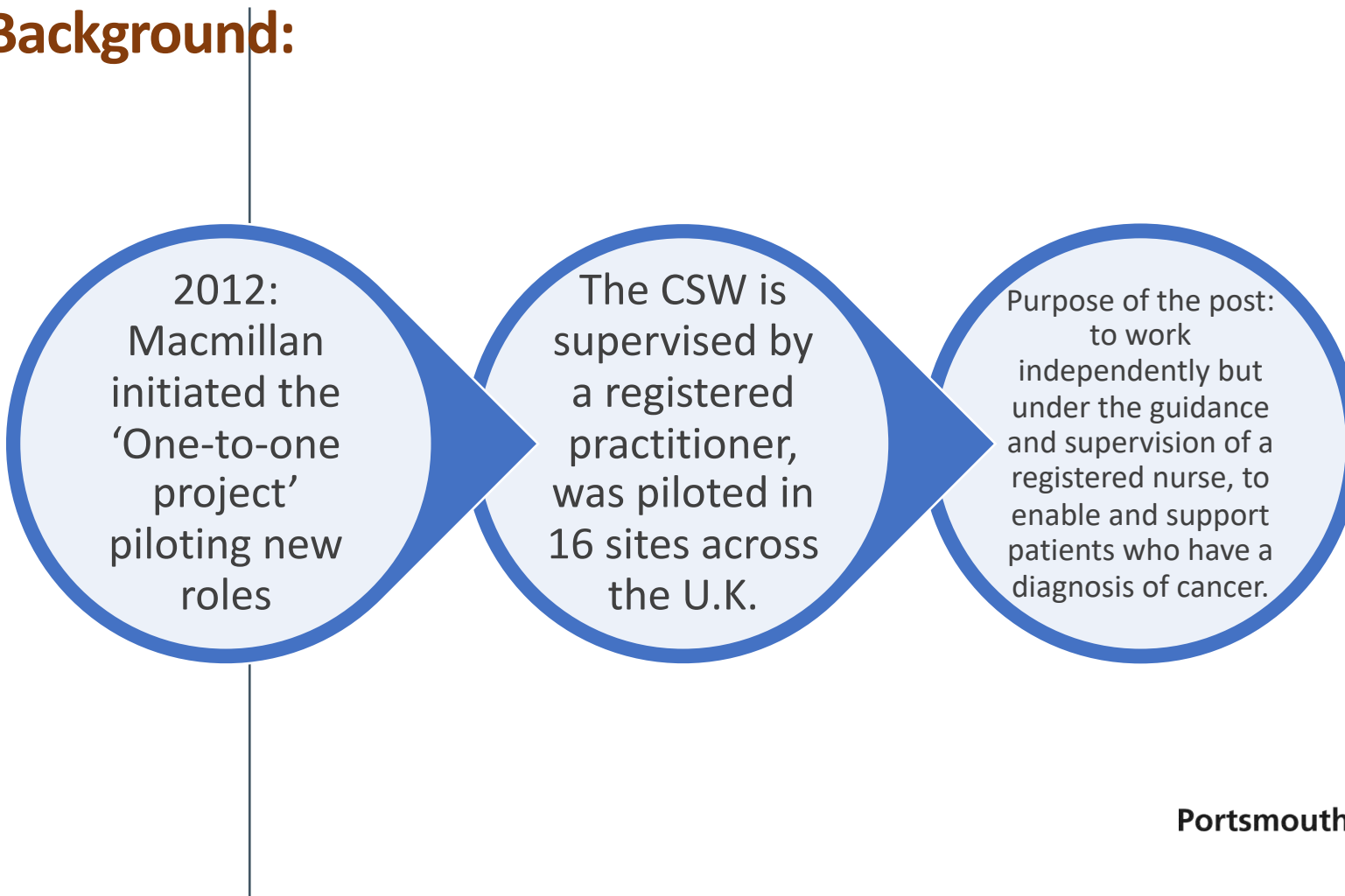
Portsmouth Hospitals University Hospital



Portsmouth Hospitals
University
NHS Trust



Background:



2012:
Macmillan
initiated the
'One-to-one
project'
piloting new
roles

The CSW is
supervised by
a registered
practitioner,
was piloted in
16 sites across
the U.K.

Purpose of the post:
to work
independently but
under the guidance
and supervision of a
registered nurse, to
enable and support
patients who have a
diagnosis of cancer.

- PHU now has 16 Cancer Support workers / Cancer Care Coordinators. We tend to have one per tumour site, the exception being Jamie who shares her work between advanced Melanoma and Primary Brain disease.
- We all work very closely with the nurse specialist teams.
- We have a varied and seemingly never ending list of roles to undertake as required.

Patient Pathway management

Co-ordinate Investigations and tests relating to the pathway – from diagnosis to discharge

Consequences of treatment , Simple symptom management

Lifestyle advice, healthy eating, exercise referrals

Motivational interviewing / healthy conversations

Holistic Needs Assessments

Supported self management interventions

Signposting – e.g. CAB & Macmillan

Referrals to complementary therapies / counselling

Liaise with charities as required

Support groups

Family / Carer support

Service Development

Referral to other agencies



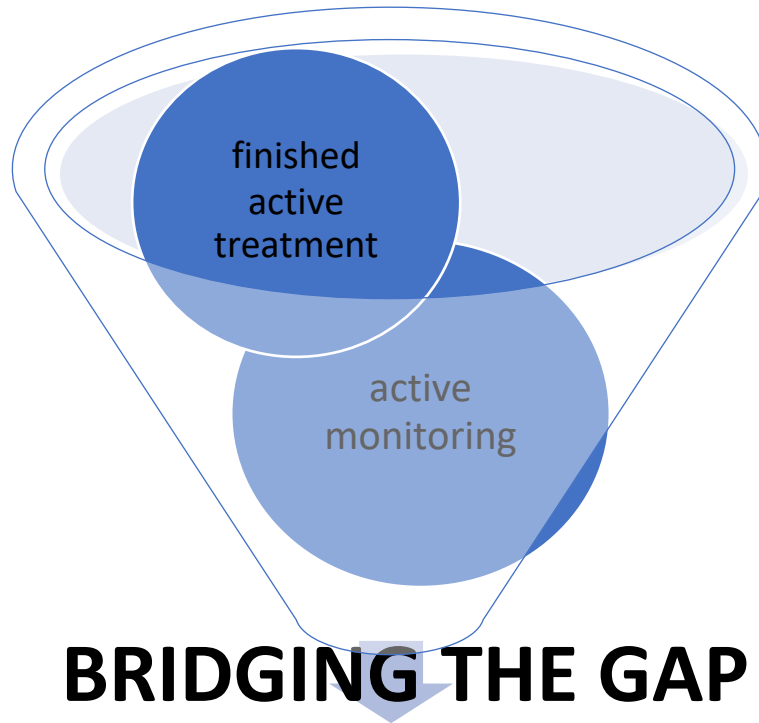
Some of the things we do...

Patient Support	Expediting Diagnostics	Tracking Staging/Re-Staging Scans
Chasing clinic appointments	Liaising with radiology admin	Distribution of patient information - e.g. chemo, booklets
Liaison with MDT Co-ordinator	Chemotherapy Day-unit liaison	Dietician, psychological, GP liaison
Monitoring patients' cancer journey	Holistic Needs Assessments	Championing Patients Choices/Opinions

New Project:

END OF TREATMENT FOR LYMPHOMA PATIENTS

END OF TREATMENT FOR LYMPHOMA PATIENTS



**BRIDGING THE GAP
BETWEEN PRIMARY AND
SECONDARY CARE**

Aim 1:

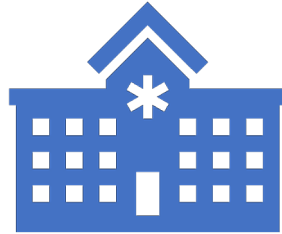


The project aims to ensure that the service will support people to live well with and beyond a Lymphoma diagnosis by providing a service for patients who have finished treatment or who are on active monitoring. To do this, we will initiate a **nurse led end of treatment clinic** and follow this up with regular **post treatment / rehabilitation workshops** for patients.

Aim 2:



Improve the communication and coordination of care between Primary and Secondary care services, so patients can benefit from a more streamlined and patient-centred approach to their treatment, resulting in improved long-term outcomes for this patient group.



It has been known that when patients finish active treatment they often struggle mentally and physically to try and return to their life before cancer.

This approach will assist with patient self-management, remote monitoring, and re-entry routes.

The information provided will include symptom recognition, and a variety of social prescribing information and contacts.

This will provide a more efficient method of aftercare and educate our patients about what is available in the community moving forward.

The anticipated outcomes of this project will be:

- To educate and empower the patient to take a more involved role in their health and wellbeing through educating and informing them.**
- To promote improved communication with primary and secondary care teams.
- To increase confidence within primary care teams to support people with a cancer diagnosis throughout the cancer pathway.**
- Providing patients with knowledge to live a healthier lifestyle can help prevent recurrences and thus improve financial impact on the NHS





Wessex
Cancer Alliance

Cancer Care Coordinators

By

Mary Edwards



What is a care coordinator?

‘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 the GPs and other primary care colleagues within the primary care network (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.’



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

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 fast track urgent suspected cancer referral and escalate breaches.
- Care Navigation

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

Cancer Care Co-ordinators across Wessex



September 2022:

13 Cancer Care Coordinators (CCCs) employed across 12 PCNs

September 2023:

34 CCCs employed across 29 PCNs

CCCs are employed in:

8 out of 18 PCNs in Dorset (44%)

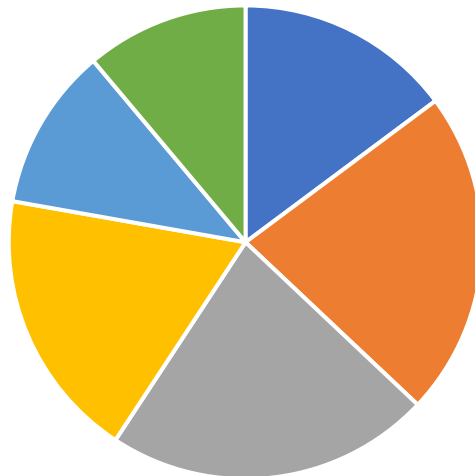
21 out of 42 PCNs in
Hampshire and
Isle of Wight (50%)

PLUS 3 more PCNs are
actively looking to recruit CCCs



Where is your role utilised in the pathway?

- Prevention
- Screening
- Early Diagnosis
- Personalised care post diagnosis
- Palliative
- Cancer Care Reviews



Examples of CCC work in Early Diagnosis of Cancer (DES)

- Promoting clinical decision support tools.
- Involved in safety netting processes.
- Contacting patients that are not attending screening
- Monitoring FiT completion and results

Examples of CCC work tackling health inequalities:

- Several CCC have been instrumental in improving Prostate case finding projects for Black men
- 2 CCC have been involved in improving screening rates and identification in the LGBTQ population
- CCC monitoring of cancer screening data and relating to socio-economic status is enabling further projects to increase likelihood of screening in these populations.

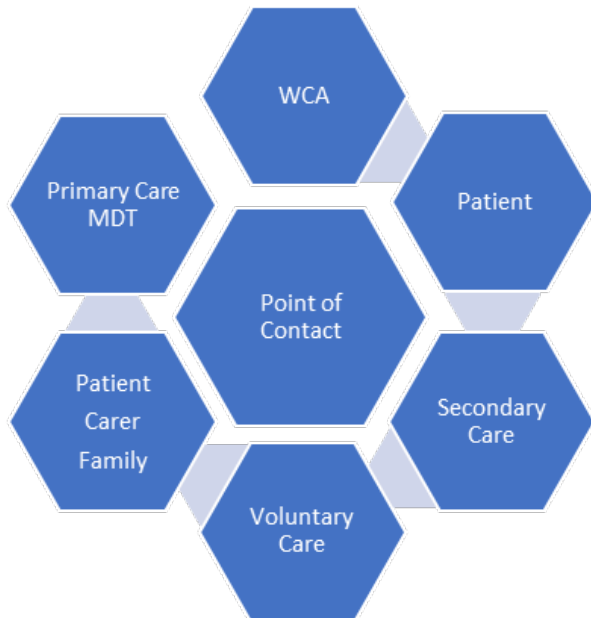
Examples of CCC work achieving the NHS Long Term Plan for cancer:

- Assisting with the completion of holistic needs assessments
- Completing or assisting with cancer care reviews
- Offering information and signposting



Why is the CCC role so important to integrated care?

The Cancer Care Coordinator role can be the gateway to Primary Care There are many opportunities to build relationships and communication between many teams, sectors patients and carers.



Examples

- Providing emotional support and quicker access for patients and carers to the GP and wider practice team.
- Being a WCA cancer champion sharing news and offers from the Alliance
- CCC are often a non-clinical cancer lead for the PCN

Going Forward:

We would like to build on the following relationships:

- CCC and pathway navigators to increase the efficiency of the pathway in the diagnostic and treatment pathway.
- Promote the role and contact details of the CCC to secondary care to assist with faster communication and actions.



Testimonials

Dr Christine Glew, Clinical Director of the Winchester Rural North and East PCN

- Recruiting Rebecca as a Cancer Care Coordinator has been one of the best decisions we have made, and is one of the most valuable roles we have added for the benefit of the practices and patients to date. We were very lucky to attract a candidate with a clinical background and to have the support of the WCA when she started - she has exceeded our expectations in terms of improving cancer screening rates and is now taking on additional training to undertake more direct patient contact. I would highly recommend this role to any PCN and the new support package to assist with recruitment will make the task straight forward.*

Katie Hunter, Avon Valley PCN Manager

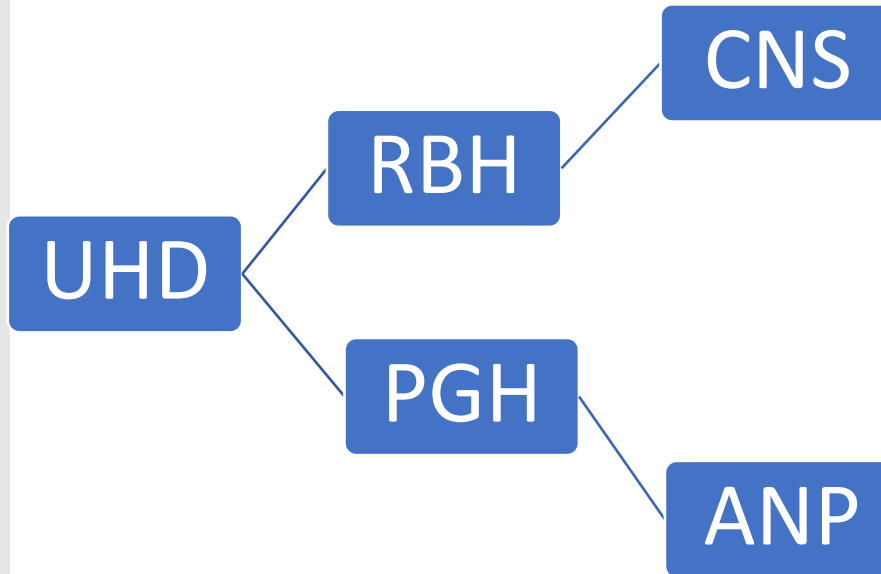
- 'Adam the Cancer Care Coordinator has taken a lot of the cancer work on and has been invaluable in bringing together cancer leads from different practices regularly to review, discuss and action the cancer priorities. Adam has also been invaluable in gathering data and investigating why somethings may not be working well on the ground prior to these meetings and presenting some possible solutions, for example, getting safety netting letters. One key example of this is the dedicating time resolving problems with the fit testing chain and being able to support Dr Williams and I to present to the local ICB and Wessex cancer alliance. Adam has also been pivotal in the role in completing health and well-being checks when someone has just been diagnosed with cancer.'*

CANCER PATHWAY NAVIGATOR

Supportive Cancer Workforce Conference
February, 2024

Sanja Agić

- Colorectal Cancer Pathway Navigator
- University Hospital Dorset (UHD)
- In role since October 2022



Fast Track

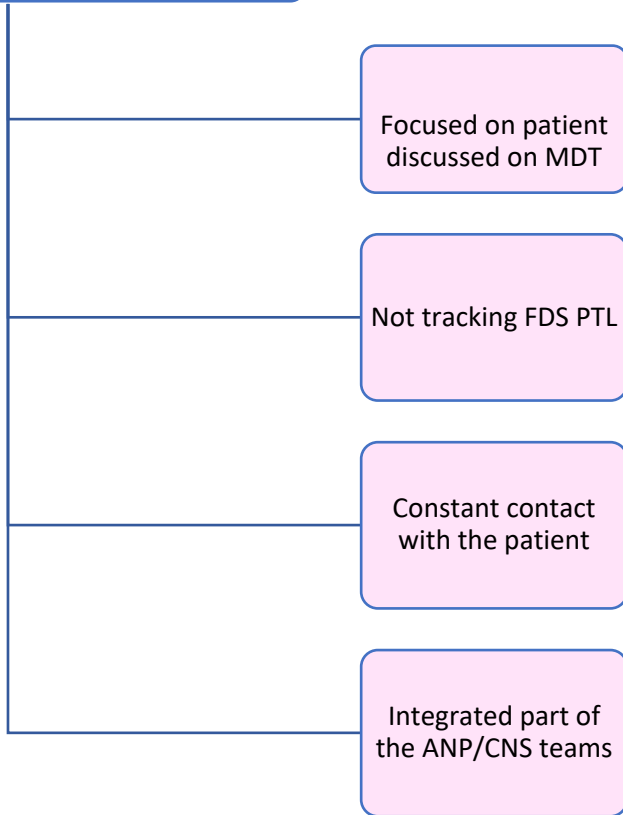
- FIT10 pathway (GP responsibility since 01/2024)
- Phone calls (DNA, blood tests, investigations, FIT, booking F/U)
- Contacting GP
- Requesting blood and FIT tests
- Chasing investigation reports
- Tracking reports and escalating and notifying ANP if result abnormal, adding to MDT

Cancer Nurse Specialist

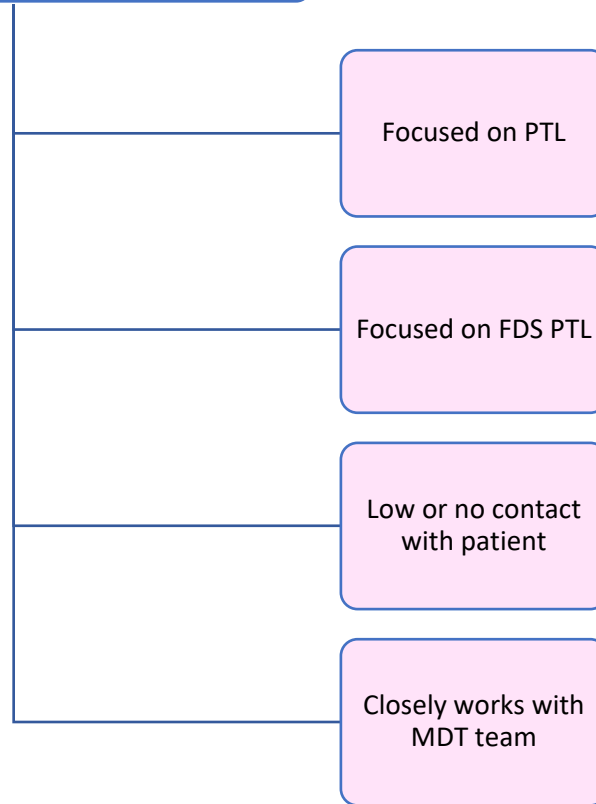
- Taking phone calls and calling patients, and wider MDT
- Attending pre-MDT and MDT meetings
- Post MDT booking, and phone calls to patient and hospital departments
- Tracking complex cases referred to other Trusts
- Ensuring that all relevant images and reports are sent/received in time for MDT discussion
- Tracking whether investigations were requested and highlight reports to clinical team

Variety of the pathway navigator role

My role



My colleagues role



Highlights and challenges

Highlights

- * Patient satisfaction
- * Belonging
- * Learning
- * Networking

Challenges

- * Poor understanding of the role
- * Slow integration in the team
- * Hot-desking
- * Working for 2 teams
- * Multi-site working

THANK YOU!



Lucie O'Brien

Gynaecology MDT Coordinator at UHS

The teams we work with

- Consultants
- CNS's
- MDT Coordinators – local and regional
- PPCs/Team leaders/Operation Managers
- Cancer centre management team

Patient pathways

- 2WW – referred in by the GP
- Urgent – consultant to consultant or incidental findings
- Subsequent treatments
- EIPTs - UHS being a specialist centre for Oncology patients, and more complex surgery referrals from different sites or within Wessex region
- Supporting patients – Tracking investigations and treatments to MDT which further facilitates decision making on the next step of their pathways
- Highlighting delays in procedures or OPAs to the retrospective teams to streamline pathways – hopefully save breach
- Data capture – used long term to help improve referrals / pathway / decision making

Positives and challenges

- Challenges – Breaches, report delays, chasing patients' history
- Positives – Always improving, teamwork, improving patient experience