



Right by You Wessex

A Co-Designed Community Outreach Model of Cancer Care

Update 2025



Background

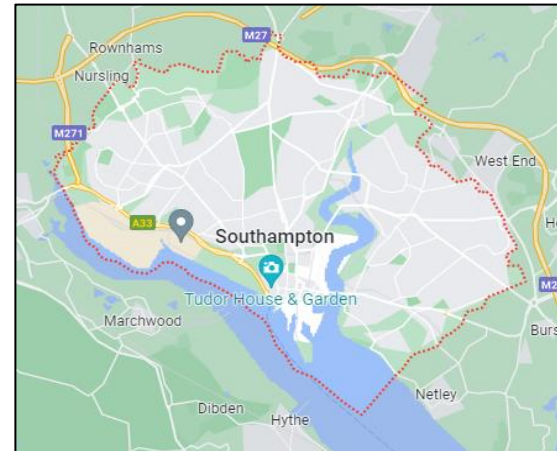
Right by You Wessex (RbY) is a community outreach model of cancer care provided across two pilot sites in Wessex.

As of Summer 2025, the service has supported >800 individuals and their families

RbY Southampton City

- Urban population of 250,000
- University and port city
- Wide ethnic diversity

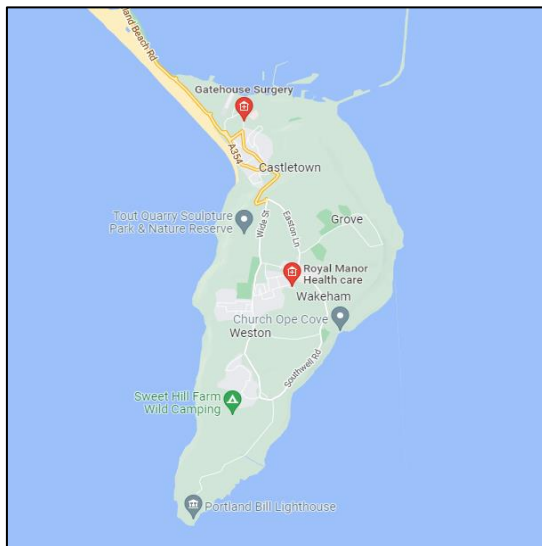
Southampton RbY Team
 3 Cancer clinical nurse specialists
 Homeless care coordinator
 Pathway navigator



RbY Portland

- Population of 13,000
- Tied island forming southernmost point of Dorset
- High levels of deprivation (99.7% reside in quintiles 1-3)
- Served by 1 GP practice
- Location of two prisons

Portland RbY Team
 Cancer clinical nurse specialist
 Cancer support worker



RBY COMMUNITY OUTREACH SERVICE DELIVERY MODEL

WHAT IS DELIVERED?	<ul style="list-style-type: none">· Longitudinal therapeutic health need assessments with highly skilled psychosocial intervention.· Complex support provision, including expert symptom and side-effect management, advocacy, and self-management support, tailored to the lived experience and needs of people with cancer.· Collaboration and shared knowledge across primary, secondary and community care services.· Includes comorbidity and frailty management.
WHO DELIVERS?	<ul style="list-style-type: none">· Experienced cancer CNSs with enhanced psychological training working at an advanced level.· Boundary spanning role across acute, primary care and community services settings.
TO WHOM?	<ul style="list-style-type: none">· People diagnosed with cancer, their family, friends, and carers.· People with complex needs (including psychological, social and clinical).· Specialist support to marginalised populations including prison and homeless communities.
HOW DELIVERED?	<ul style="list-style-type: none">· Service users are supported in their preferred location, typically their own home.· Support is also provided via telephone, text, and email (depending on preference and need).
WHEN?	<ul style="list-style-type: none">· At any stage in the cancer pathway from pre-diagnosis to post-treatment, including palliative care.· Continual, repeated needs assessments are undertaken at times appropriate for the service user.



How Does A Community Outreach Model Differ from 'Usual Care'?

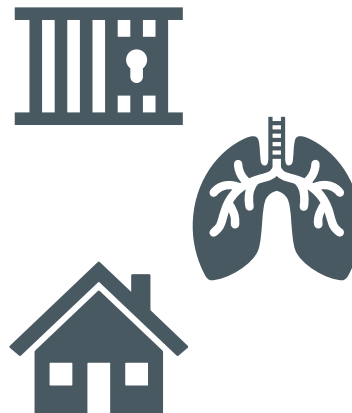
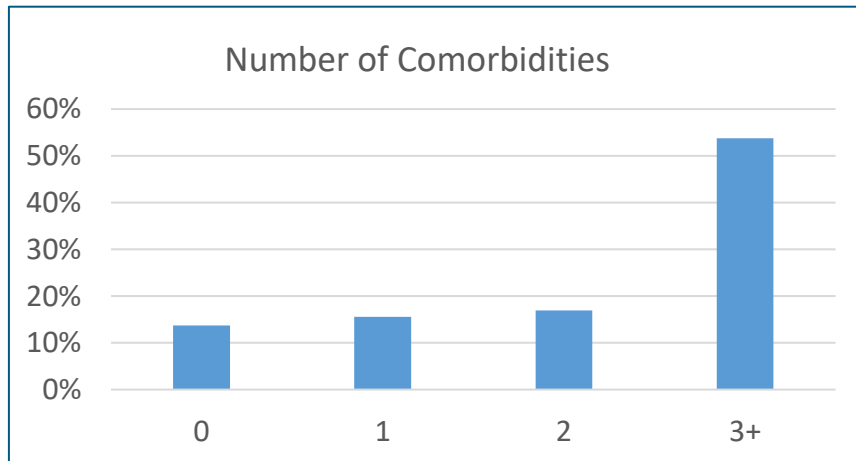
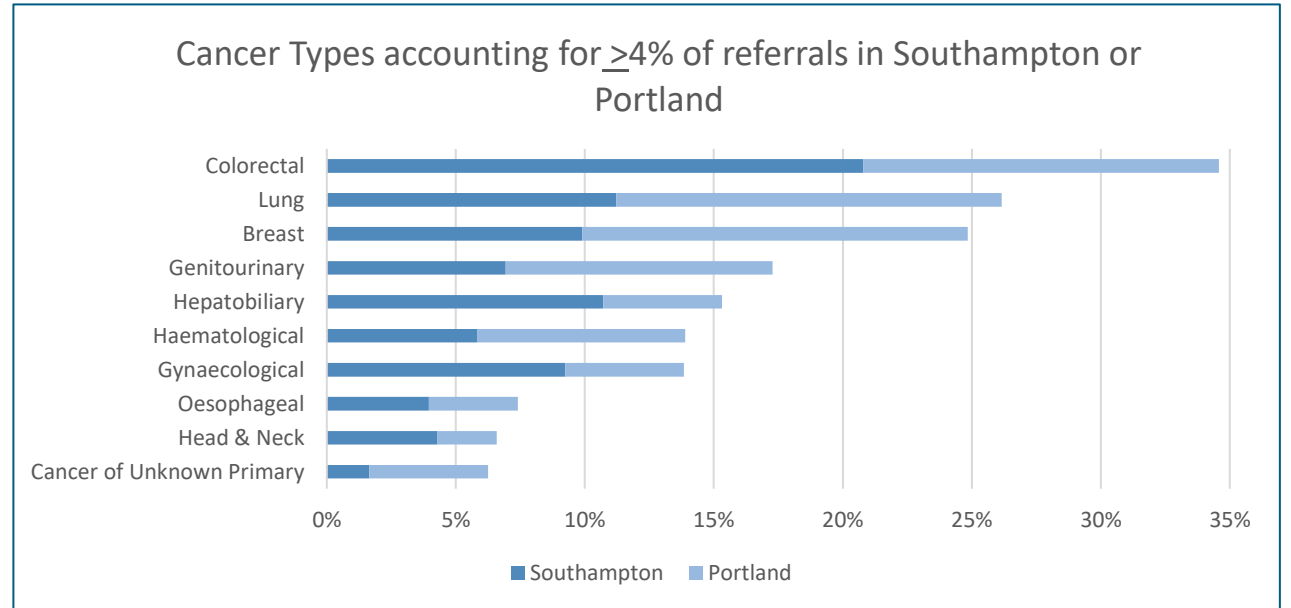
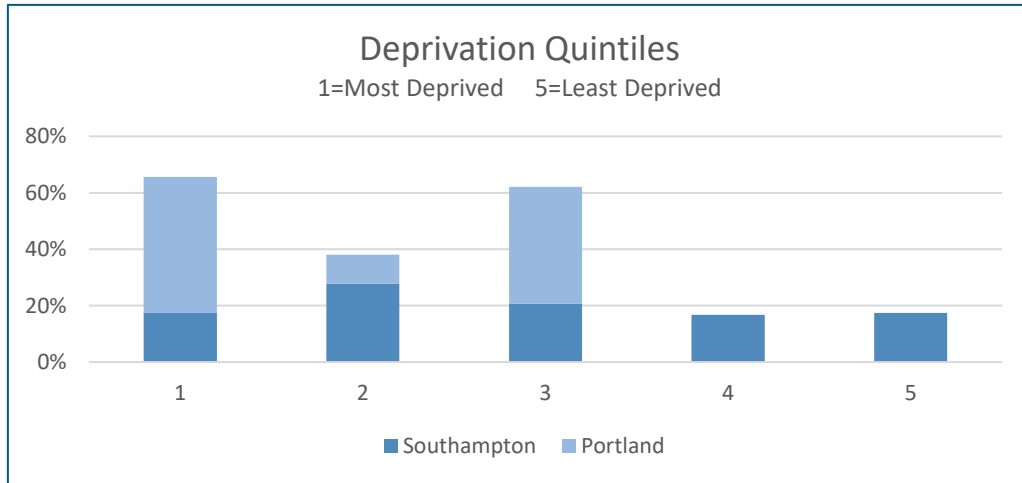


RbY Wessex presents a complementary but distinct offer from existing cancer services:

- **Fitting around the service user** in terms of time, location and accessibility / method of support.
 - **Providing continuity and consistency of care provision**, across the cancer journey by one team, enabling evaluation of effectiveness of support and reprioritisation as health needs change.
 - **Adopting a proactive approach, with anticipatory care planning** and pre-emptive (as opposed to reactive) identification and management of support needs.
 - **Assuming responsibility for managing the care and support needs** of the service user (where appropriate), rather than escalating or referring to other services. This is enabled by the experience and skill-mix within the RbY team.
 - Providing **level 2+ psychological support** where gaps exist in current psychological service provision.
 - Providing opportunity for **supported clinical and non-clinical decision making** within one service.
 - Enabling access to and **facilitating the transition of care** to other services. For example, supporting transition to specialist palliative care at the right time and in the right way for patients.
 - Providing **integrated holistic care and support** that operates across organisational boundaries.
- Enables **tailoring of care** (by all involved) and **prevents duplication**, ultimately **streamlining service provision**.



Service User Characteristics



22	18
People Experiencing Homelessness	Prisoners HMP The Verne

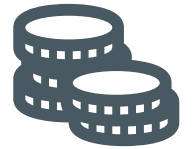
*totals as of Summer 2025



Identify & Support Wide Range of Concerns

- Emotional & psychological support
- Physical symptom & side effect management + comorbidities
- Practical support (e.g., financial, housing, medication management)
- Family support

- Information provision to improve knowledge and understanding
- Liaison with primary, secondary & community services
- Complex decision-making support
- Advocacy during appointments
- Facilitate service user access and engagement with other clinical teams
- Signposting and referrals to other support services
- Anticipatory assessments / communication / care planning
- Avoid: Conflicting care or advice
 - Unnecessary / unwanted cancer treatment
 - Crisis escalation & unplanned care



Patient / Family Experience & Outcomes

Improved:

- Emotional & psychological wellbeing
- Complex symptom & side effect management
- Knowledge of cancer & related services
- Activation, self-efficacy, & self-management
- Avoidance of care duplication or conflicting advice
 - Confidence in accessing new services
- Access to & engagement with cancer care
- Carer support (enabling continued care)

Facilitation & coordination of complex care needs

Health Service Use

- Actively facilitate engagement with appropriate services
85% are non-NHS funded
- Community outreach advanced CNSs enable timely, proactive and in situ identification & management of complex care needs
- Anticipatory care planning prioritises prevention over crisis
 - **Prevents crisis escalation**
 - **Reduces unplanned care**
 - **Avoids admissions**
- Enables **early facilitated discharge** from acute care
 - Prevents the need to refer to other services
- Where escalation is required, **timely action prevents worsening of need** (often rapidly escalating)

Impact of Right by You

Integration of Care

- Timely updates provided to professionals involved in the patient's care
- Facilitate and promote improved communication
- Integration is cross-sector and cross-speciality (including comorbidity & frailty management)
 - Enables **tailoring of care** (by all involved)
- Appropriate referrals & improved communication **prevent duplication of care**
 - Engaging appropriate services at the right time
 - **Streamlining service provision.**

Macmillan Professionals Awards 2023
Integration Excellence Award Winners

Improved integration across primary, secondary & community care

Workforce

- Addresses the limitations of time, environment, knowledge of local support services and psychological support provision in primary & secondary care
 - Model of care designed to meet increasing demand and respond to unmet need
 - Improved knowledge & enhanced job satisfaction among HCPs
- "Predominantly, the whole psychology & support of the patient's emotional wellbeing, that's not dealt with in secondary care. That is something that is definitely added by RbY"*



Health Service Utilisation: Data Collection Methods

Data Collection

- Quantitative service data were collected by RbY staff across a six-month period (01/04/24 – 01/10/24).
- Data were collected on 137 service users (81 Southampton, 56 Portland) across 442 interventions (223 Southampton, 219 Portland).

Cost Benefit Analysis

- Data collected included assessment, care and support provided to service users and the estimated impact of RbY intervention on patient health service use.
- Unit cost source data were used to predict associated cost savings.
- Data were extrapolated to represent 100% of service delivery over 12 months.

Service Scalability

Using population data, combined with cost benefit analysis data, we can predict the cost and return on investment of scaling up the RbY service across Wessex.



Health Service Utilisation: Cost Benefit Analysis



Annual Predicted cost savings across RbY

Health Service Use Avoided	Unit Cost (including inflation calculated to June 2024)		Number Avoided	Potential Savings	
	Min	Max		Min	Max
GP Appointment	£45.59	£45.59	579	£26,396.61	£26,396.61
GP Home Visit	£123.16	£123.16	75	£9,237	£9,237
Practice Nurse Appointment	£13.36	£13.36	327	£4,368.72	£4,368.72
Practice Nurse Home Visit	£27.37	£27.37	12	£328.44	£328.44
AARS Practitioner Appointment	£10.39	£27.69	255	£2,649.45	£7,060.95
Primary Care TOTAL				£42,980.22	£47,391.72
Telephone Call (e.g., to CNS or AOS)	£10.64	£31.95	507	£5,394.48	£16,198.65
Consultant Appointment	£243.19	£243.19	60	£14,591.40	£14,591.40
CNS Appointment	£174.42	£174.42	204	£35,581.68	£35,581.68
Acute Oncology Service (AOS) Day Admission	£459.38	£501.24	87	£39,966.06	£43,607.88
A&E Visit	£137	£445	78	£10,686	£34,710
Hospital Admission	£2,325.80	£3,935.98	81	£188,389.80	£318,814.38
Ambulance Call-Out	£290.74	£290.74	102	£29,655.48	£29,655.48
Secondary Care TOTAL				£324,264.90	£493,159.47
NHS Talking Therapies Referral**	£1,025.70	£1,025.70	105	£107,698.50	£107,698.50
Community Mental Health Team Referral**	£539.52	£2,023.20	93	£50,175.36	£188,157.60
Mental Health Crisis Team Referral	£299.85	£2,098.95	60	£17,991	£125,937
Counselling Referral**	£193.95	£387.90	147	£28,510.65	£57,021.30
PCN Mental Health Practitioner Referral**	£325.20	£433.56	90	£29,268	£39,020.40
Mental Health Services TOTAL **for management as opposed to one-off appointments				£233,643.51	£517,834.80
Community Team Input (e.g., District Nurses)	£27.10	£57.64	105	£2,845.50	£6,052.20
Palliative Care Telephone Call	£8.78	£26.34	93	£816.54	£2,449.62
Palliative Care Nurse Appointment	£93.20	£93.20	39	£3,634.80	£3,634.80
Community Health TOTAL				£7,296.84	£12,136.62
TOTAL ANNUAL SAVINGS				£608,185.47	£1,070,522.61



TOTAL ANNUAL SAVINGS	
Min	Max
£608,185	£1,070,523

Predicted cost savings due to health service use avoided:

*Annual savings Southampton + Portland
(combined pop^N 344,908) = £1.07m*

Scaled up to Hants & IoW ICB (pop^N 1.9m) = £5.9m

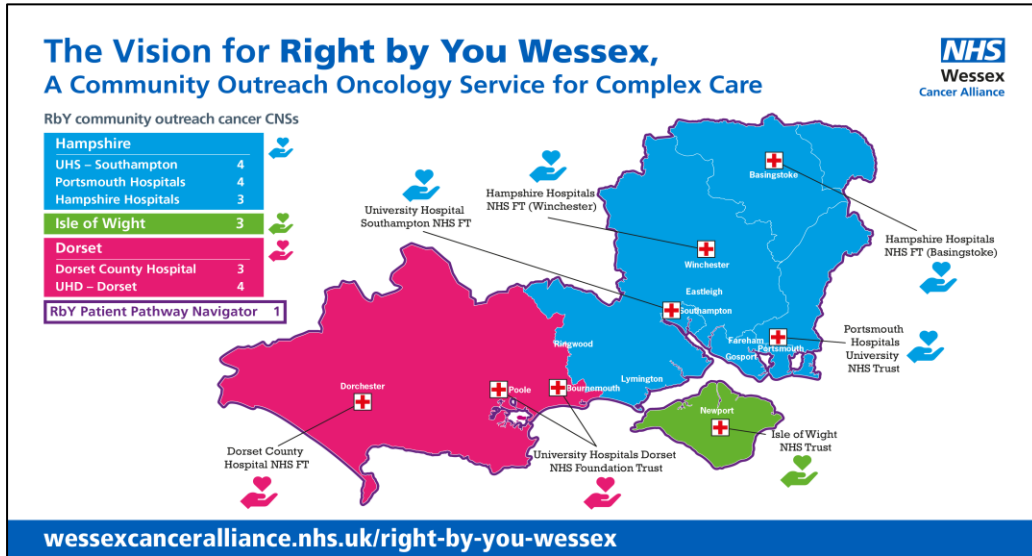
Scaled up to Dorset ICB (pop^N 827,883) = £2.57m

Wessex-wide predicted cost savings = £8.5 million





Service Scalability: Proposed Staffing / Cost and Savings of Wessex-Wide Rollout



Proposed Wessex-wide model and delivery costs

Staffing	Banding	Intermediate AFC 24/25 Salary + 30% Estimated On-Costs	WTE / PA	Staffing Costs	Scalable Running Costs (mileage, parking, people safe hire)
Lead Cancer Nurse Specialist	Band 8a	£73,390	2	£146,780	£4,653
Cancer Nurse Specialist	Band 7	£63,084	19	£1,198,596	£44,200
Patient Pathway Navigator	Band 5	£42,021	1	£42,021	N/A
				£1,387,397	£48,853
					£1,436,250

Total predicted cost savings = £8.5 million
(Hants & IOW £5.9m, Dorset £2.57m)

Delivery cost = £1.44 million

Net saving = up to £7 million





A Strategic Enabler of the NHS 10-Year Plan



NHS 10-year Plan Priority	RbY Wessex Contribution
<p>Proactive and preventative care, especially for people with complex needs. Anticipatory care planning is central to reducing emergency admissions, supporting people to stay well at home.</p>	<p>Tailored support based on individual preferences (location, timing, communication method). Continuity of care by one team across the cancer journey enables deep understanding of personal needs and preferences. Anticipatory care planning ensures that support is proactive, not reactive, aligning with the goal of personalised, preventative care.</p>
<p>Integrated working across systems and neighbourhoods to bring care closer to home.</p>	<p>Boundary-spanning CNS roles work across acute, primary, and community settings. Integrated holistic care prevents duplication and streamlines service provision. Facilitated transitions (e.g., to palliative care) ensure seamless care across the system.</p>
<p>Timely, appropriate mental health care, integrated mental health into physical health pathways, improving outcomes and reducing distress. Give people more control over their health and wellbeing.</p>	<p>Provides Level 2+ psychological support, addressing gaps in current provision. Offers supported decision-making for both clinical and non-clinical issues, reducing anxiety and improving confidence in care choices.</p>
<p>Reducing health inequalities and improving access to care for underserved groups</p>	<p>Provides specialist support to marginalised populations (e.g., homeless, prison populations). Flexible, accessible delivery methods reduce barriers to care for underserved groups.</p>
<p>Development of a modern, flexible workforce to meet rising demand and deliver more care in community settings.</p>	<p>CNSs with enhanced psychological training and advanced practice skills represent a modern, flexible workforce. The team assumes responsibility for care management, reducing unnecessary referrals and easing pressure on other services. Expert symptom and side-effect management in the community improves quality of life and treatment adherence.</p>