

INDICATIVE ROLE SPECIFICATION FOR A MACMILLAN NURSE PRIMARY CARE AND A MACMILLAN NURSE COMMUNITY CARE

Indicative level of practice - Level 6 NHS Career Framework
(Skills for Health, 2006)



October 2011

Introduction and context

Macmillan has been working with the Department of Health in England (DHE) and NHS Improvement on the National Cancer Survivorship Initiative (NCSI) to develop new models of aftercare following completion of treatment and rehabilitation, as the current model of follow-up is unsustainable. The emerging aftercare models demonstrate that care needs should be assessed at key transition points and a plan of care developed to reflect risk stratification into one of 3 levels of care (supported self-management, shared care or complex care) to ensure that people are supported by the right person with the right skills and knowledge, to meet their individual needs.

In order to develop a sustainable aftercare model and provide the most effective and accessible care for people affected by cancer, there needs to be a change in the current cancer care pathway and the staff that are needed to support it. Increasingly, there will be an increased role for nurses working in Primary Care to build on their existing long term condition management skills to support people affected by cancer.

As one workforce solution, Macmillan has developed two indicative roles, called a Macmillan Nurse Primary Care (MNPC) and a Macmillan Nurse Community Care (MNCC), whose main purpose is to support those people who have had a holistic needs assessment and been risk stratified as having needs that require ongoing support - shared care. Shared care between acute and primary/community care and between the professional and person affected by cancer. The roles will enable patients and their carer/s to navigate the complex health and social care system following completion of cancer treatment. We will be piloting these new roles in 2012 in both the practice and community settings along with 2 other new roles. Localities may choose to pilot one or more of the roles depending on local need and infrastructure. The other roles are: Macmillan Complex Case Manager and Macmillan Cancer Support Worker. We see these new roles supporting the care pathway based on 3 risk stratified levels of aftercare:

Level 1	Self-Care with support and open access to the MDT	Macmillan Cancer Support Worker
Level 2	Shared Care	Macmillan Nurse Primary Care or Macmillan Nurse Community Care
Level 3	Complex management through MDT	Macmillan Complex Case Manager

The MNPC/MNCC Role is expected to be an existing practice nurse or district nurse currently working with people affected by long term conditions (LTC) who will provide weekly sessional time to look at the specific needs of people living with and beyond cancer in their practice population and in most cases across a number of practices. It would be ideal if the role was supported by an existing Macmillan GP. This role may be based in a GP practice and be undertaken by a Practice Nurse or in the patient's own home and undertaken by a District Nurse – this will be determined by the localities. The aim of this role is to work with people affected by cancer as a LTC specialist and not as a cancer specialist. The cancer expertise and knowledge will be achieved by building local relationships with site specific Clinical Nurse Specialists (CNSs), Multi-Disciplinary Teams (MDTs) in secondary care as well as learning and development provided by Macmillan. The Macmillan Nurse Primary/Community Care will work closely with existing teams in the locality to ensure clear definition of roles and define locally agreed pathways for generalist palliative care. The Macmillan Nurse Primary/Community care

will develop systems and processes, to enable the pathway to be integrated to ensure the role is embedded and complements existing service provision.

The NHS Career Framework Levels (2008) describe practice at level 6 as “professionals, who require a critical understanding of detailed theoretical and practical knowledge, are specialist and /or have management and leadership responsibilities. They demonstrate initiative and are creative in finding solutions to problems. They have some responsibility for team performance and service development and they consistently undertake self development”.

Scope of Role:

The scope of the role will vary depending on the contractual time commitment and the local priorities determined during the set-up of the role and through discussion with the local Macmillan Service Development Team. The Macmillan Nurse in Primary or Community Care is encouraged to develop their role in the core elements outlined below and additional elements can be added to meet local priorities.

Expected Patient Outcomes

Patients risk stratified into shared care and supported by the Macmillan Nurse in Primary Care or the Macmillan Nurse in Community Care will be:

- Supported to maximise their quality of life, living with and beyond cancer.
- Encouraged to self-manage with the responsibility of care being shared between the patient, their carer/s and the nurse and between the MNPC or MNCC.
- Given support to recognise possible signs of deterioration, recurrence or long-term effects of treatment.
- Enabled to re-access specialist services without delay should they need to do so.

Core elements of role:

The **core elements** of role specification must be **reflected** in all Macmillan Nurse in Primary or Community Care job descriptions (JDs), although the format and language is likely to differ according to the employing organisations (EO) preferences. Each Macmillan Development Manager has the responsibility to agree this with the EO for every new post approved and must ensure that the contents are in line with this. There is an expectation that the Senior Macmillan Development Manager and General Manager of the region will also take responsibility to check that JDs are reflecting our position before approving funding.

- 1. Provide proactive aftercare for people living with cancer, taking on the role of key worker for those people risk stratified into Level 2 - Shared Care (NCSI risk stratification model (Feb, 2011)).** *To work with secondary and tertiary care to act as the recipient of treatment summaries (TSs) on all practice population patients and support the transition of aftercare to primary care taking a Shared Care approach (shared between acute and primary care and between the professional and person affected by cancer). To enhance communication between primary, secondary and tertiary care in order to promote a seamless service and improved patient experience.*
 - Influence the development of local systems that improve communication between all providers, with particular attention given to the interfaces between primary care, secondary care, out-of-hours (OOH) and social care providers.
 - Develop a robust communication network with Cancer MDTs where close collaboration is required to ensure that assessments and care plans are shared and agreed.
 - Develop a process to receive all TSs for cancer patients in the practice population and phone patients and invite them and their carer for a holistic assessment, determined by individual circumstances to identify current and future needs.

- Co-create a care plan for current and anticipated future healthcare needs, encouraging people to self-manage where appropriate
- Agree with patient and carer the frequency of care plan reviews and re-assess according to need, in order to share care between the patient and primary care.
- Facilitate information provision for cancer patients, enabling patients' understanding of their condition and treatment, navigation of available services and access to information and support for self management where appropriate.
- Coordinate the necessary assessments, appointments or investigations to fast track people back into the system if required
- Sign-post to local health and well-being events, if they haven't attended an event already and/or other self-management programmes
- Coach patients and carers to understand what signs, symptoms or situations to be aware of that indicate concern, including long term consequences of cancer and its treatment
- Coach patients and carers on how to make contact when they feel that their condition or needs have changed, including what to do out of hours
- Coach patients and carers to select healthy lifestyle choices using motivational interviewing skills to support behaviour change
- Support information prescription delivery; this role may include printing out information prescriptions, assisting people accessing emailed information prescriptions, or offering to provide information prescriptions based on the all-cancers information pathway
- Provide emotional and psychological support to patients and their carers.
- Refer on or sign-post to other sources of support
- Act as advocate and facilitator to resolve issues that may be perceived as barriers to care
- Define local pathways for surveillance and monitoring through investigations, as appropriate and feedback results through predetermined Standard Operating Procedures
- Support ongoing disease surveillance through coordination of tests and monitoring investigations, feedback of results for non-complex cases and referral back into the appropriate MDT.
- Use the practice based consultation and patient involvement groups to ensure that developments are patient-centred
- Demonstrate in practice the Macmillan Human Rights Standard for Cancer Care
- Ensure that people affected by cancer are aware that they are interacting with a Macmillan Professional and know about the full range of resources and services available through Macmillan.
- Actively engage with Macmillan Cancer Support to contribute expertise and experience and support the Macmillan Corporate Strategy.

2. Proactively manage the Cancer Care Review of all people affected by cancer who have completed treatment. *To meet QOF requirements, all people affected by cancer should be reviewed in the first 6 months following a cancer diagnosis*

- Ensure there is a robust process for all practice population patients and their carers to be invited to a cancer care review.
- Ensure the cancer care review is completed and a care plan developed for current and future needs, including an agreed review process according to individual need
- Use the review as space to allow the patient and carer to tell their story and use the narrative to influence redesign the local care pathway.
- Provide cancer care professionals involved in the acute phase with feedback on their patients experience
- Provide and develop appropriate audit and outcomes measure information in order to evaluate the service.

3. Education. *To facilitate and enable the education of primary health care teams, working with and through other stakeholders as required, and supporting the use of Macmillan primary care tools and models of good practice.*

- Develop a local directory to support people living with cancer to access appropriate information and support, sign-post to a range of local support services and take an approach which helps people to self manage where appropriate. This should encompass all sectors and take account of voluntary services.
- Advise patients on self-care management principles and provide consistent planned aftercare to reinforce and further promote this information
- Deliver patient-centred, self-management support and education as necessary, including how to self-assess to promote a strong focus on health and wellbeing to improve health outcomes
- Support the delivery of patient and carer training and education, including use of equipment if appropriate
- Encourage and support active and healthy lifestyle choices
- Provide input to existing educational programmes, with particularly emphasis on vocational training courses.
- Enhance the knowledge and skills of primary health care teams in providing care to cancer patients. This is likely to include early diagnosis, the cancer care pathway, symptom control, oncological emergencies and supportive and end-of-life care using other professionals as appropriate, such as the local CNS's and Specialist Palliative Care team.
- Particular emphasis will be on educating and supporting receptionists in the practice to better triage incoming calls from cancer patients, which might include setting up a flagging system.
- Support the use and / or roll-out of Macmillan educational initiatives, e.g. Sexuality Toolkit, Out of Hours toolkit, e-learning and learning from our pilot project 'Practice Nurses managing cancer as a long-term condition'.
- Provide placement supervision for nursing staff from acute settings, developmental posts and pre-registration learners to provide opportunities for future succession planning and increasing professionals' knowledge and understanding of cancer in primary and community care.
- Demonstrate self-directed learning, actively seeking role development opportunities to enhance practice, knowledge and role progression
- Identify personal learning and development needs.

4. Service redesign. *To work with Macmillan and other stakeholders to support pathway and service redesign taking account of national and Macmillan priorities, while responding to local need. Redesign should support national agendas of achieving quality and productivity in cancer care and achieving Macmillan's outcomes for people living with cancer (outlined later in this document).*

- Facilitate and inform the integration of cancer pathways between health and social care and support implementation of national guidance.
- Proactively identify opportunities for redesign in alignment with Macmillan's outcomes for people living with cancer, including support for and spread of recognised tools and models of good practice in cancer care.
- Identify and highlight any gaps in service provision with particular emphasis on cancer as a long-term condition and the consequences of cancer and its treatment, which may occur many years after completion of treatment.

- Contribute to the development of local systems that improve communication between all providers, with particular attention given to the interfaces between primary care, secondary care, out-of-hours (OOH) and social care providers.
- Within the professional scope of the role contribute to the implementation of models of good practice as developed by Macmillan to support communication between providers (e.g. Treatment Summary and Cancer Care Review templates, both currently being piloted in England and the OOH Toolkit).

Key relationships and national priorities

There is an inherent understanding that the following key relationships and priorities will run through all facets of the Macmillan Nurse Primary/Community Care role.

Key Relationships

- Patients and their carers.
- Macmillan GP Advisor(s) and/or Macmillan GP's, Local GP Practices, the wider primary and community care teams and the UK-wide Community Care Community.
- Community specialist palliative care providers, providers of out-of-hours care, social care providers and voluntary sector organisations.
- Cancer commissioning leads or equivalents in the devolved nations, Cancer Networks and acute providers of cancer and palliative care services especially cancer site specific CNS's and Cancer MDTs.
- Macmillan Development Manager, other Macmillan Professionals and NHS Accreditation Bodies.

National Priorities across the UK

- End-of-Life strategies across the UK.
- National Cancer Survivorship Initiative (England).
- Improving Outcomes: A Strategy for Cancer (England).
- Information prescriptions (England).
- NICE Improving Outcomes Guidance (England and Wales).
- Clinician-led Commissioning (England and Northern Ireland).
- Better Health, Better Care (Scotland).
- Better Cancer Care (Scotland).
- Cancer Control Programme (Northern Ireland).
- Living with cancer agendas (assessment & care planning, new models of follow-up and support in primary care).
- Long-Term Conditions agendas (personalised care plans, personal budgets and managing cancer as a long-term condition).

Priorities of Macmillan Cancer Support

Macmillan has identified nine key outcomes that we wish to achieve for people living with cancer by 2030. These are outlined below and underpin all of Macmillan's work, with our investments in primary and community care typically supporting outcomes 1, 3 and 6 (highlighted).

By 2030, the 4 million people living with cancer in the UK will say:

 I was diagnosed early	I understand, so I make good decisions	I get the treatment and care which are best for my cancer, and my life 
Those around me are well supported to help me, and themselves	I am treated with dignity and respect	I know what I can do to help myself and who else can help me 
I can enjoy life	I feel part of a community and I'm inspired to give something back	I want to die well

PERSON SPECIFICATION MACMILLAN NURSE IN PRIMARY AND COMMUNITY CARE

	<u>ESSENTIAL</u>	<u>DESIRABLE</u>	<u>EVIDENCE</u>
EDUCATION AND QUALIFICATIONS	<ul style="list-style-type: none"> • Registered General Nurse • First level degree in related subject • Practice or community nursing qualification • Evidence of continued professional development • Communications Skills Training or qualification • Recognised teaching qualification or prepared to work towards 	<ul style="list-style-type: none"> • Research qualification • Post-registration qualification in cancer/palliative care or relevant subject • Examination and Assessment qualification • Evidence of modules specifically related to role delivery 	<p>Application form CV NMC eligibility to practice check Professional Portfolio</p>
RELEVANT EXPERIENCE	<ul style="list-style-type: none"> • Relevant post registration experience, at Level 6 within practice or community nursing. • Experience of working with people with long term conditions • Experience of teaching • Leadership and management experience • Experience of multi-professional working • Evidence of advanced communications skills • Ability to lead and influence change • Understanding of community services and providers • Understanding of commissioning and national drivers 	<ul style="list-style-type: none"> • Experience of audit and research • Understanding of Macmillan Cancer Support and its role across the UK. • Post-registration experience in cancer/palliative care or relevant subject • Knowledge, understanding and experience of cancer care and treatment • Coaching/CBT/motivational interviewing training or experience 	<p>Interview References Application form Presentation</p>
SKILLS AND ABILITY	<ul style="list-style-type: none"> • IT literate • Teaching/assessment and presentation skills • Organisation and negotiation skills • Effective communication • Leadership and motivational skills • Ability to motivate self and others • Ability to work 	<ul style="list-style-type: none"> • European Computer Driving Licence or equivalent • Supervision and group facilitation skills 	<p>Interview References Application form Presentation</p>

	<p>autonomously and as part of a team</p> <ul style="list-style-type: none"> • Flexible attitude to working • Exemplar written communication skills • Willing to learn and adopt best practice 		
PERSONAL CAPABILITIES	<ul style="list-style-type: none"> • Diplomatic • Calm and objective • Assertive, confident, yet approachable • Personally and professionally mature • Recognition of own limitations • Demonstrates enthusiasm • Able to travel between sites within community area and between practices 		Interview
EFFORT	<ul style="list-style-type: none"> • Ability to deal with complex and difficult emotional situations and handle difficult questions and sometimes conveys unwelcome news. 		Interview