

**WE ARE
MACMILLAN.
CANCER SUPPORT**

National Cancer Survivorship Initiative

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The National Cancer Survivorship Initiative (NCSI) will consider a range of approaches to survivorship care and how these can best be tailored to meet individual patient's needs

Cancer Reform Strategy
December 2007

Who is a Cancer Survivor?

A cancer survivor is someone living with or beyond cancer.

Someone who:

- Has completed initial cancer management and has no apparent evidence of active disease
- Is living with progressive disease and may be receiving cancer treatment but is not in the terminal phase of illness (last six months of life)
- Has had cancer in the past.

Background

- 2 Million survivors within the UK and this is predicted to rise by 3.2% per annum
- Long term survivors of cancer report poorer health and well being than the general population

What are we trying to achieve?

- Measurable improvements to the health, well being and experience of cancer survivors and their families
- Delivery of safe, quality, effective and value for money services
- Improved communication and coordination of service delivery across multiple organisations and agencies
- Principles of post treatment care and support that will inform future commissioning and NHS workforce

7 Workstreams Established

- Assessment and care planning
- Managing active and advanced disease
- Consequences of cancer and its treatment
- Survivors of childhood and young people's cancer
- Work and finance
- Self-care and self-management
- Research

NCSI Vision for 2012

- Those living with and beyond cancer are supported to live as active a life as possible for as long as possible
- People have the information they need
- They are empowered to manage their own care
- Aftercare is based on the individual needs of the patient
- Particular needs are addressed and care plan is planned

Assessment and Care Planning

Noëline Young

NCSI Assessment and Care Planning
Workstream

The vision is to provide answers to the questions that patients ask

“So what exactly has been done to me?”

“What happens next?”

“Why am I having these appointments?”

“How will this medical / emotional /
financial / practical / spiritual issue be
addressed?”

NCSI Assessment and Care Planning Workstream

- Assessment and Care Planning
- Treatment Record Summary
- Cancer Care Review
- Transition from Treatment to Follow- up Care

Survivorship

- Survivorship can be a sad, lonely and scary place for people affected by cancer
- But it does not have to be like that
- By learning how to improve the quality of care survivors receive and communicating more effectively, patients can be focused, supported and motivated to become more self caring

Why Assess Patients Needs?

- Patients that currently have a routine follow-up have reported that their needs are not being met
- Resources are being wasted by providing services that are not fit for purpose
- Assessing patients will mean that patients needs are addressed and resources are used appropriately

Why Assess Patients Needs?

“I feel like my whole life has been thrown up into the air, chopped in a million pieces and is now on the floor in front of me. How do I make sense of this? Where do I start?”

Why a Care Plan?

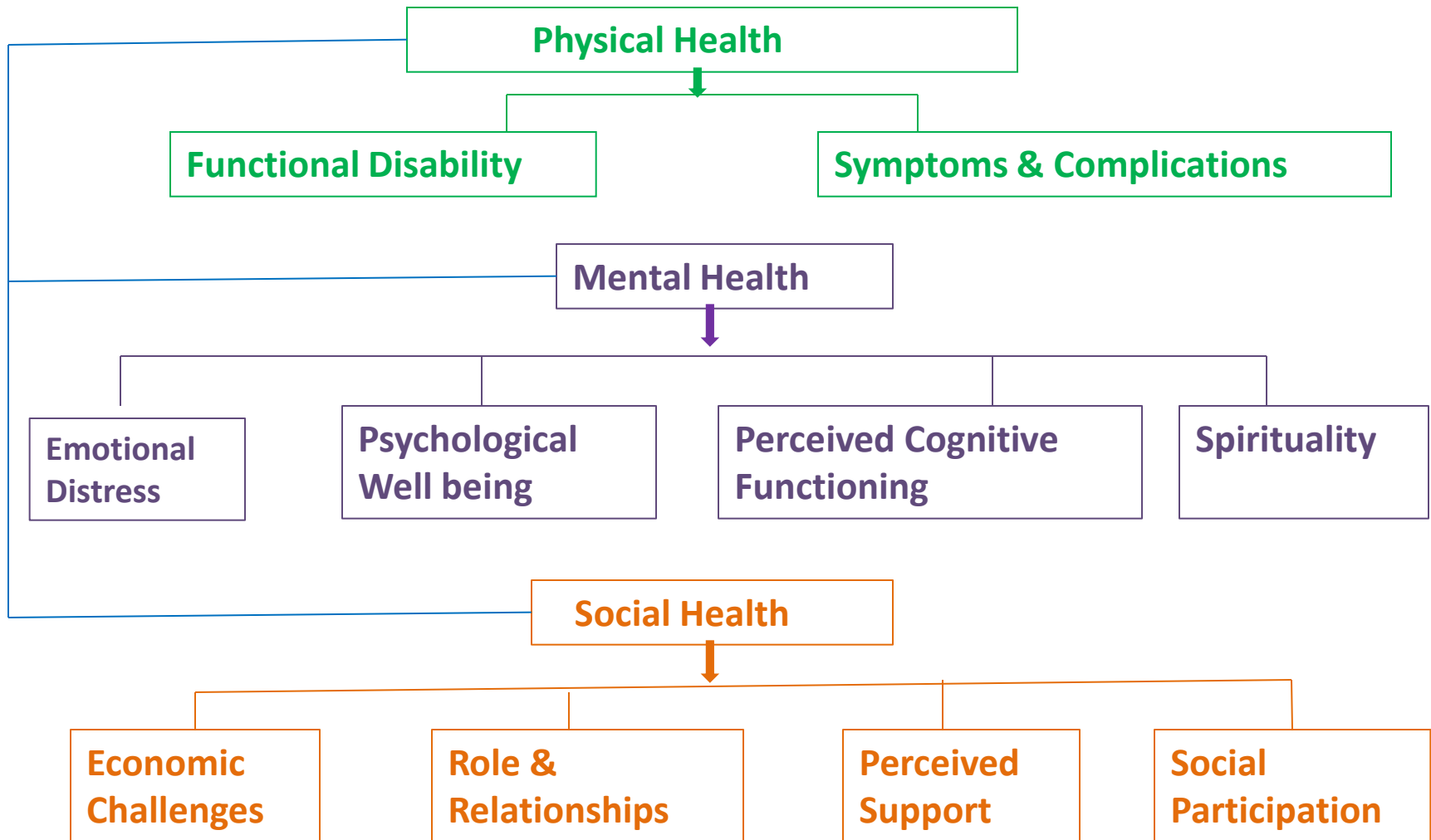
“Cancer patients who feel comfortable communicating with their health care providers report greater satisfaction with their care, a stronger sense of confidence in their abilities to cope with cancer and a better quality of life than patients who were less positive about their communication skills”

Michael Feuerstein (2006)

Why a Care Plan?

- Improving Supportive and Palliative Care Guidelines (2004)
- Priority Action 8 All Parliamentary Group on Cancer Inequalities (2009)
 - All Cancer Patients should receive a regular assessment of their care needs at key points in their cancer journey
 - Ensure that services are better co-ordinated and meet patients needs

Conceptual Framework of Health Related Quality of Life



Assessment Pathway?

Self Assessment

Contact Assessment

Specialist MDT Assessment

Specialist Assessment

Treatment Record Summary

- Copy of the treatment record summary to be forwarded to the GP and given to the patient
- Provided by the consultant and/or by extracting information from the Assessment and Care Plan

Cancer Care Review

- GPs play a pivotal role in providing care in the community
- Cancer Care Review is carried out by the GP at 6 months following diagnosis
- This enables the GP to identify the needs of the patient and their family
- Able to offer information, advice and support.
- QOF points attached to this review



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By assessing and communicating with people living with and beyond cancer we are identifying individual needs and planning for the future whatever their prognosis, faith, gender, sexual orientation, age or disability

World Cafe

- We want your thoughts and ideas
- Each table represents the stages of the care pathway
- You can visit each table as much or little as you like
- Join in the discussions or just leave your comments or thoughts
- **You can write on the table cloth.**

Questions

1. How will assessment and care planning assist in identifying the needs of all cancer patients
2. How does this work for all stages of the care pathway as indicated on your table
3. How will assessment and care planning help to tackle inequalities