Developing a model for providing integrated and seamless personalised care to patients with life limiting conditions

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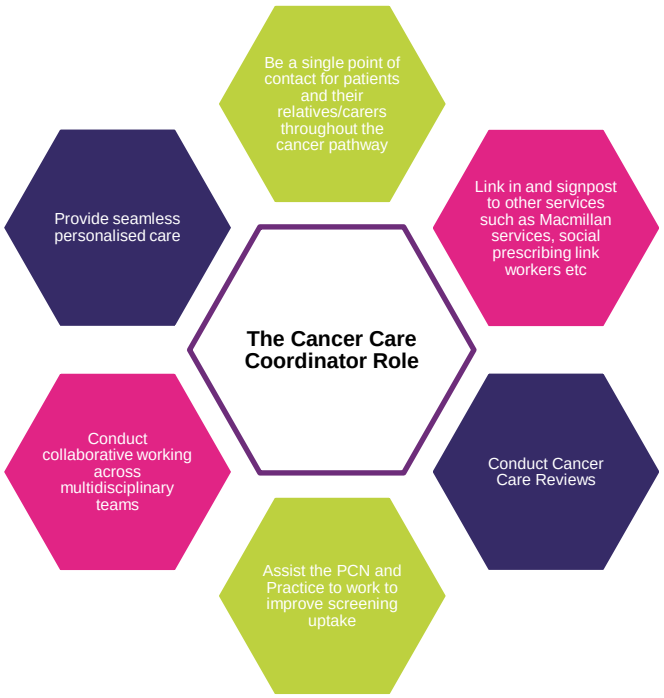
Background and Aims

In response to the Long-Term plan ambition to deliver more person-centred care to all, Greater Manchester Cancer Alliance successfully piloted the role of the Cancer Support Worker (CSW). With over 50 CSWs embedded in cancer teams across GM, this new role supports delivery of elements of the NHS Comprehensive Model of Personalised Care for cancer patients; specifically personalised care and support planning and supported self-management. However, to truly deliver a comprehensive model and provide seamless personalised care to patients, greater links are needed between primary care / community services and secondary care; a concept that is very much supported by patients. The increasing number of cancer survivors has led to an increase in the number of people requiring follow-up care, monitoring and management. Therefore, primary care has an important role in not only supporting early diagnosis, effective referral processes and pathways but also supporting people to live well with and beyond cancer. To address the above, additional capacity is required to implement this standard of care for all patients, therefore our project is piloting the role of the Cancer Care Coordinator (CCC) as a boundary spanning role between primary and secondary care within Primary Care Networks (PCNs) across Greater Manchester.

The Cancer Care Coordinator Role in Primary Care Networks



GM Cancer Alliance are piloting nine CCCs across nine PCNs to support new ways of working. This is an 18-month pilot initiated in April 2022 in collaboration with GM Workforce Collaborative, HEE and Macmillan. Localities involved in the pilot are:

- Stockport
- Salford
- Tameside
- Bury
- Oldham

The time between a referral being made, receiving the first appointment and follow up after cancer treatment is a difficult and anxiety inducing time for patients, and so having a dedicated role to support patients during these times will be an invaluable resource. The pilot project supports to ensure all appropriate patients have a cancer care review, care plan and health/wellbeing information after a cancer diagnosis.

Service user representatives have been involved from the outset of the project, coproducing patient surveys and confirming the need for a point of contact within primary care to support integrated care.

Core Benefits

- Increased referrals to Social Prescribing Link Workers
- One Workforce model for providing seamless personalised care for patients with life limiting conditions
- Supporting the Quality and Outcomes Framework indicators (CAN004 and CS005)
- Meeting the targets set out in the NHS Long Term Plan, including ensuring every person diagnosed with cancer will have access to personalised care
- Increased patient satisfaction
- Increased number of cancer care reviews and reduced variation in quality of cancer care reviews

For more information, please email
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