The Cancer Care Coordinator, an economical version of a CNS or an essential addition to the CNS team in future proofing and ensuring the delivery of high-quality cancer care?

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Role Development

- CCC started December 2019
- Completed competencies & training
- Developed CCC EHNA clinic for all new cancer patients
- Introduced into the wider MDT to ensure collaborative working
- Allocated a CNS who micromanaged development and implementation

COVID-19

- All face to face contact with patients stopped
- CCC triaged large proportion of calls & follow-up patients with close CNS support.
- Blood tests and investigations tracked by the CCC then given to CNS to check, normal results given to patient by the CCC.
- Implementation of a database to enable deferred patient follow-up appointments to be managed effectively. Ensuring patient reassurance & safety.
- Flexible service model - introducing new ways of working to ensure patient confidence and safety and deal with any second wave of COVID-19

Aim of the Project

Promote self care

- Embed the role of the CCC in the CCNS team.
- Challenge preconceived CNS scepticism of the role.
- Provide personalised care & PSFU.
- Reduce routine unnecessary face-to-face follow up appointments.
- Release CCNS time for more complex patients.
- Increase the numbers of EHNA offered.
- Evaluate data.

Results of the CCC role & PSFU

"The role of the CCC is essential for this service moving forward in the current climate"

Fergus Reid Colorectal Consultant and Cancer Lead Stockport

- 58% of CNS follow-up appointments potentially moved to PSFU
- 80% of new patients offered EHNA
- CCC’s EHNA clinics generate income (£52 per appointment)
- 28% of service calls dealt with by CCC

THIS RELEASES CNS TIME TO FOCUS ON MORE COMPLEX PATIENTS NEEDS, SERVICE AND ROLE DEVELOPMENT.

What does this mean to Stockport NHS?

- Reduced face to face clinics free up space for newly diagnosis patients.
- Direct access to the service via CCC phone = reduced A&E & clinic attendance.
- Frees CNS to enable rapid access & triage complex patients needs, this prevents A&E attendance & enables diversion to community management
- Reduces the need for CNS overtime.

Implementation

- CNS led on job specification, shortlisting & interviews.
- Induction program & competency framework for the CCC.
- Establish CCC Clinic for EHNA.
- Training as front of house for patients to receive blood test and investigation results.
- Pathway mapping.
- Collation of data & analysis, reporting to key stakeholders.

Acknowledgements

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How do we know this?

- Patient Feedback

"I cannot think of anything that could have been handled better during the course of my illness and I am so grateful for the care and attention that I received from the most dedicated and capable people."

Analysis

- Somerset Cancer Registry
- Macmillan Activity Tracker
- CNS Database
- Patient satisfaction surveys

What Next?

- Secure funding for continuation of the CCC role.
- Implement the technology to fully roll out PSFU (Infoflex, a remote monitoring IT platform)
- Audit interventions to ensure Colorectal patients receive quality patient-centred care at Stockport.

References

2. NHS England (2019), Universal Personalised Care: Implementing the comprehensive Model.

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