MACMILLAN CANCER CARE NAVIGATION SERVICE

Enhancing patient experience through embedding a Macmillan Cancer Care Navigator within the MDT

AT A GLANCE

- **Project aim:** 18 month pilot between Aug 2021 and Jun 2022 to **improve cancer patient experience** by improving information sharing & communication between the multi-disciplinary team supporting patients.
- **Cohort:** Cancer patients in Tower Hamlets.
- **Personalised Care Team:** Macmillan Cancer Care Navigator (MCCN) embedded as part of the Multi-Disciplinary Team (MDT).
- **Referral:** Community Health Services, GPs or anyone in the virtual MDT.
- **Funding:** Macmillan funded project.
- **Who:** Macmillan in collaboration with Tower Hamlets.

RESULTS

- The service has resulted in **191 referrals** to variety of services.
- Breast cancer and colorectal cancer patients were most common.
- **46%** referrals were received from GPs & **25%** received from community health services.
- Impact report to be shared soon.

THE CHALLENGE

- Patients report having to repeat information about their cancer due to poor communication between all roles in the virtual team surrounding someone living with cancer.

- A clear need to improve communications between the **acute and community setting**.

THE ACTION PLAN

- The MCCN proactively establishes professionals in virtual team and ensures good communication & information sharing for the MDT to function effectively.
- The team **adapted their approach to improve communication with GPs** & to increase referrals from primary care, through sharing project information via GP channels.
- Health Needs Assessments (HNA) are produced by Macmillan to identify **wider social issues** and are completed by the clinical nurse in hospital, then again in the community.
- A personalised support care plan is created and shared with the GP & other professionals in virtual team.
- Clinical concerns are passed to a clinical nurse specialist and the MCCN links to other local & national support services (Macmillan, charities, SP or other agencies) for social needs.
- The MCCN has ongoing contact with the patient, follows up with the GP & virtual team and supports **referrals into community health services** outside hospital or to alternative support via the virtual team.
- Patients are discharged via an agreed process but the MCCN keeps in touch for a period of time.

TIMELINE / NEXT STEPS

- To engage practice nurses & GPs in primary care in the service.
- To focus on **two tumour sites** for receiving referrals.
- The long term plan is for all 12 Care Navigators in each locality to **support other conditions as well as cancer**.
- Aiming to link in with work in Tower Hamlets where GP surgeries are contacting patients as part of three monthly review.

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