Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Cancer Services "Key Worker" Policy

This procedural document supersedes: PAT/PA 15 v.7 – Cancer Services – "

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Executive Sponsor(s):	Chief Nurse
Author/reviewer: (this version)	Lesley Barnett - Deputy Director of Nursing for Cancer, Chemotherapy and End of Life Services
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Target audience:	Trust-wide

Amendment Form

Version	Date Issued	Brief Summary of Changes	Author
Version 8	3rd December 2021	Policy reviewed and rewritten by SYB Lead Cancer Nurses and agreed across SYB Cancer Alliance • Definition key worker added • Expended introduction • New context section added • New section who can be a keyworker • New section on allocation of a keyworker • New section on Documentation and record keeping • Expanded section on role and responsibilities • New Personalise care section	Lesley Barnett
Version 7	26 January 2021	• Policy Reviewed with little change • Standard paragraphs regarding Patients Lacking Capacity added • Standard Data Protection section added	Stacey Nutt
Version 6	July 2017	• Policy changed into new format • Section 3 – Duties and responsibilities is new	Stacey Nutt
Version 5	21 October 2014	• Format updated to new Trust style • Addition of Appendix 2 - Equality Impact Assessment form • New sections added: - Monitoring and Compliance - Equality Impact Assessment	Lesley Barnett

Version 4	Oct 2011	• Review dates etc changed • Section 4 - first new bullet point added and under second bullet point 'nominated' changed to 'confirmed'	Lesley Barnett
Version 3	January 2009	• Added an 'Amendment Form' and 'Contents' page and numbered paragraphs • Minor format changes	Lesley Barnett
Version 2	March 2007	• Patient Audit Tool now developed – page 5 • Addition to key worker role under core responsibilities – page 5 • Name change from Cancer Unit Steering Group to Cancer Locality Steering Group – page 6	Deborah Whitehead and Gillian Horne

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1 INTRODUCTION

This policy is intended to assist Providers and Commissioners to define the role and responsibilities of the Key Worker and suggests appropriate Health Care Professionals to undertake the role during different stages of the cancer pathway (Appendix A).

The Key Worker policy provides a framework for "Key Worker" roles, utilising best practice and a consistent approach across South Yorkshire and Bassetlaw Cancer Alliance (SYBCA) to provide a seamless service to those affected by cancer.

The Key Worker role has been pivotal to the cancer patient pathway since its inception in 1995 (Calman Hine)[1] and has continued to evolve with the ambition to enhance and deliver a first class service to people affected by cancer and their families.

The identification of a Key Worker is a pre-requisite of the cancer site-specific Multi-Disciplinary Team (MDT) National Quality Surveillance indicators. This may change throughout the pathway from the suspicion of cancer.

Definition of the Key Worker; *"A person who, with the patient's consent and agreement, takes a key role in co-ordinating the patients care and promoting continuity, ensuring the patient knows who to access for information and advice"* NICE (2004)[2]

Care for people with cancer or when cancer is suspected is often complex and may involve input from different health professionals working in primary care, secondary care and specialist centres as well as the voluntary and third sectors. Effective communication and co-ordination of care is essential to provide high quality patient centred care and a seamless service to those affected by cancer. It is suggested that people find times of their cancer experience challenging, for example:

- When cancer is suspected
- At diagnosis
- During treatment
- The period immediately following completion of treatment
- During relapse of disease
- When end of life is approaching

Ensuring that individualised person-centred care is well co-ordinated at both strategic and operational levels will lead to improved quality of life for those affected by cancer and higher satisfaction with services. Co-ordination is required to ensure that services work together with no loss of continuity. This co-ordinating role is central to the person's cancer pathway by providing specialist information, support and guidance.

The 2019 National Cancer Patient Experience survey (CPES) results demonstrate the at the number of people who report having the name of a clinical nurse specialist (CNS) (Q.19) was 92% nationally with CPES showing that people who have access to a clinical nurse specialist have a more positive experience across nearly all areas of treatment and care.

2 PURPOSE

- To define the role of the Key Worker
- To define who/which Health Care Professions would be appropriate to be a Key Worker
- To outline the responsibilities of the Key Worker
- To ensure the specialist multi-disciplinary teams incorporate the Key Worker role into operational policies and clinical practice where applicable
- To provide a model for use across the East Midlands Cancer Alliance

3 CONTEXT

In most cases the CNS is the Key Worker for people affected by cancer across the whole of their treatment pathway. CPES results show there is however, an inequity in provision of CNSs, as people with rare and less common cancers are less likely to have access to a CNS, therefore less likely to feel supported and empowered to make informed decisions about their treatment and care as they move through the pathway, consequently they are more likely to report a significantly worse experience of care. With the additional pressures on the CNS workforce including:

- An increasing incidence of cancer
- Improved survival rates[3]
    - The number of people living with and beyond a cancer diagnosis in England is set to rise from 2 million, to almost 4 million in 2030 and by 2040, almost a quarter of people aged at least 65 will be cancer survivors.[4]
- Ageing population – 70% of those with cancer are likely to have another long-term condition
- Ageing CNS workforce and vacancies - 38% of CNSs are aged 50 and over in 2017 compared to 33% in 2014[3]
- It's estimated that around 20-30% of CNS time is used on administrative tasks and specialist skills are not being optimised [5]

The growing demand means that roles such as Cancer Support Workers, and other allied professionals are also known to provide "keyworker" support to people affected by cancer.

With the Faster Diagnosis Standard there are ever evolving roles within Primary Care, Care Coordinators, Health and Well-being coaches and in secondary care, Care Navigator roles who provide the role of a keyworker to support early diagnosis of cancer or not within 28 days of referral.

The Cancer Strategy 'Achieving World Class Cancer Outcomes - 2015-20[5] recognised the need for all people diagnosed with cancer to have access to a Cancer Nurse Specialist (CNS) or a Key Worker, and for this to be available through a greater part of their cancer pathway to help coordinate their care.

> **Recommendation 61:** NHS England and the Trust Development Authority should encourage providers to ensure that all patients have access to a CNS or other key worker from diagnosis onwards, to guide them through treatment options and ensure they receive appropriate information and support.
>
> In parallel, NHS England and Health Education England should encourage providers to work with Macmillan Cancer Support and other charities to develop and evaluate the role of support workers in enabling more patient centred care to be provided.
>
> The Cancer Strategy 'Achieving World Class Cancer Outcomes - 2015-20[6]

Keyworkers are a lynch pin for people with cancer enabling the following NHS Long Term Plan ambitions to be fulfilled:

> By 2021, where appropriate every person diagnosed with cancer will have access to personalised care, including needs assessment, a care plan and health and wellbeing information and support. This will be delivered in line with the NHS Comprehensive Model for Personalised Care.
>
> NHS Long Term Plan 7

4 DUTIES AND RESPONSIBILITIES

- **Cancer Clinicians**
  - Have a responsibility to ensure patients with a new cancer diagnosis are provided with the name of their key worker and are aware of how to contact them.

- **Cancer Clinical Nurse Specialists**
    - Will take on the role of key worker for patient's diagnoses with cancer and assume the role of keyworker
    - The CNS must inform the patient if the name of their key worker changes to someone else.
- **Lead Cancer Nurse**
    - Ensure all elements associated with the Cancer Quality Surveillance process are met in reference to the key worker.

5 WHO CAN BE A KEYWORKER

This is usually the Site-Specific CNS at the point of diagnosis but may change depending on the individual needs of the person and where they are in the cancer pathway. For instance, the GP is the Key Worker when someone initially consults them and the GP suspects cancer.

The most appropriate people to be a Key Worker at points of the cancer pathway includes:

- General Practitioners or additional Primary Care Network staff such as Care Co-ordinators, Health and Wellbeing Coaches within the diagnostic part of the pathway.
- Cancer Nurse Specialists/Advanced Nurse Practitioner/Consultant Nurses
- Allied Health Professionals E.g.: Therapeutic Radiographers
- District Nurses/Advanced Care Practitioners/Community Matrons
- Practice Nurses
- A member of the Specialist Palliative Care Team

Cancer Support Workers may, under the direction and supervision of a CNS, undertake less complex keyworker activity for people with cancer. See section 8 core keyworker responsibilities for more detail.

6 ALLOCATION OF A KEYWORKER

- The allocation of a Key Worker occurs at the point of diagnosis though in some instances this may be during the diagnostic stage. Developing roles within Primary Care such as Care Coordinators and Health and well -being coaches sees the identification of a "keyworker" occur from referral from GP. These roles act as keyworker and navigator through the diagnostic part of the pathway. These developing roles within Primary Care should be supported by a health care professional with appropriate knowledge and skills such as GP, Practice Nurse or associated PCN clinical role.
- The developing roles of the Care Navigator within secondary care sees the transition of Key worker from Primary Care into secondary care where a single point of contact

is provided for patients within the diagnostic setting. This is to ensure patients are supported from the beginning of the pathway.

- Once a person receives a diagnosis the role of the Key Worker is introduced to the person at or as soon after diagnosis as possible
- Within Secondary Care the Key Worker will usually be the Site-Specific Clinical Nurse Specialist (CNS) (this includes Advanced Nurse Practitioner/ Consultant Nurses). Alternatively, the role may be undertaken by a Healthcare Professional (HCP) appropriately equipped to meet the person affected by cancer/carers individual needs
- People with cancer must have an allocated Key Worker throughout their cancer pathway irrespective of the care setting. The name of the Key Worker MUST be identified and communicated to the person and their family/carers' as well as documented in the relevant clinical record.

7 CHANGES TO ALLOCATED KEY WORKER

The Key Worker may change during the cancer pathway depending on the individual needs of the person. When handover of the Key Worker role is indicated, it must be done in full consultation with the person and the family/carer where appropriate.

A clear handover from one Key Worker to another is essential to ensure continuity of care and a seamless service for patients/carers. This should include their personalised care and support plan (PCSP). Changes must be kept to a minimum as the value of continuity of care cannot be over emphasised (Calman-Hine 1995)1

In the absence of the identified Key Worker an appropriate Health Care Professional will ideally provide appropriate "cover" to ensure continuity of care. To maintain continuity of care and a seamless service across the pathway for persons affected by cancer, it is essential that there is a formal handover of the persons personalised care and support plan

8 DOCUMENTATION AND RECORD KEEPING

• The name and contact details of the Health Care Professional must be recorded and evidenced in persons' records with reference to the term Key Worker.
• It is imperative that Key Worker details are recorded in the persons clinical records.
• The person and their family/carer (where appropriate) will be informed of the name of the Key Worker verbally and will be provided with the name and contact details of the Key Worker in writing.

Auditing the role of the keyworker occurs through a number of processes:-

Within Primary Care and the new developing roles within the diagnostic part of the pathway there is a current pilot taking place to evaluate these roles in supporting the faster diagnosis work. This includes patient feedback forms of their experience of the 28 day faster diagnosis standard (FDS) part of the pathway and FDS referral audits for Care coordinators to complete ensuring they are using the Cthesigns referral tool and checking all 2week wait referrals are sent to secondary care complete reducing delays in the pathway.

Within secondary care the role of the Care Navigators as single point of access/Key worker is again being evaluated through patient feedback forms and patient stories to support the development of these roles.

The effectiveness of the Keyworker role (when undertaken post diagnosis by a CNS/CSW) is audited through the National Cancer Patient Experience Survey where survey results are used to inform service improvements. As part of Quality Surveillance allocation and identification of a keyworker forms a part of the reportable MDT indicators. There are local audits that take place in the form of patient feedback questionnaires and patient engagement events.

9 KEYWORKER CORE RESPONSIBILITIES

The Key Worker core responsibilities can be carried out by a number of roles as referred to in section 4 and may include the following:

- Introducing themselves to the person and ensure that the person and family/carer have their contact details
- To coordinate the person's care and act as their first point of contact for the person when specialist advice and support is needed
- Advising the person how to contact their Key Worker – such as virtually (e-mail, video conferencing), telephone support, clinic visits or visits to the clinical area
- Act as an on-going point of contact for the person and their family/carers
- Ensure people are offered personalised care and support along their cancer pathway whether they are passive recipients or active participants in their care
- Support people in the development of self-management strategies
- Support the person affected by cancer in making informed decisions
- Refer the person on to other agencies/services where appropriate to meet their individual needs
- Act as an advocate for the person affected by cancer and where relevant offer insight into the concerns and wishes of the person
- Promote continuity of care and manage transitions of care throughout the persons cancer pathway and across organisational boundaries

• Provide verbal and written information to meet peoples /carers individual needs
• To offer Holistic Needs Assessments (HNA) to the person to complete at defined points in the pathway. A completed HNA will highlight the most important concerns to the person at that time that need to be addressed before, during or after treatment.
• Access one hour's clinical supervision monthly as defined by the National Quality Surveillance indicators if trained at level 2 as above
• To ensure that any change of Key Worker is done in full consultation with the person and family/carer and that the person is provided with revised contact details.
• To ensure that the next Key Worker has the appropriate information about the person to fulfil the role
. • To encourage the person affected by cancer to live actively and well following the end of their cancer treatment

Roles unique to a CNS in a Key Worker capacity also include:

• Be a recognised Level 2 practitioner on completion of level 2 training for non-psychology trained health care professionals in the assessment of the holistic needs of adults living with and beyond cancer , providing psychological support and identifying and referring people with complex needs, to the Clinical Psychologist/ Psychiatrist as defined by the National Quality Surveillance indicators. This training is in addition to attendance on the National Advanced Communication course.
• The CNS will use information from the HNA to develop and agree a personalised care and support plan in consultation with the person affected by cancer.
• Ensure people are offered health and wellbeing and support information (HWBSI)
• Contribute to MDT discussions and patient assessment/care planning decisions of the team including ensuring the persons most recent HNA results are considered appropriately in MDT decision making
• Ensure people are offered entry into clinical trials where available
• Contribute to the management and leadership of the service –
• Lead/participate in research and audit to enhance patient care
• Act as a resource, providing specialist advice related to the tumour type

9.1 The Role of a Cancer Support Worker

The term Cancer Support Workers (CSW) is used in this document however it also includes the roles of Cancer Navigators. CSW's often work as part of the cancer care team alongside registered practitioners, usually a Clinical Nurse Specialist (CNS). They can support with delegated non-complex tasks to enable the CNS to focus their expertise on managing the complex care needs of people affected by cancer at different points of the pathway.

This includes patients who are: -

- being investigated for a cancer diagnosis
- receiving treatment for their cancer
- living with and beyond cancer following treatment

Support Worker activities may include: -

- Coordinating care or provide a single point of access for people affected by cancer to easily re-enter the system when they need to.
- The role, which is focused on a partnership with the person affected by cancer, allows the support worker to empower the person to self-manage
- They can provide appropriate advice and escalate any issues to a specialist where necessary
- Direct liaison with patients on optimal pathways to facilitate planned diagnosis (e.g. ordering wheelchairs/equipment; coordinating appointments with patients; organising referrals)
- Supporting people to undertake a holistic needs assessment
- Providing advice and support within outpatient clinics to free up consultant/nurse led clinic time.
- Triage telephone calls that come into the CNS service
- Provide general information, help and support
- Support the development, implementation and evaluation of dedicated Health & Wellbeing events

There may be locally agreed variation to these activities

10 PERSONALISED CARE PACKAGE

The Key Worker will actively promote personalised care to the person affected by cancer.

There are four elements to the personalised care package (previously known as the Cancer Recovery Package)

a) Personalised Care and Support Plan (PCSP) based on a Holistic Needs Assessment (HNA)

The Key Worker will offer a Holistic Needs Assessment to the person affected by cancer / their carers at key stages of the patient pathway. These are often:

- Around the time of diagnosis
- Commencement of treatment (if appropriate)
- Completion of treatment
- Disease Recurrence
- End of Life Care
- At the persons request without any explanation

The other elements of the personalised care package which may involve the Key Worker are:

b) Health and Wellbeing Support and Information (HWBSI)

c) Treatment Summary (TS)

d) Cancer Care Review (CCR)

Further details are in Appendix B

11 PROCEDURE

PATIENTS LACKING CAPACITY

Sometimes it will be necessary to provide care and treatment to patients who lack the capacity to make decisions related to the content of this policy. In these instances staff must treat the patient in accordance with the Mental Capacity Act 2005 (MCA 2005).

- A person lacking capacity should not be treated in a manner which can be seen as discriminatory.
- Any act done for, or any decision made on behalf of a patient who lacks capacity must be done, or made, in the persons Best Interest.
- Further information can be found in the MCA policy, and the Code of Practice, both available on the Extranet.

There is no single definition of Best Interest. Best Interest is *determined on an individual basis. All factors relevant to the decision must be taken into account, family and friends should be consulted, and the decision should be in the Best interest of the individual. Please see S5 of the MCA code of practice for further information.*

12 TRAINING/SUPPORT

- The Key Worker must have post-registration training and education in advanced communication and/or counselling skills.
- The Key Worker must have knowledge of cancer and its treatments
- The Key worker is responsible for identifying any other training needs required in relation to fulfilling this role.
- The Key worker must be either a recognised core-member of the relevant cancer/ specialist palliative care MDT or a member of the patient's primary health care team.
- Be a recognised Level 2 practitioner on completion of level 2 training for non- psychology trained health care professionals in the assessment of the holistic needs of adults living with and beyond cancer

Please note: The training requirements of staff will be identified through a learning needs analysis (LNA). Role specific education will be co-ordinated/ delivered by the topic lead. Alternatively, training may be accessed via an approved e-learning platform where available.

13 MONITORING COMPLIANCE WITH THE PROCEDURAL DOCUMENT

What is being Monitored	Who will carry out the Monitoring	How often	How Reviewed/ Where Reported to
Patient experience- SURVEY/FOCUS GROUP	Cancer Quality Surveillance Team	Annual	Reported to Lead Cancer Nurse and CMT
Patients Experience and allocation of keyworker	National Cancer Patient Experience Survey	Annual	Reported to Lead Cancer Nurse and CMT,PEIC

14 DEFINITIONS

ANP	Advanced Nurse Practitioner
CCR	Cancer Care Review
CNS	Clinical Nurse Specialist
CPES	National Cancer Patient Experience Survey
EMCA	East Midlands Cancer Alliance
HCP	Healthcare Professional
HNA	Holistic Needs Assessment
HWBSI	Health and Wellbeing and Support Information

MDT	Multidisciplinary Team
PCSP	Personalised Care and Support Plan
TS	Treatment Summary

15 EQUALITY IMPACT ASSESSMENT

The Trust aims to design and implement services, policies and measures that meet the diverse needs of our service, population and workforce, ensuring that none are disadvantaged over others. Our objectives and responsibilities relating to equality and diversity are outlined within our equality schemes. When considering the needs and assessing the impact of a procedural document any discriminatory factors must be identified.

An Equality Impact Assessment (EIA) has been conducted on this procedural document in line with the principles of the Equality Analysis Policy (CORP/EMP 27) and the Fair Treatment For All Policy (CORP/EMP 4).

The purpose of the EIA is to minimise and if possible remove any disproportionate impact on employees on the grounds of race, sex, disability, age, sexual orientation or religious belief. No detriment was identified.

16 ASSOCIATED TRUST PROCEDURAL DOCUMENTS

This policy must be used in conjunction with

- PAT/PA 19 – Mental Capacity Act 2005 – Policy and Guidance, including Deprivation of Liberty Safeguards (DoLS)
- PAT/PA 28 – Privacy and Dignity Policy
- CORP/EMP 4 - The Fair Treatment for All Policy
- CORP/EMP 27 - Equality Analysis Policy

17 DATA PROTECTION

Any personal data processing associated with this policy will be carried out under 'Current data protection legislation' as in the Data Protection Act 2018 and the UK General Data Protection Regulation (GDPR) 2021.

For further information on data processing carried out by the trust, please refer to our Privacy Notices and other information which you can find on the trust website: https://www.dbth.nhs.uk/about-us/our-publications/information-governance/

18 REFERENCES

Department of Constitutional Affairs Mental Capacity Act (2005): Code of Practice, 2007 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/497253/Mental-capacity-act-code-of-practice.pdf

1 Calman-Hine Report: A Policy Framework for Commissioning Cancer Services: A Report by the Expert Advisory Group on Cancer to the Chief Medical Officers of England and Wales (1995).

2 Leary, A. and Oliver, S. Clinical nurse specialists: adding value to care. Royal College of Nursing. 2010. (ref 30% admin)

3 Maddams J et al. 'projections of cancer prevalence in the United Kingdom, 201-2040. Br. J. Cancer 107:1195-1202 (2012) https://www.ncbi.nlm.nih.gov/pubmed/22892390

4 National Institute for Clinical Excellence (2004). Guidance on cancer services: improving supportive and palliative care for adults with cancer. The manual. London: National Institute for Clinical Excellence.

5 NHS (2019) The NHS Long Term Plan. NHS, Available at https://www.longtermplan.nhs.uk/online

6 CSW Impact brief https://www.macmillan.org.uk/_images/Support-Workers_tcm9-283189.pdf

7 Macmillan Competency Framework for Nurses supporting people living with and affected by cancer (2020)

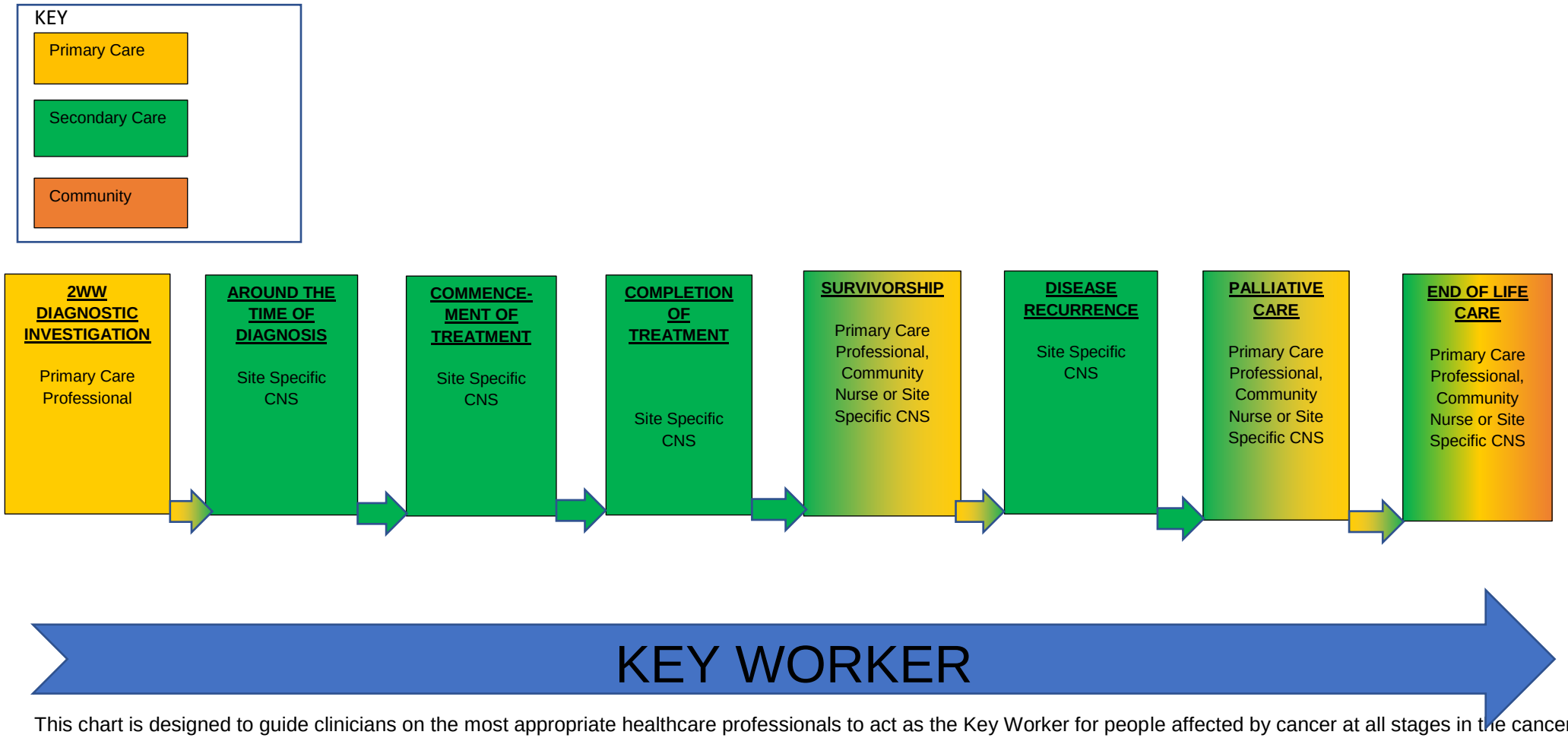
https://www.macmillan.org.uk/_images/competency-framework-for-nurses_tcm9-297835.pdf

8 Maddams J et al. 'projections of cancer prevalence in the United Kingdom, 201-2040. Br. J. Cancer 107:1195-1202 (2012) https://www.ncbi.nlm.nih.gov/pubmed/22892390

National Institute for Clinical Excellence (2004). Guidance on cancer services: improving supportive and palliative care for adults with cancer. The manual. London: National Institute for Clinical Excellence.

NHS (2019) The NHS Long Term Plan. NHS, Available at

APPENDIX 1 – KEY WORKER SUPPORT FOR PEOPLE LIVING WITH CANCER



This chart is designed to guide clinicians on the most appropriate healthcare professionals to act as the Key Worker for people affected by cancer at all stages in the cancer pathway. In most cases the hospital site specific Clinical Nurse Specialist will be the Key Worker during the acute treatment stages. The Primary Care Professional, working in collaboration with other professionals, may be the Key Worker when patients are in the community. At the End Of Life the Key Worker may change depending on the care setting, i.e. home, hospice, hospital.

The role of the voluntary sector is NOT reflected here in supporting people affected by cancer

APPENDIX 2 – PERSONALISED CARE AND SUPPORT PLAN PACKAGE

1. Personalised Care and Support Plan informed by a Holistic Needs Assessment

The Holistic Needs Assessment (HNA) informs the development of a Personalised Care and Support Plan (PCSP) for the individual following discussions with their CNS or key worker. It assesses the physical, practical, emotional, spiritual and social needs of the person and highlights the most important issues at that time that need to be addressed during or after treatment.

PCSPs should be completed and agreed by the CNS and the individual.

The Key Worker will offer a Holistic Needs Assessment of the patients/carers needs at key stages of the patient pathway. These are often:

- Around the time of diagnosis
- Commencement of treatment (if appropriate for patient care)
- Completion of treatment
- Disease Recurrence
- End of Life Care
- At the persons request without any explanation

2. Health and Wellbeing Support and Information (HWBSI)

All individuals will have access to health and wellbeing support and information. This support may be in the form of an event where there is education and support sessions aimed to provide individuals with the information and reassurance to build the confidence they require to enable them to lead as normal and active life as possible after their cancer treatment.

These sessions may also aim to increase awareness of the local facilities, supportive care and opportunities that are available to them and their families and to promote collaboration between service providers to ensure sustainability of this essential element of supported self-care.

In summary, health and wellbeing information and support **may** be delivered as: 1:1 appointments, rolling programmes or group events

Signposting and access to local services for cancer as a long-term condition health and wellbeing management - On line tools and support – examples include: https://www.cancercaremap.org/ and https://www.macmillan.org.uk/

3. Treatment Summary (TS)

A treatment Summary (TS) is a document produced by a healthcare professional after a significant phase of an individual's cancer treatment. It is designed to be shared with the person living with cancer and their primary care team, to enable them to manage their health and wellbeing. The TS and PCSP can inform and support effective Cancer Care Reviews.

4. Cancer Care Review (CCR)

An individual's GP practice offers a Cancer Care Review (CCR) to them approximately six months after diagnosis. The CCR is a holistic conversation between the individual and their healthcare professional in their GP practice. It is aided by the HNAs, PCPS and TS. It allows an opportunity for the individual to raise any concerns that may be affecting their quality of life, taking into account their existing conditions and medication and enables individuals to discuss their cancer experience and supports them to manage their own health and wellbeing. The GP Practice can support individuals expressing concerns during their review and signpost them to services such as social prescribing.

APPENDIX 3 – COMPETENCIES FOR KEY WORKER ROLE

- Work as an integral member of the multi-disciplinary team to ensure continuity of patient care.
- Initiate and participate in case conferences with all professionals involved in the delivery of patient care.
- Communicate and co-ordinate information to patients' and carers, evaluating their levels of understanding and utilising a range of skills/techniques to overcome any communication difficulties.
- Demonstrate ability to verbally summarize patient information to facilitate understanding.
- Act as an advocate for the patient who has or may have cancer.
- Act as a communication resource and co-ordinator for other members of the multi-professional team in the care of the key worker's patient caseload.
- In conjunction with the MDT, provide patients' with comprehensive information on the options available to them for treatment and care. Utilize their specialist knowledge and skills regarding disclosure of information.
- Co-ordinate the onward referral of patient and/or family members to appropriate clinical or support services.
- Ensure accurate follow-up documentation is maintained including any changes in the named key worker.
- Utilize support strategies and interventions available to care for patients with complex needs, e.g. patient exhibiting denial/anger following a cancer diagnosis, adverse reactions to alteration in body image.
- Demonstrate their knowledge of holistic cancer care relating to areas such as screening, curative and palliative treatment, spiritual care, aspects of nutrition and pharmacology, rehabilitation, discharge and collaborative working.
- Initiate appropriate referral or access to sources of specialist support for those experiencing for e.g. sexual or fertility difficulties as a result of their illness or treatment.

- Utilize all forms of patient information to enable the patient to have a better understanding of their diagnosis and treatment plan. This will include the use of specific resources for patient/carers from minority groups.
- Facilitate the development of teaching and learning skills used to educate patients and other personnel.

- Contribute to the monitoring, audit and evaluation of adherence to policy/procedures/ guidelines and standards of practice, initiating changes where appropriate to improve delivery of care to patients/carers within the MDT.
- Ability to recognize abnormal grief reactions and refer onto appropriate agencies and healthcare professionals.
- A comprehensive knowledge of the assessment, care, management support, training education and information requirements for patients receiving chemotherapy or radiotherapy and their carers and treatment for related complications across the care pathway for the particular specialty area
- Assess and provide support that is appropriate to the context and sensitive to meet the patient/carer and/or family's needs, facilitating access to additional support from other healthcare professionals or agencies as applicable and with the agreement of the patient and/or carer.
- Understand the ethical issues relating to treatment in advanced disease.
- Have sufficient knowledge and links with national/local support groups and be able to provide/record information relating to these groups to guide and advise patients.
- Providing information, education and relevant telephone contacts to patients and carers regarding the procedures and side effects of chemotherapy and general radiotherapy such as fatigue and skin reactions.
- Be knowledgeable about the management of common side effects for treatments associated with the client group encountered in their practice.
- Be aware of local contact arrangements in the event of patients experiencing unwanted side-effects.
- Demonstrate knowledge to prepare, inform and educate patients/carers for survivorship and where applicable, primary care personnel regarding any associated care requirements, symptom management and contact details on discharge.
- Participate in inter-professional/inter-agency evaluation and audit to effect change for the continued improvement of the quality of care and service for patients.

APPENDIX 4 - EQUALITY IMPACT ASSESSMENT PART 1 INITIAL SCREENING

Service/Function/Policy/Project/Strategy	Care Group/Executive Directorate and Department	Assessor (s)	New or Existing Service or Policy?	Date of Assessment
Key Worker Policy PAT/PA 15 v8	Cancer Services	SYB Lead Cancer Nurses	Existing	October 21

1) Who is responsible for this policy? SYB Cancer Alliance Lead Cancer Nurses

2) Describe the purpose of the service / function / policy / project/ strategy? All adult patients with a cancer diagnosis

3) Are there any associated objectives? National QST standard

4) What factors contribute or detract from achieving intended outcomes? Workforce

5) Does the policy have an impact in terms of age, race, disability, gender, gender reassignment, sexual orientation, marriage/civil partnership, maternity/pregnancy and religion/belief?

- **If yes, please describe current or planned activities to address the impact** [e.g. Monitoring, consultation]

6) Is there any scope for new measures which would promote equality? n/a

7) Are any of the following groups adversely affected by the policy?

Protected Characteristics	Affected?	Impact
a) Age	No	
b) Disability	No	
c) Gender	No	
d) Gender Reassignment	No	
e) Marriage/Civil Partnership	No	
f) Maternity/Pregnancy	No	
g) Race	No	

h) Religion/Belief	No	
i) Sexual Orientation	No	

8) Provide the Equality Rating of the service / function /policy / project / strategy – tick (✓) outcome box

Outcome 1	Outcome 2	Outcome 3	Outcome 4

If you have rated the policy as having an outcome of 2, 3 or 4, it is necessary to carry out a detailed assessment and complete a* **Detailed Equality Analysis form in Appendix 4

Date for next review: October 2024

Checked by: SYB Cancer Alliance Lead Cancer Nurses **Date: October 21**