Tower Hamlets Living With Cancer Programme

Macmillan Local Authority Partnership

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TOWER HAMLETS

MACMILLAN CANCER SUPPORT

Video clip – setting the scene

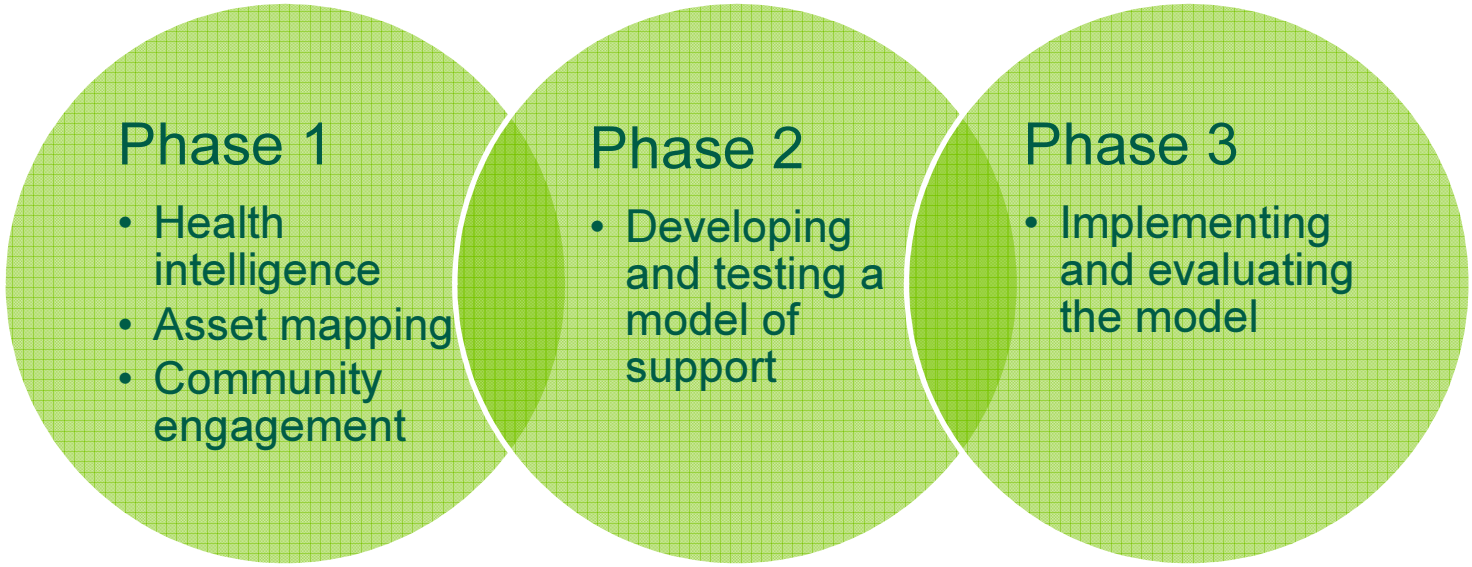
https://vimeo.com/239621401

What is the Tower Hamlets Living with Cancer Programme?

A £1 million partnership between Tower Hamlets Council and Macmillan, also involving NHS and voluntary sector partners.

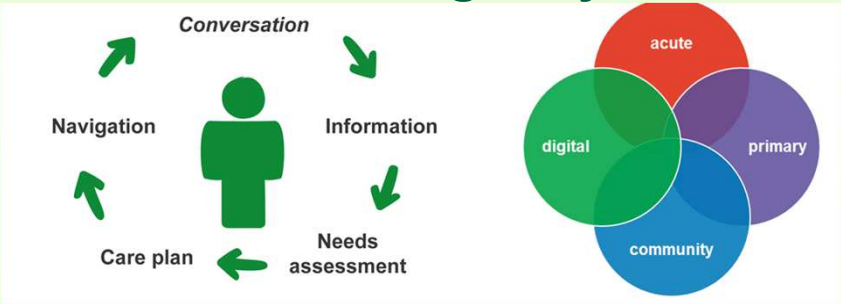
The partners will:

- Co-design new services and support
- Achieve a more joined up approach between existing services and systems
- Ensure this is sustainable

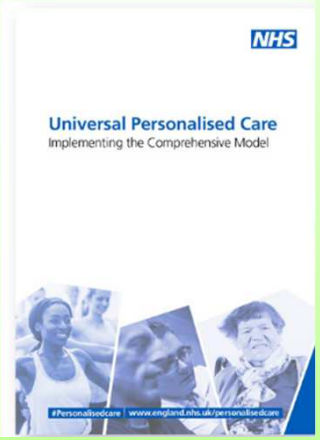


Alignment with national and local strategy

Macmillan 'Right by You'

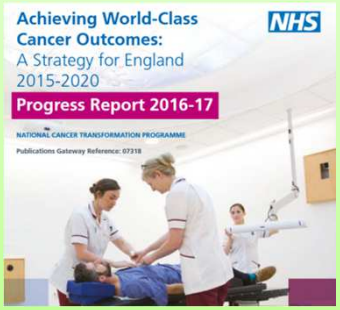


NHS Personalisation agenda



Tower Hamlets Living with Cancer Programme

National Cancer Strategy 2015-20



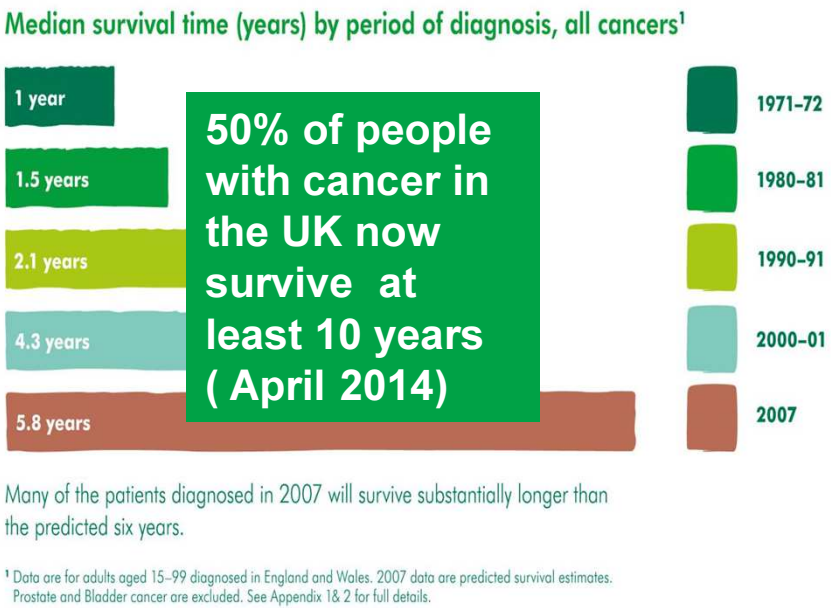
LBTH local transformation:

- Information, Advice and Guidance
- Adult Social Care
- Social prescribing
- Care coordination

Why is this important?

Increasing number of people living with cancer, for an increasing number of years

- Cancer needs to be recognised as a long term condition
- Not everyone has a good quality of life – many long term consequences
- 72% of people living with cancer in Tower Hamlets have another long term condition

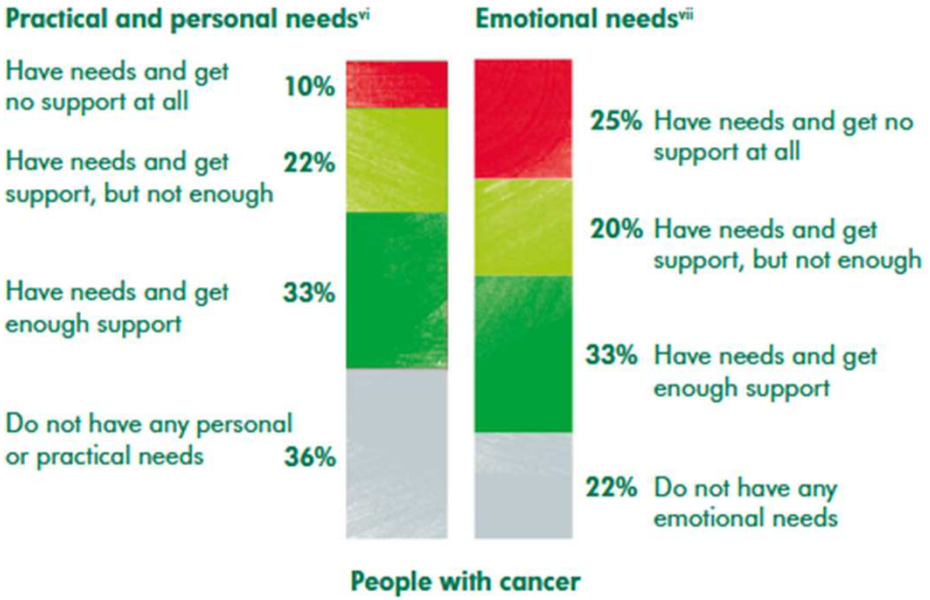


Why is this important? - evidence

Evidence from the Nuffield Trust shows that 15 months after diagnosis, cancer patients have:

- 60% more A&E attendances
- 97% more emergency admissions
- 50% more contact with their GPs than a comparable group.

Macmillan's evidence on the social care needs of people with cancer:

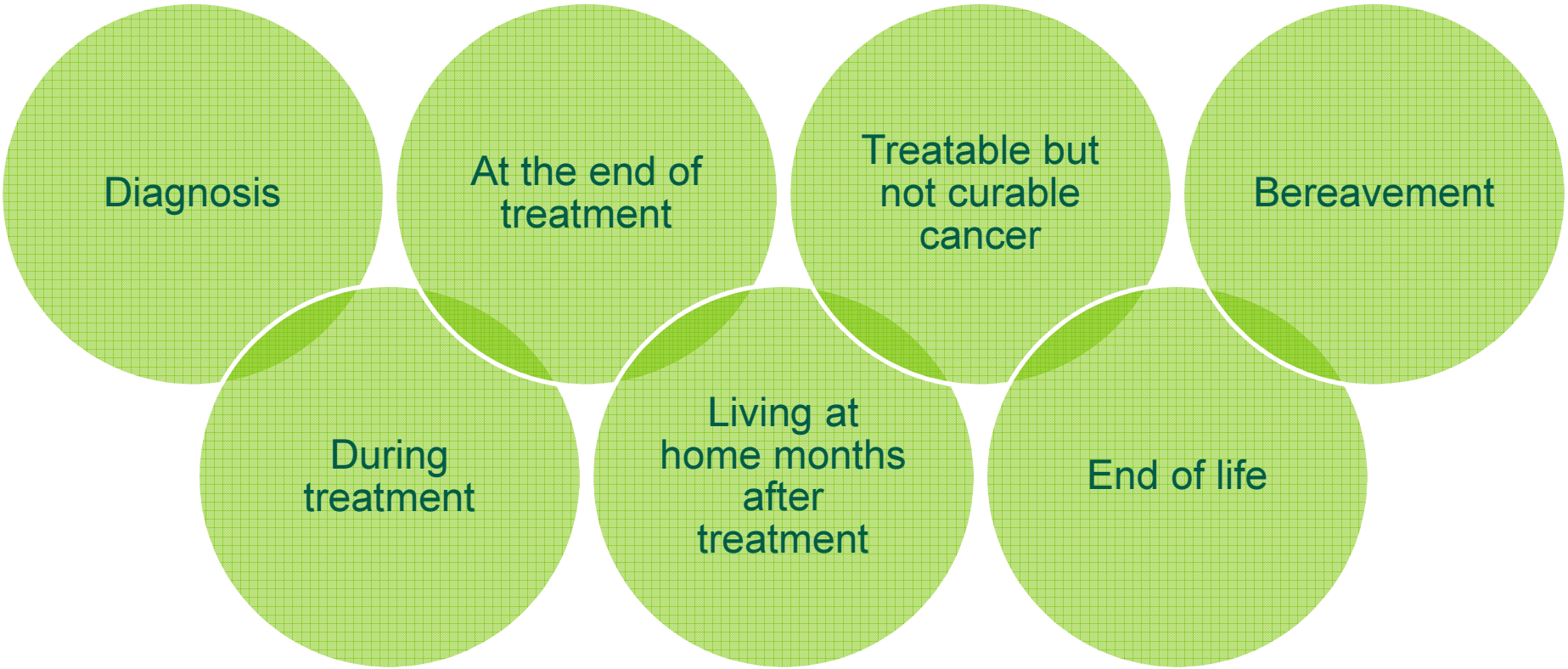


References and online links:

1. Chitnis X, Steventon A, Glaser A and Bardsley M (2014) Use of health and social care by people with cancer. Research report. Nuffield Trust.
2. Hidden at home – the social care needs of people with cancer (2015). Research report commissioned by Macmillan Cancer Support.

Our findings and reflections from insight gathering and asset mapping to date…

People need support at the right time, and their needs change over time



The team around the person

Social prescriber

Physiotherapist

Pharmacist

Macmillan Information & Support Manager

Look Good, Feel Better facilitator

Peer support group

Occupational therapist

Psychologist

Clinical Nurse Specialist

Specialist housing advisor

GP

Benefits & finance advisor

Friends and neighbours

Oncologist

Surgeon

Radiographer

Yoga instructor

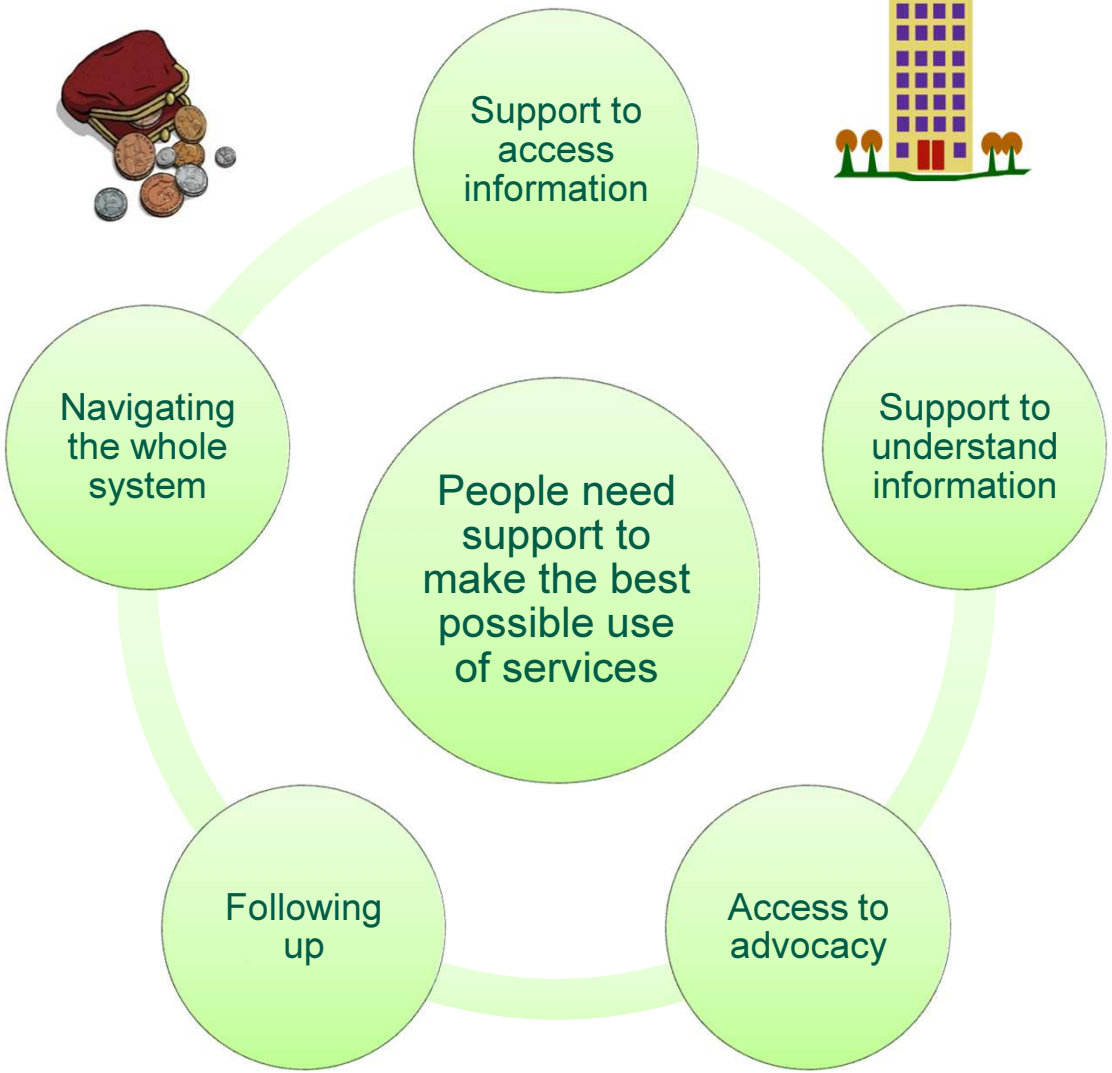
Social worker

Macmillan Support Worker

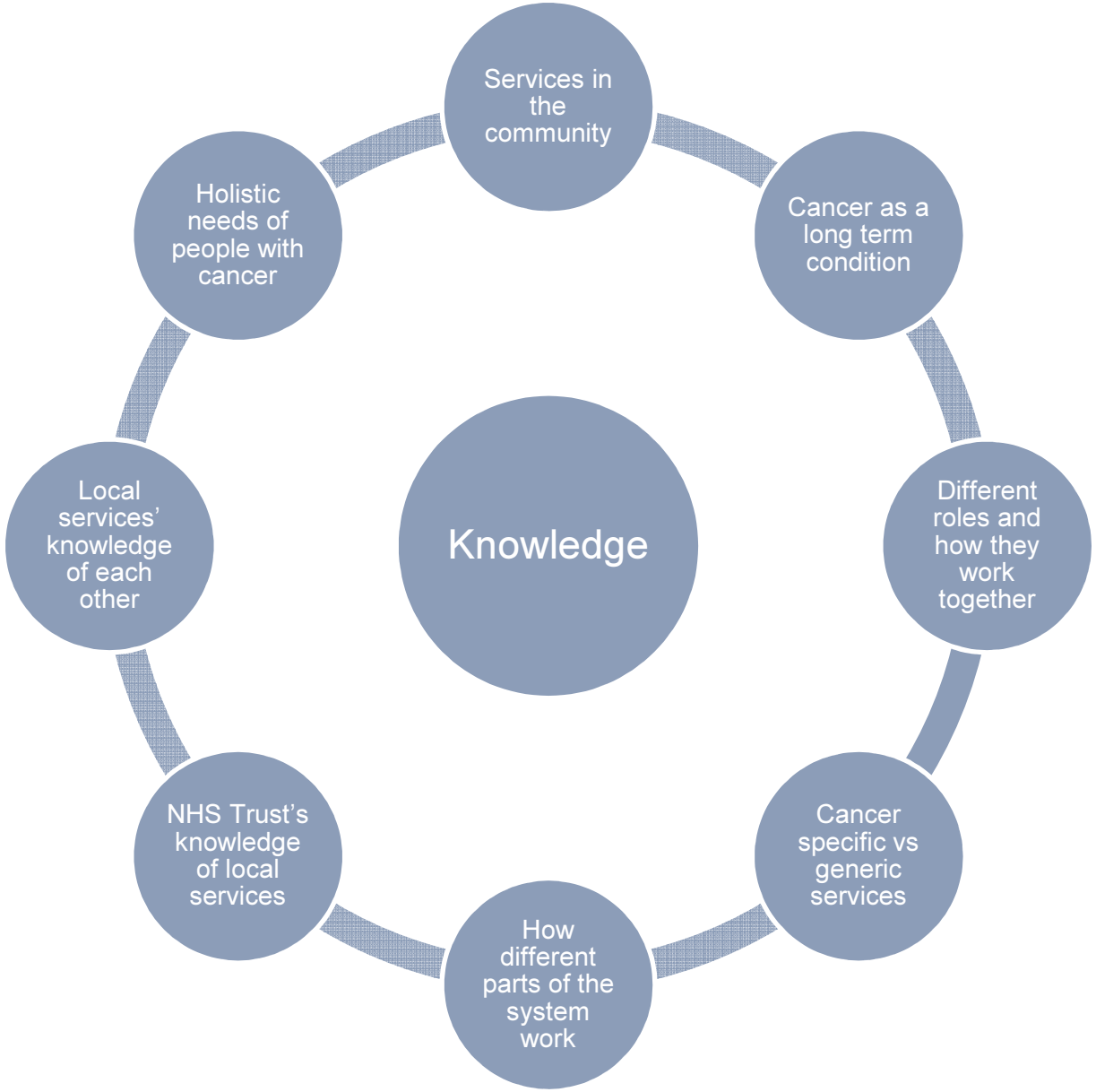
People face challenges in accessing support

Headline findings from insight from 48 residents:

- People not asked about their holistic needs systematically.
- Most felt unprepared for “the end of the sausage machine” and for long term consequences of treatment – many experience depression / low self-esteem for months and years.
- Impact on housing and finance can be severe – people who rent privately are particularly vulnerable; welfare system complex to navigate.
- Social isolation / loneliness – participation in community activities requires a level of physical and emotional wellbeing.

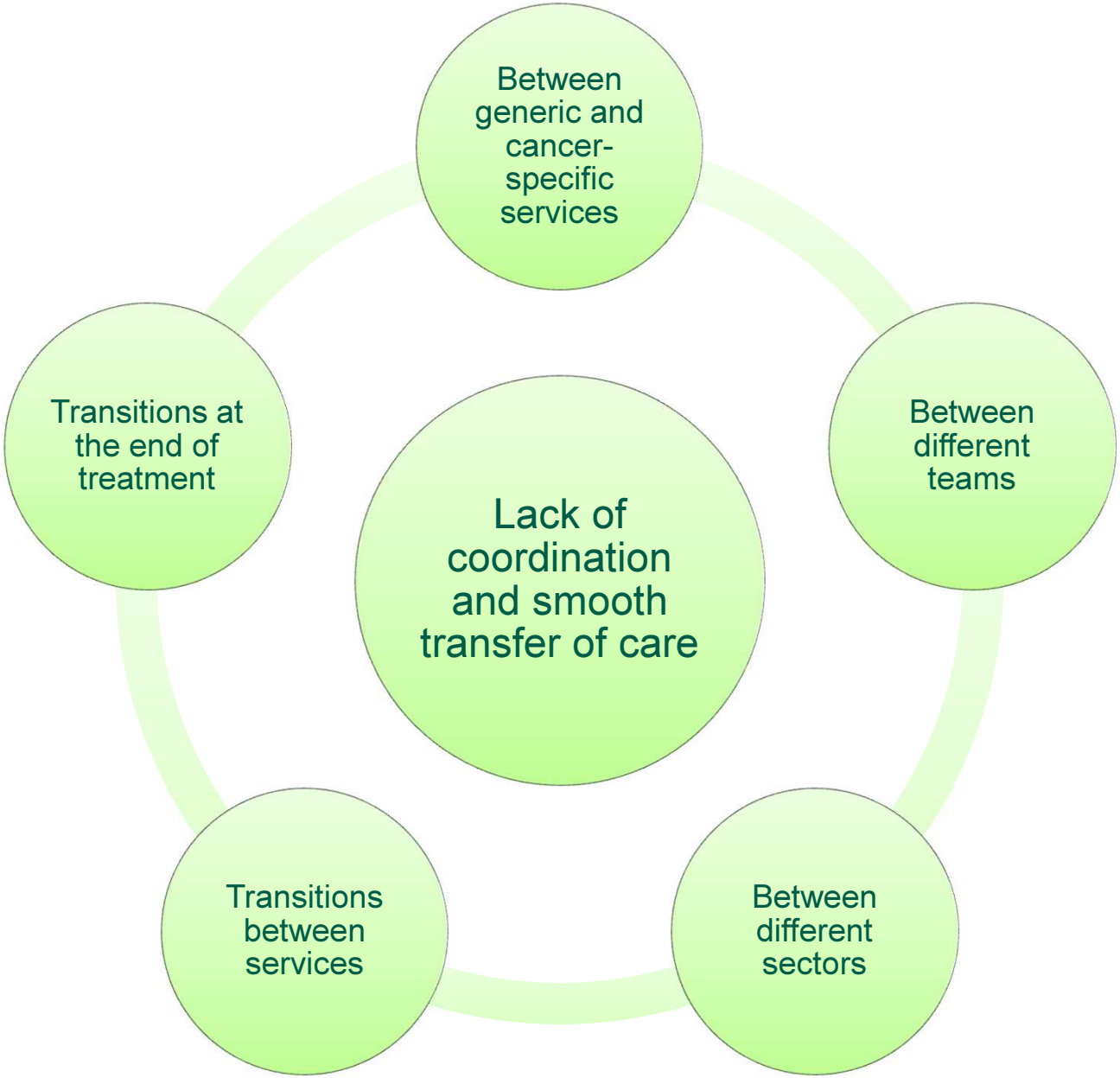


What people need to know to give help and get help:

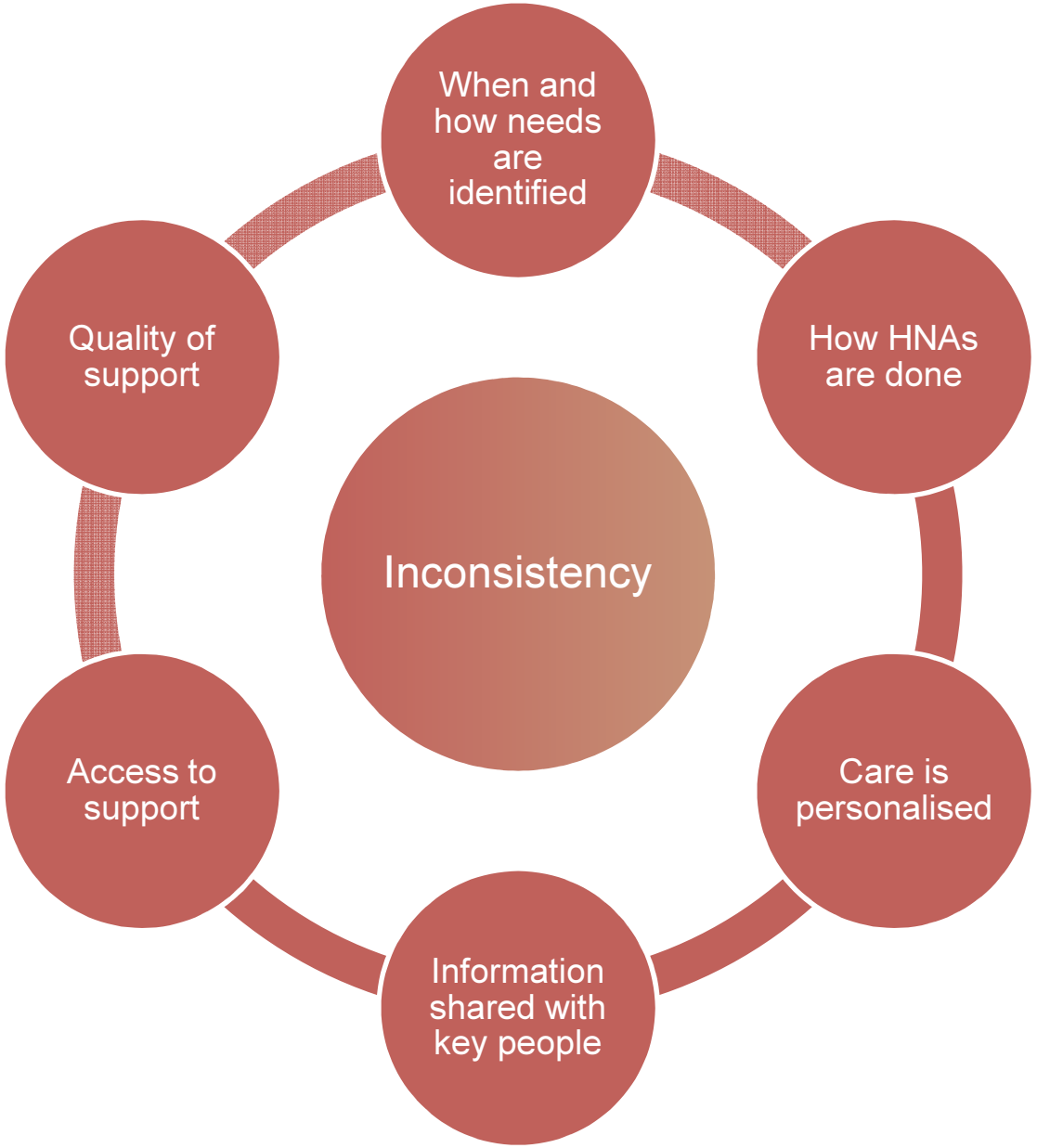


Solutions – increasing knowledge

People do not have a seamless experience of care:



People face inconsistencies:



Solutions – identifying and supporting people's holistic needs

Holistic Needs Assessment (HNA)

- Undertake HNA at diagnosis for every person with cancer.
- Establish if the person has any other co-morbidities for which they are being monitored.
- Create a personalised care and support plan – establish their level of need, support requirements, and 'activation'.
- Understand a person's network of support, and establish family / carers' needs - or if they are alone.
- Establish if a person has additional support needs, e.g. interpreter, advocacy, learning disability.
- Ask all patients about employment, finance, housing, and pro-actively provide information about available advice & support.
- Seek consent to share information with key professionals / team around the person.

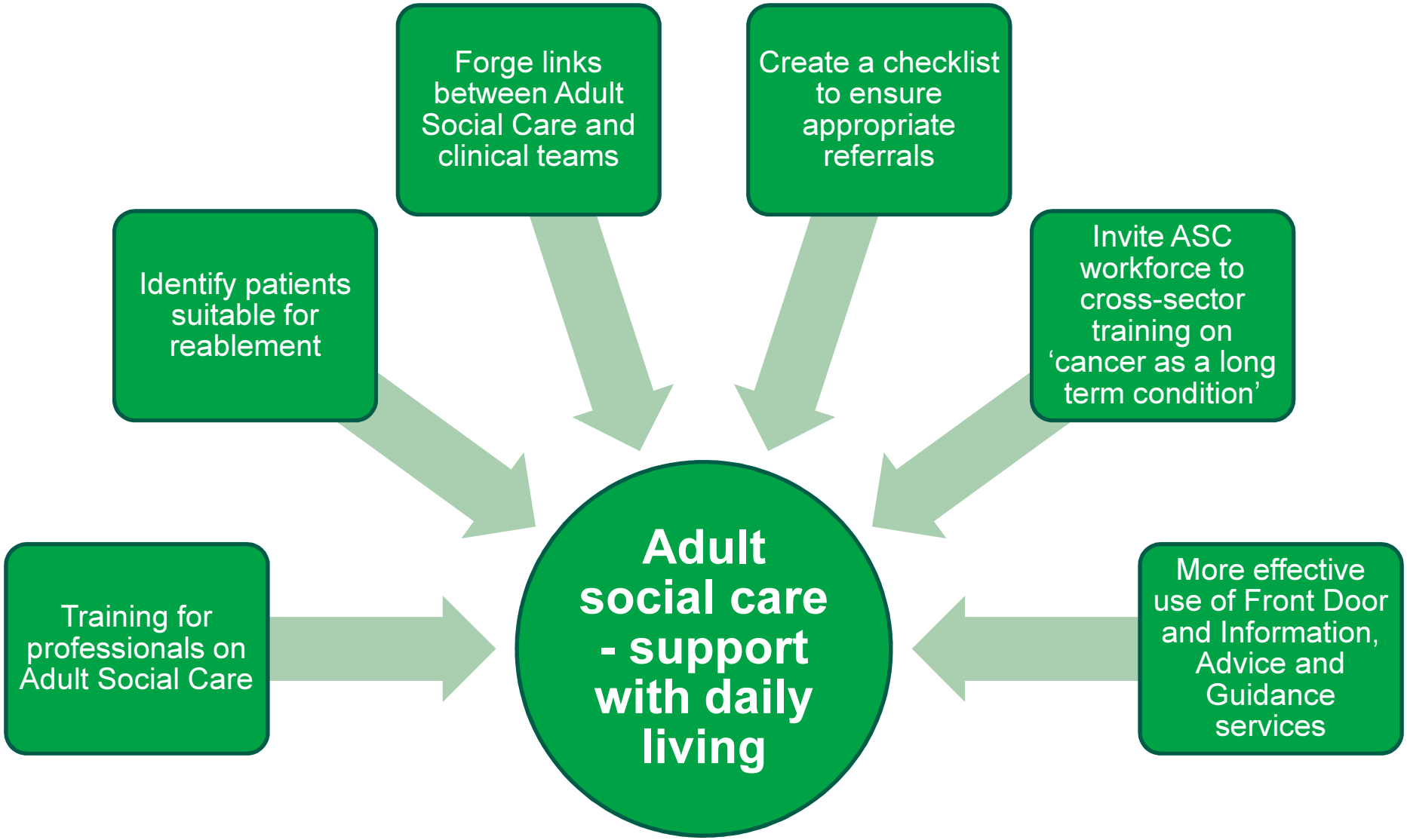
Case management

- Link people to the Macmillan Information and Support Service.
- Link people to relevant support groups, and link carers to relevant services.
- Identify all professionals involved, e.g. generic social prescribing, housing, care navigation.
- Identify the key agencies in the team around the person that we need to liaise with.
- Pass on clinical concerns to the clinical team / CNS to follow up.
- Depending on tumour type, identify whether the patient is likely to be on a stratified follow-up pathway.
- Update the GP and other professionals, share the care and support plan.
- Follow up signposting and referral to other services, to ensure uptake and impact.
- Follow up with the patient after an agreed period of time, to see how things are progressing.
- Provide feedback on progress to all relevant professionals.

Primary and community care

- Establish support needs at the end of treatment – repeat HNA / undertake non-clinical element of Cancer Care Review.
- Follow up with the GP.
- Follow up any referrals into community health services or other services outside the hospital, e.g. IAPT, lymphoedema, housing.
- Check whether an assessment for adult social care was deemed appropriate / necessary.
- Check whether the person is vulnerable (e.g. lonely and experiencing low emotional wellbeing) – refer to appropriate support, e.g. support groups, befriending, Compassionate Neighbours, community activities – through Poplar HARCA, Ideas Stores etc.
- Follow up and discharge the person via agreed process, and inform the team around the person.

Solutions – early access to adult social care



Quick wins:

- Cancer peer support groups in the community
- Provide support flexibly, e.g. through multiple locations
- Coordinate HOPE (Help to Overcome Problems Effectively) self-management courses
- Health and Wellbeing events in the community
- Training on cancer as a long term condition

Thank you for listening.

Any questions…?