

A COMPETENCE FRAMEWORK FOR NURSES

Caring for Patients Living
with and Beyond Cancer

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Foreword

Macmillan Cancer Support and UKONS are delighted to be working in partnership to endorse this publication. We know there are more than 2 million people living with cancer in the UK today, but as Macmillan highlighted in the research publication *Throwing Light on the Consequences of Cancer and its Treatment* not all of them are living well.

The gruelling mental and physical legacy often remains many years after cancer treatment. Macmillan estimates that more than 500,000 people in the UK are currently facing poor health or disability as a result of their cancer treatment. It is essential that people living with and beyond cancer experience better and safer care.

As the population ages and cancer incidence rises there is a great need to share expertise through education, raise political awareness and to link with other organisations. UKONS and Macmillan bring nurses from across various specialities together to share knowledge, learn from best practice, and push for change in cancer nursing. The Macmillan Consequences of Cancer and its Treatment Collaborative (CCaT), as part of the National Cancer Survivorship Initiative, have long recognised the need to develop the skills, knowledge and confidence of nurses who care and support people with long term consequences of cancer and its treatment.

This document will encourage nurses to acquire new skills and to embrace innovative ways of managing cancer as a long-term condition. There could not be a more appropriate time for nurses to take a greater role in driving this change. And there could not be a more appropriate document to help empower and enable them to do so.

We hope that this competence framework will support nurses to help people to recover from episodes of ill health and to manage ongoing physical and mental health conditions as a result of cancer and its treatment.

We warmly thank the Royal College of Nursing for endorsing this document. This new framework is for use in adult services and builds on the existing RCN *Career and competency framework for nurses working in the field of long-term follow-up and late effects care of children and young people after cancer* (RCN 2011). RCN and the Teenage Cancer Trust are currently developing a competence framework for nurses working with teenage and young adult cancers. Initiatives like these are central to the ongoing work to make changes to cancer pathways and improve standards to enable people living with and beyond cancer to live as healthy and as good a quality of life for as long as possible.

On behalf of Macmillan, UKONS and the NCSI

Professor Jane Maher, Macmillan Cancer Support Joint Chief Medical Officer, and Consultant Clinical Oncologist at Mount Vernon Cancer Centre and Hillingdon Hospital

Natalie Doyle, UKONS President, Nurse Consultant: Living With and Beyond Cancer at the Royal Marsden NHS Foundation Trust in London

This testimonial from a patient who is living with multiple consequences of cancer treatment shows the powerful impact that the kind of nurse-led late effects care outlined in this document can deliver:

'I wanted to say a huge thank you and (show) appreciation for your amazing patient care, commitment and understanding that I received in my appointment. I have to say that the appointment was different to any I have experienced before. When I left my consultation I had a fantastic feeling that I had someone that actually connected with the issue(s) I had and understood them as well as I experience them, this is a very rare quality.

I personally feel that having someone that understands and connects with the medical condition you are experiencing, is just as important as receiving a prescription/treatment for the ailment. This may sound a small statement but it's actually a big relief for a patient.'

Male cancer survivor (38 years of age), with complex health needs as a result of previous treatment, including bone marrow transplant received at age 17.

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Introduction

This is the first competence framework for UK nurses involved in the care of adults living with and beyond cancer. It identifies core domains of care that are relevant to the needs of cancer survivors who have, or may be at risk of developing, consequences of cancer and its treatment.

The framework builds upon the report *Evaluation of Health Workforce Readiness and Confidence in Managing the Consequences of Cancer as a Long-term Condition* (Faithfull and Samuel, 2011). It provides details of the skills and knowledge nurses need to provide safe and effective care using the principles identified in *Living With and Beyond Cancer: Taking Action to Improve Outcomes* (National Cancer Survivorship Initiative, 2013). Importantly, this framework aims to underpin developments in policy and practice that are consistent with an individual nation's programmes for transforming cancer care after treatment (Scotland) and transforming follow-up (Northern Ireland), all of which involve developing integrated care models with community and primary care.

This competence framework is appropriate for all nurses who care for cancer patients in any setting. It may also be relevant to allied health professionals (AHPs). This framework does not include competences for nurses caring for patients with disease-specific requirements of advanced cancer, those who require end of life care, or for children (aged 16 years or under). Some teenagers and young people aged 16 to 24 may be cared for in adult services. An existing age-appropriate RCN competence framework is recommended (RCN 2011) in addition to that presented here.

The CMO recently extended the definition of young people to include those up the age of 25 in line with the United Nations definition of young people (CMO report, 2012). The DH same sex guidance (http://www.gov.uk/government/uploads/system/uploads/attachment_data/file/200215/CNO_note_dh_098893.pdf) refers to young people into their 20s. Where adolescent facilities/services are not available, young people should be offered the choice of whether they are cared for in a children's or adult facility/service.

Purpose of a competence framework

A competence framework describes the range of knowledge, skills and performance levels required to help nurses provide safe, effective and accountable practice.

Competence can be defined as:
“The state of having the knowledge, judgment, skills, energy, experience and motivation required to respond adequately to the demands of one’s professional responsibilities” (Roach, 1992, p61). The Nursing and Midwifery Council uses competence to describe the skills and ability to practice safely and effectively without the need for supervision (Dolan, 2003).

Context of this competence framework

There are more than two million people currently living with or beyond cancer in the UK. This number is increasing by 3.2% every year and, if this rate continues, four million people could be living with cancer by 2030 (Maddams et al., 2012).

A recent Macmillan report has estimated that as many as 500,000 people living with and beyond cancer have one or more physical or psychosocial consequences of their cancer or its treatment that affects their lives on a long-term basis (Macmillan Cancer Support, 2013).

National health policy has recognised the need for action to improve outcomes for people affected by consequences of cancer and its treatment. Recently, the Department of Health and NHS England's 3rd annual Report *Improving Outcomes: A Strategy for Cancer* clearly stated the need to improve education for health professionals on consequences of treatment. This message was supported by the All Party Parliamentary Group on Cancer in their December 2013 report *Cancer Across the Domains*, which also called on NHS England to do more to provide specialist services for consequences of treatment.

Evidence shows that many cancer survivors have unmet needs (Armes et al., 2009), particularly at the end of treatment, whilst others are struggling with consequences of treatment (Macmillan Cancer Support, 2013; Bhuva et al., 2012; Santin et al., 2012) that could be either avoided or managed (Andreyev, 2012; Reulen et al., 2011; Woodward et al., 2011). The quality and provision of nursing support has a significant impact on cancer survivors' needs and subsequent outcomes (Cockle Hearne et al., 2013). Changing the way

we support cancer survivors is therefore an outcomes priority to ensure care is provided to meet the full range of patients' needs. Although cancer care requires a multi-disciplinary team (MDT) approach, nurses are in an ideal position to provide and lead in the delivery of these services. Many already possess the prerequisite skills needed to support patients living with and beyond cancer.

Late treatment consequences (late effects) can occur at any time after treatment. A cornerstone of the care pathway for people living with and beyond cancer is the development of approaches to facilitate monitoring, patient support and clinical management of late effects. Evidence suggests that patients have a wide range of individual care needs in relation to late effects. Some will require monitoring for many years or even specialist care for the rest of their lives. Others may need support to reach a degree of self-monitoring and responsibility for their own health needs (Foster and Fenlon, 2011).

There are a number of factors that influence an individual's risk of developing late effects. These include the type of cancer, the cancer treatments received, age at diagnosis, gender, time lapsed since treatment, individual psychosocial responses to diagnosis and treatment, in addition to psychological, social and environmental influences (Stein et al., 2008; Macmillan Cancer Support, 2013).

Long-term follow-up care is designed to match a patient's personal journey through cancer; it needs to balance individual patient approaches to coping with cancer and its treatment, with a calculated risk stratification associated with their cancer treatments.

The Recovery Package

In the document *Living With and Beyond Cancer: Taking Action to Improve Outcomes* (National Cancer Survivorship Initiative, 2013), the NCSI identifies a number of key interventions that could make an immediate difference to the care of patients living with and beyond cancer, and nursing care is integral to all of them. These interventions include the introduction of the Recovery Package which comprises:

- A Holistic Needs Assessment (HNA) which should be carried out at or near diagnosis and at the end of treatment and again whenever health and social needs change, resulting in a written care plan outlining the actions to be taken to address identified needs.
- A Cancer Care Review (CCR) which should be carried out by the patient's GP practice three months following a diagnosis of cancer. This should include post-treatment support and information to enable self-management.
- A Treatment Summary from the hospital team which should inform the patient and GP about the care and treatment received, possible treatment toxicities and/or late effects, and the ongoing management plan and any required actions to support the patient.
- Access to a Health and Wellbeing education event. Where all aspects of living with cancer as a long-term condition can be addressed to enable rehabilitation and self-management. This event should include advice about work and finance, physical activity and local services.

Throwing Light on the Consequences of Cancer and its Treatment

In its document *Throwing Light on the Consequences of Cancer and its Treatment* (Macmillan Cancer Support, 2013), Macmillan makes key recommendations to everyone involved in redesigning services and support for people living with and beyond cancer.

General recommendations

- Prevent or minimise consequences of cancer and its treatment where possible, through healthier lifestyle choices, better surveillance, improved imaging, minimally invasive surgery, targeted radiotherapy and the use of modern drugs.
- Inform patients of potential consequences of cancer and its treatments, with simple strategies for self-management, and the value in taking early action and how to seek appropriate help.
- Identify patients at potential risk, summarising the interventions received in a Treatment Summary that codes potential consequences so they can be easily anticipated, recognised and monitored in primary care.
- Assess potential consequences through regular Holistic Needs Assessments, the use of 'power' questions and Patient-Reported Outcome Measure (PROM) tools at regular time points.
- Support patients through local care pathways for the consequences of cancer and its treatment, which should include support for self-management and referral to appropriate specialist services.

Underpinning the recommendations for improving cancer services is the need to promote a cultural shift in professionals towards shared decision making and supporting patient self-management. Our competence framework provides details of the skills and knowledge nurses need to deliver such care.

How these competences were derived

The foundation work from which these competences were derived involved a two-part process. First, a workforce readiness steering committee, via the NCSI, developed a structured training needs analysis.

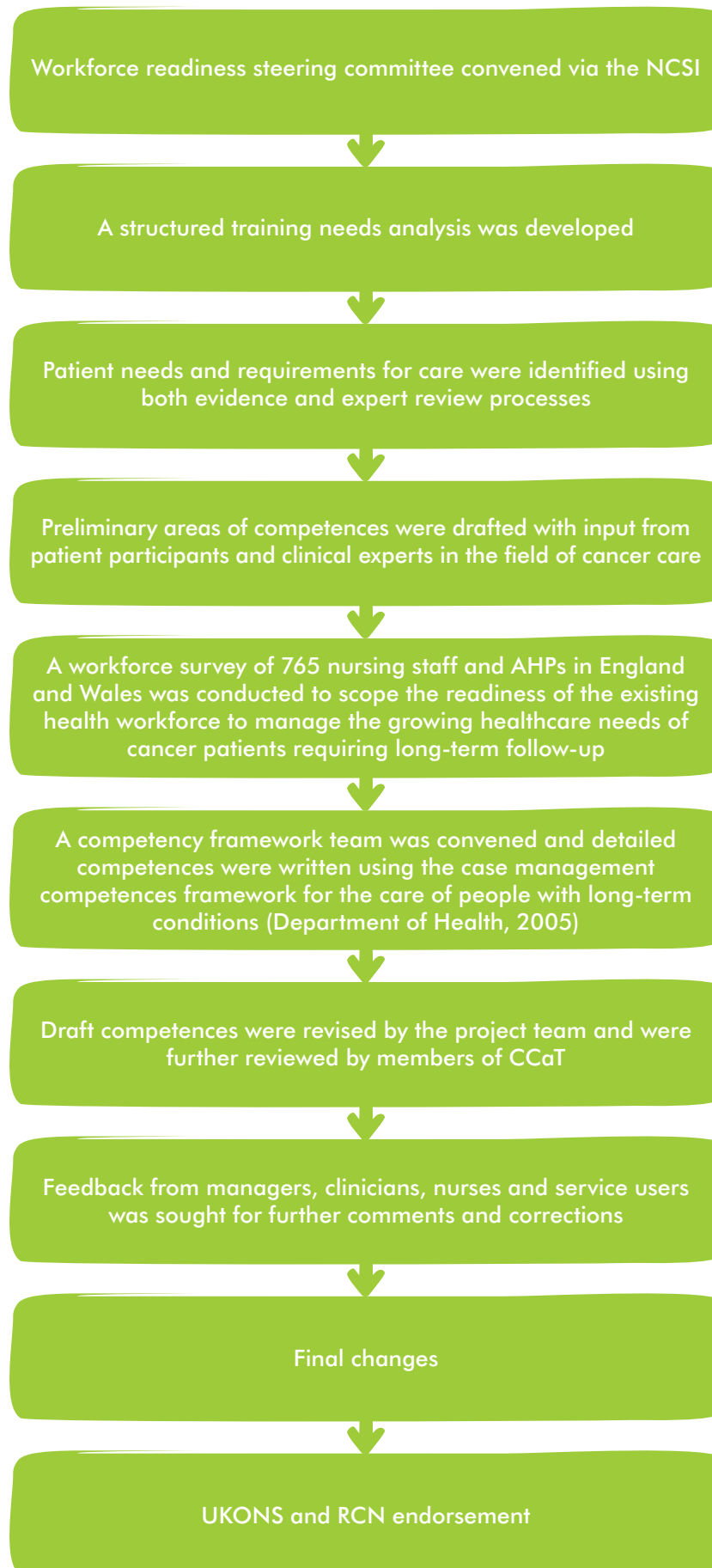
This part of the project used evidence from the literature and clinical practice, alongside the perspectives of patients and clinical experts, to identify the scope of patient's care needs. This provided the foundation for the initial areas of competence.

Second, in 2011 a workforce survey of nurses and AHPs in England and Wales was conducted to scope the readiness of the existing health workforce to manage the growing healthcare needs of cancer patients requiring long-term follow-up (Faithfull and Samuel, 2011). The data were collected by e-surveys targeted at healthcare professionals working directly with cancer patients or supporting cancer patients in both oncology and community care. Web links were disseminated through the Queens Nursing Institute, UK Cancer Network and professional bodies. The primary focus of the questionnaire was to establish which services were provided after cancer treatment had been completed, the symptoms and concerns that were commonly addressed, and the skills and confidence of nurses and AHPs in meeting the care needs of this group of patients.

From this detailed report (Faithfull and Samuel, 2011), a competency framework team was convened and detailed competences were written using the case management competences framework for the care of people with long-term conditions (Department of Health, 2005) (see *The underpinning principles of the competency framework*). The draft framework went through an iterative process with the project team and was further reviewed by members of the CCaT Collaborative before being submitted for the next stage of the process: stakeholder evaluation.

Detailed feedback was sought through a national stakeholder evaluation event for cancer nurses convened through both UKONS and Macmillan Professionals. Service users' opinions and feedback were sought through Macmillan Cancer Voices, and feedback from senior clinicians and management was sought via an e-survey cascaded through members of the NCSI Consequences of Treatment workstream.

Figure 1: How the framework was derived



Scope of the competences

The intention of the competence framework is to include the range of skills and knowledge required by qualified nurses working with people living with and beyond cancer, including those involved in long-term follow-up and late effects care.

The competences in this document are not designed to meet the learning needs of healthcare assistants or associates on levels 1, 2, 3 and 4 of the Career Framework for Health and the Department of Health Nursing Careers Framework (Department of Health, 2004).

This framework has been devised to be used alongside generic competences developed by Skills for Health and the RCN, where these are appropriate, for particular aspects of the role. For example, the RCN competency framework for advanced nurse practitioners (RCN, 2012) may be a useful supplementary competency for nurses carrying out extended roles in relation to patient assessment, diagnosis and care planning.

This document does not set out to determine grades for specific roles and is not a template for a 'super nurse'. Some roles may require the nurse to work at 'essential' level in some aspects of their work while working at 'specialist' level in others. It is also anticipated that nurses working at 'specialist' level would hold the skills identified at 'essential' level, and that a nurse at 'leadership'

level would hold many of the skills of the essential and specialist nurse within a particular competency domain. Matching this document against the Knowledge and Skills Framework (KSF) was considered but not undertaken, as it is not used by all health institutions across the UK. Information about the KSF can be found on the Skills for Health website and this can be used as a supporting tool and as an adjunct to existing role descriptions.

A wide variety of role names are associated with nurses working in this specialty; for example, Clinical Nurse Specialist, Advanced Nurse Practitioner, Practice Nurse, and Ward Manager. To save confusion, the term **nurse** will be used throughout the document. We acknowledge that nurses working with those living with and beyond cancer may either work exclusively in this specialty or as part of a wider nursing role. This will depend on local service needs and evolving care pathways.

The term **carer** is used to describe someone of any age who provides unpaid support to a family member or friend with cancer who could not manage without this help.

The underpinning principles of the competency framework

The content of this document reflects the cumulative efforts of the project team and the diverse group of nurses who contributed to the original survey to evaluate workforce readiness and confidence in managing the consequences of cancer as a long-term condition (Faithfull and Samuel, 2011).

The content of this framework was influenced by the development of a competency framework aimed at meeting the aftercare needs of children and young adults (Siddall et al., 2011).

The case management competences framework for the care of people with long-term conditions (Department of Health, 2005) was also a key influence on the development of this document. The case management framework divides populations with long-term conditions into three levels according to their need for support:

- **Level 1** – individuals who require a low degree of support to enable them to self-manage their own condition.
- **Level 2** – individuals who are considered high risk because their condition is unstable, and who require structured, more intensive support services to help them manage their condition.
- **Level 3** – individuals with high-intensity needs; for example, requiring frequent admission to hospital as a consequence of their condition.

This approach to developing care provision and services for patients based on the level of complexity of need fits with the stratification approach that is central to managing late effects and

long-term care of cancer survivors. Within our framework we defined high-risk and high-intensity-need patients as follows.

High-risk patients in late effects/survivorship care are those who require close monitoring and complex care plans for a variety of reasons. They include patients who:

- have a high risk of developing late effects complications and require close surveillance
- require complex physical care/interventions due to their cancer and its previous treatment (or co-morbidities)
- are finding it difficult to adapt psychologically or socially following their cancer and its treatment
- are vulnerable or hard to reach and may not attend for monitoring and surveillance or to use the services provided.

Core domains from the case management of long-term conditions competences were used as the structure for the current framework. However, some changes were required since the long-term conditions framework focuses on the needs of level 2 and 3 patients whereas our framework aims to encompass the skills and knowledge required for a wider range of patients, including those who require support to manage self-care. The eight core domains were as follows:

1. Clinical nursing practice
2. Care co-ordination
3. Proactive management of late effects/ survivorship care – helping individuals make informed choices
4. Psychosocial wellbeing
5. Identifying high-risk individuals, promoting health and preventing ill health among high-risk individuals and groups
6. Supporting self-care, self-management and enabling independence
7. Professional practice and leadership
8. Interagency and partnership working.

Our framework does not include competences relating to managing care at the end of life. Competences relating to this aspect of care can be found in the Skills for Health competence document *Common Core Competences and Principles for Health and Social Care Workers Working with Adults at the End of Life* (Skills for Health, 2009). This framework is applicable for nurses in an adult services setting that are caring for patients at the earliest age of sixteen and above. In most cases adult services should take on responsibility for the care of adult survivors of childhood and adolescent cancer. This framework will help adult services to ensure they are sufficiently prepared and competent to take over the care of young people and recognise the specialist care and services they require. Nursing competences specifically for survivors of childhood cancer, including care during the transition from children's to adult cancer services, can be found in the RCN competence document *An Integrated Career and Competence Framework for Nurses Working in the Field of Long Term Follow-up and Late Effects Care of Children and Young People after Cancer* (RCN 2011).

However this does not negate the need for adult services to take on responsibility for the care of survivors of childhood and adolescent cancer. Adult services do need to ensure they are sufficiently prepared and competent to take over the care of young people and recognise the specialist care and services they require. They should work in partnership with services caring for children and young people to support this transition as a managed process.

Headline competences

Within each domain are competences specific to core roles identified for nurses working in cancer survivorship, late effects and long-term follow-up care.

These relate to core roles identified in the previous report (Faithfull and Samuel, 2011) along with a separate review of the literature (McCabe et al., 2013). The competency 'knowledge of cancer and its treatment in relation to survivorship and late effects care for adult cancer survivors' is a core element of the framework and needs to be completed to support competency in any of the other domains or core roles.

Other core roles include:

- Initiating and interpreting tests and investigations
- Assessment of holistic needs
- Medication in adult late effects/survivorship services
- Symptom management for the consequences of cancer and its treatment
- Care plans, surveillance plans and treatment summaries – personalising the cancer pathway for individuals using survivorship and late effects services
- Transitional care – supporting the move from acute hospital care to primary care services

- Promoting self-management
- Providing information to support self-care, self-management and enable independence
- Research, audits and service evaluations
- Service development
- Education.

Competences are categorised by level of skill and knowledge from essential to specialist to leadership. The flow from essential through to leadership assumes a gain in knowledge or skill and it has been assumed that nurses working at 'specialist' level will have gained the competences within the essential level.

How to use the framework

The framework focuses on knowledge, skills and interventions specific to nurses providing aftercare or working with patients living with and beyond cancer.

Although the intention is for this framework to have a stand-alone function, it should be used in conjunction with other frameworks that focus on core skills and competences for all qualified nurses and in conjunction with local, national or international guidelines.

Further Reading and Resources

Information about consequences of treatment and how to meet the needs of people living with and beyond cancer can be found in the Macmillan document *Throwing Light on the Consequences of Cancer and its Treatment* macmillan.org.uk/throwinglight

You can find a range of clinical guidance which will be continually updated and added in the Macmillan Consequences of Treatment Toolkit: learnzone.org.uk

More information about both transition and specialist late effects care can be sought from our parallel competency framework (Siddall et al., 2011) rcn.org.uk/_data/assets/pdf_file/0005/408254/004172.pdf

Further RCN nursing competence frameworks can be found at: rcn.org.uk

Further guidance on medication can be found from: Department of Health (2004). *Management of Medicines – A Resource to Support Implementation of the Wider Aspects of Medicines Management for the National Service Frameworks for Diabetes, Renal Services and Long-Term Conditions* webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4088754

More information about managing care at the end of life can be found from existing guidance: *A Guide for Health and Social Care Workers Working with Adults at the End of Life* (Department of Health et al., 2009). skillsforcare.org.uk/Document-library/Skills/End-of-life-care/Commoncorecompetencesandprinciplesforendoflifecare.pdf

Further information about the KSF can be found at: skillsforhealth.org.uk

Benefits of the framework

The competence framework provides benefits for nurses, their employers, patients and the public.

Nurses benefit because the framework helps to:

- identify and develop the knowledge and skills required to deliver consistently high standards of care;
- identify the level of practice and plan a career in a more structured way;
- pinpoint personal education and development needs;
- realise the potential of their roles more effectively;
- seize opportunities to influence the direction of nursing in this relatively new field of clinical care;
- foster and improve professional relationships with medical colleagues and AHPs through a greater understanding of skills and responsibilities.

Employers benefit because the framework provides:

- a model to identify and develop the knowledge and skills required to ensure safe and consistently high standards of care;
- an insight into the expertise and competence of nursing staff;
- assistance in planning current and future services.

Patients and the public benefit because the framework makes it possible to deliver:

- care that meets their needs and concerns;
- consistently high standards of care;
- increased effectiveness of service provision;
- improvement in early identification of long-term and late treatment consequences; and
- a smoother transition from specialist to primary care.

It is envisaged that the framework will be a useful tool for:

- supporting job descriptions;
- assessing clinical competence at differing levels;
- developing personal goals and objectives;
- performance appraisal.

Dissemination and next steps

This is the first framework for nurses providing care for adult cancer patients living with and beyond cancer.

It is hoped that this framework will help nurses to identify their current level of practice to plan their career in a more structured way by identifying their personal education and development needs.

Progress through the levels will be different for each nurse, depending on the context, level of skill, performance appraisal and individual objectives.

Where aftercare and late effects services currently do not exist, this framework can contribute to service design, organisational planning and supporting job descriptions.

It is anticipated that this framework will also be used to design and develop education packages, influence conference programmes and education days through partner academic institutions, professional societies such as UKONS and through charities such as Macmillan Cancer Support. It may also prove to be of benefit to international organisations such as the European Oncology Nursing Society, which fosters the development of cancer nursing across Europe.

DOMAIN 1

**CLINICAL
NURSING
PRACTICE**

1a. Knowledge of cancer and its treatment in relation to people living with and beyond cancer

This competency is core to the framework and needs to be completed to support competency in any of the other domains or core roles

Essential

Has knowledge of the following that underpins own practice and clinical care:

- Cancer, cancer treatments and their potential long-term effects
- The range of psychological and social consequences of cancer
- Late effects complications common to own area of practice eg endocrine, bone, cardiac, fertility, continence
- Treatments and interventions for late effects complications common to own area of practice
- Principles underlying ongoing care for people living with and beyond cancer eg late effects risk stratification, surveillance, self-management, screening
- The normal ageing process and how this might influence people living with and beyond cancer
- Other common long-term conditions that may influence care eg diabetes, cardiac and respiratory conditions, dementia
- The impact of the ageing process on older people's communication needs eg sensory impairment, cognition and confusional states

Specialist

The same as essential, plus has knowledge of the following that is used for specialist practice and developing services in own area of practice:

- The relative risks of complications associated with different cancers and treatments, and the factors that can influence this
- The potential current and long-term physical, psychological and social consequences of cancer and its treatment for people living with and beyond cancer
- The range of care pathways for people living with and beyond cancer, from adjustment to living well following cancer (health promotion), to active surveillance, to complex symptom management and end of life care
- Potential late effects consequences appropriate to own client group/specialty (tumour-site-specific, treatment modality, service location) eg endocrine, bone health, cardiac toxicity, psychosexual issues, fertility, dental health, early menopause
- The monitoring required for specific late effects complications

Leadership

The same as specialist, plus has knowledge of the following that is used for autonomous practice and for local, regional and national service development:

- Interventions to manage complex physical and psychological consequences of cancer and its treatment
- Approaches to engaging service users and evaluating their perspective
- Developing and integrating care pathways in relation to the living with and beyond cancer agenda
- Change management and service improvement theory and methodology
- Local and national policies that may influence the care of people living with and beyond cancer
- The wide range of local and national organisations and networks involved in providing services for people living with and beyond cancer treatment
- The wider influences on service delivery eg commissioning, strategy and planning

1b. Initiating and interpreting tests and investigations used in cancer treatments, ongoing monitoring and late effects care

Essential

- Demonstrates knowledge of tests and investigations commonly used in cancer care in own area, including rationale for use and normal ranges of results
- Carries out investigations appropriate to own area of practice
- Requests and carries out investigations used in cancer care and ongoing monitoring at the request of clinicians or according to protocols and guidelines
- Provides appropriate explanations to individual patients about the reasons for, and intention of, tests and investigations
- Provides descriptive and procedural information about tests and investigations
- Makes appropriate decisions to seek help where necessary in relation to findings of tests and investigations used in cancer care for people living with and beyond cancer
- Demonstrates a good working knowledge of the legal framework and guidelines relating to the consent process
- Provides support and further explanation to the patient and family after the clinician has discussed test results
- Ensures that privacy and dignity, health and safety and consent issues are met when requesting, assisting with or carrying out tests and investigations

Specialist

As essential, plus:

- Independently initiates a wide range of investigations used in the care of people living with and beyond cancer, following agreed guidelines and protocols
- Understands the role of risk stratification in ongoing surveillance for people living with and beyond cancer
- Tailors tests and investigations within surveillance care plans according to potential consequences for the individual patient
- Understands the tests and investigations associated with protocols for ongoing cancer treatments and incorporates these into an individual patient's care plan
- Accurately interprets the findings of tests and investigations used in cancer care and ongoing monitoring and surveillance
- Uses specialist knowledge to recognise deviations in expected test results
- Identifies results that require urgent and/or specialist intervention and facilitates the appropriate care
- Makes appropriate changes to the care plan in the light of findings, in conjunction with clinicians or within protocols and guidelines
- Ensures the needs of patients with complex needs are met when obtaining consent for tests and investigations eg learning difficulties, dementia
- Works to resolve challenging issues relating to consent
- Provides detailed information to individuals about tests and investigations; identifies new support or information needs arising from findings or results
- Uses expertise to explain difficult news the patient may have been given in relation to the results of tests and investigations and provides appropriate interventions to help them and their family as they come to terms with their implications

Leadership

As specialist, plus:

- Applies expertise to prescribe, initiate, interpret and monitor diagnostic tests and investigations used in the care of people living with and beyond cancer independently and without supervision, according to the individual's clinical need
- Acts as an expert resource for other healthcare professionals (HCPs) when dealing with complex or challenging situations relating to ethical aspects of tests and investigations
- Plays a leading role in developing protocols and clinical guidelines relating to tests and investigations for surveillance and monitoring for people living with and beyond cancer
- Uses expertise to relay difficult news about the results of tests and investigations to people with cancer and their families

1c. Assessment of holistic needs of adult patients living with and beyond cancer

Essential

- Has an understanding of the Holistic Needs Assessment process and its implications for practice
- Carries out nursing assessments with people living with and beyond cancer using structured assessment tools
- Carries out nursing assessments of symptoms commonly experienced as a consequence of cancer and/or its treatment by patients in own clinical area
- Recognises actual and potential problems that might require further attention
- Makes appropriate decisions to seek help where necessary in relation to findings following patient assessments and reports concerns to appropriate colleagues, prioritising those who require urgent intervention
- Assesses lifestyle issues that are of concern for individual patients based on objective measurements (eg BMI, alcohol consumption) and individual priorities
- Accurately documents the findings from assessments

Specialist

As essential, plus:

- Uses skills in history-taking and evaluation of diagnostic tests to carry out assessments within protocols and guidelines and/or in conjunction with a senior nurse or medical clinician
- Carries out holistic assessments, recognising the range of physical, psychological and social consequences of cancer and its treatment
- Assesses the individual's concerns and priorities for care
- Uses specialist knowledge and skills to assess the physical, psychological and social factors that can affect the emotional and psychological wellbeing of people living with and beyond cancer
- Carries out assessments to monitor for side effects and outcomes of any ongoing cancer treatment within agreed protocols
- Uses knowledge of the relative risks of late effects complications to ensure that assessments are appropriate for a patient's individual needs (eg type of cancer, treatment received, age, co-morbidities)
- Recognises signs and symptoms of late effects complications, including those relating to the specific cancer and treatments received
- Recognises signs and symptoms requiring a change in the care pathway eg cancer recurrence, end of life care
- Identifies assessment findings that require urgent and/or specialist intervention and facilitates the appropriate care
- Assesses the impact of cancer diagnosis and treatment on lifestyle and future employment needs
- Recognises other common health problems that may be identified during assessment and makes appropriate referrals for ongoing care
- Ensures that assessments reflect current best practice and are evidence-based

Leadership

As specialist, plus:

- Independently reviews and assesses patients to develop appropriate care plans according to their needs
- Acts as an expert resource for other HCPs when dealing with complex or challenging situations relating to assessment
- Works collaboratively with others to develop and implement the range of assessment tools and clinical guidelines that are required for people living with and beyond cancer, including late effects services
- Evaluates the effectiveness of assessment tools and guidelines in terms of their impact on patient outcomes and services
- Develops systems for documenting late effects identified during assessments that help to increase wider knowledge about survivorship, late effects and late effects services

1d. Medication in adult services for people living with and beyond cancer

Essential

- Demonstrates knowledge of medications commonly used in own area of practice in relation to cancer, cancer treatment and late effects care, including indication, mode of action and adverse effects
- Understands the principles of safe handling and administration of anti-cancer therapy
- Provides advice and explanation to patients on medication used in cancer care
- Offers advice and information in relation to the management of side effects of medication used in cancer care
- Identifies side effects that require urgent and/or specialist intervention and seeks appropriate help
- Evaluates adherence to long-term medications, provides advice and refers to appropriate healthcare colleagues if issues are identified
- Signposts patients to appropriate care teams for management of medicines-related issues (eg review of medications, non-adherence)
- Demonstrates ability to access the range of sources of information available to ensure that knowledge about medicines is up to date

Specialist

As essential, plus:

- Demonstrates a comprehensive understanding of the medications appropriate to own client group/specialty (eg anti-cancer therapy (including chemotherapy), hormonal therapy, analgesia) and how they impact on health
- Ensures systems are in place to ensure anti-cancer therapy is given safely and according to protocols and guidelines (eg education of patients/relatives and HCPs involved in their care)
- Evaluates effectiveness and outcomes of medication, and consults with clinician regarding changes
- Uses specialist knowledge to monitor, prevent and manage side effects associated with medications used in cancer care
- Provides individualised patient information about medications used in cancer care to enable informed consent and self-management
- Provides patient information to enable self-monitoring, prevention and management of common side effects of medicines used in cancer care
- Discusses issues relating to concordance with the patient, ensuring that they understand the potential benefits of the medicine while exploring their reasons for non-adherence
- Is able to provide advice about dietary supplements and herbal/homeopathic remedies and their interactive properties with prescription medicines

Leadership

As specialist, plus:

- Works with the MDT to develop protocols and guidelines for medications used in cancer care services eg Patient Group Directions, treatment pathways, administration of anti-cancer therapy
- Develops patient information on medicines used in services for people living with and beyond cancer
- Works with other service providers to develop policies and pathways to promote safe practice in relation to cancer medicines used across the range of service settings
- Evaluates interventions and services provided to support medication provision in terms of their impact on patient outcomes and the effectiveness of service delivery

Further guidance on medication can be found from:

Department of Health (2004). Management of Medicines – A Resource to Support Implementation of the Wider Aspects of Medicines Management for the National Service Frameworks for Diabetes, Renal Services and Long-Term Conditions

webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4088754

1e. Symptom management for the consequences of cancer and its treatment

Essential

- Identifies symptoms associated with cancer, its treatment and late effects in relation to own specialty
- Identifies symptoms of common co-morbidities eg diabetes, dementia, cardiac and respiratory conditions
- Demonstrates knowledge of the principles of symptom management in relation to cancer, cancer treatments and common late effects complications
- Provides information on and support with symptoms that can be managed with 'simple' measures such as diet, activity and medications
- Distinguishes between symptoms that can be managed with simple measures and those that require urgent and/or specialist intervention
- Signposts individuals to appropriate sources of support and information for symptom management
- Provides support to help patients come to terms with long-lasting symptoms

Specialist

As essential, plus:

- Has an in-depth knowledge of symptoms associated with cancer, cancer treatment and late effects within own specialty area
- Where possible, distinguishes between symptoms associated with cancer, cancer treatments, late effects, co-morbidities, recurrence, progression and new malignancy and takes action to ensure patients are placed on the appropriate care pathway
- Identifies symptoms that require urgent and/or specialist intervention and facilitates appropriate care
- Initiates further tests and investigations to assist with diagnosis and treatment of symptoms and evaluates the effectiveness of symptom management
- Has a comprehensive knowledge of the range of interventions and services available to support symptom management
- Provides advice and support on symptom management interventions common to own specialty area for individuals living with and beyond cancer
- Provides a range of interventions to support the management of complex symptoms arising from cancer, cancer treatment and late effects
- Identifies when specialist or alternative sources of support are required for symptom management

Leadership

As specialist, plus:

- Uses expert knowledge to independently diagnose, assess and evaluate symptoms
- Acts as an expert resource for other HCPs when dealing with complex symptoms
- Develops guidelines and pathways to facilitate effective symptom management across the health, social care and voluntary sectors
- Provides education for other healthcare practitioners and care providers across the health, social care and voluntary sectors in symptom management for cancer, cancer treatments and late effects
- Provides leadership in the management of symptoms that individuals may find difficult to discuss (eg sexual dysfunction, incontinence) and those that are difficult to resolve
- Develops systems for documenting symptoms that help to build knowledge about cancer and its treatment, survivorship, late effects and late effects services
- Evaluates interventions and services provided for symptom management in terms of the impact on patient outcomes and the effectiveness of service delivery

DOMAIN 2

CARE

COORDINATION

2a. Care plans, surveillance plans and treatment summaries – personalising the cancer pathway for individuals living with and beyond cancer

Essential

- Documents clear and accurate information about individuals using services for people living with and beyond cancer
- Liaises with the MDT in creating care plans or treatment summaries for people living with and beyond cancer
- Provides accurate and appropriate information when assisting others with developing care plans and treatment summaries
- Provides information and explanations to individuals and their family members in relation to their care plan
- Demonstrates good practice with respect to governance and confidentiality issues relating to care plans and patient records
- Provides individuals with written information to support their care plan eg crib sheet of signs and symptoms to be monitored for in relation to cancer, cancer treatments, recurrence or likely late effects
- Recognises when changes may be needed in the care plan and takes appropriate action eg cancer recurrence, new malignancy, end of life care
- Has knowledge of other common conditions that require screening and monitoring eg diabetes, stroke and heart disease
- Understands the importance of communicating ongoing care needs to primary and other healthcare providers beyond specialist follow-up

Specialist

As essential, plus:

- Works with individuals to develop care plans that
 - reflect their priorities and concerns
 - encourage self-care and self-reporting of significant symptoms
- Creates treatment summaries for individuals using protocols and guidelines
- Uses specialist knowledge to create individual risk and late effects surveillance care plans according to agreed protocols and guidelines
- Uses specialist knowledge to incorporate any current or ongoing cancer treatments into the care plan
- Incorporates a range of physical, psychological and social assessments within the care plan eg monitoring with tests and investigations, health promotion activities, psychosocial adjustment, work and social functioning

Specialist (Continued)

- Coaches individuals to be aware of concerning signs, symptoms and situations in relation to the risks associated with their cancer and their current and previous cancer treatment
- Coordinates care for individuals according to their treatment summary/care plan
- Uses specialist knowledge to recognise and intervene when deviations occur from the expected progress of an individual in relation to their care plan
- Reviews and adapts the care plan with individuals to ensure it meets their changing needs
- Develops care plans for individuals stratified as having complex care needs
- Ensures care plans are evidence-based and reflect current best practice

Leadership

As specialist, plus:

- Independently develops, implements and evaluates care plans for people living with and beyond cancer
- Uses clinical examination skills to develop care plans for individual patients
- Acts as an expert resource for other HCPs when dealing with challenging situations arising from care plans eg different perspectives on treatment decisions between individuals and their families
- Leads the development of care pathways to guide practice in cancer care and treatment, late effects and follow-up services
- Ensures services and pathways are delivered appropriately within own specialty or clinical field to meet the relative risks of complications and complexity of needs
- Leads the development of pathways across service providers to facilitate rapid and effective movement of individuals when the need to do so is identified eg rapid re-entry to acute care services following signs of recurrence
- Evaluates the effectiveness of the systems and methods used for care planning, surveillance plans and treatment summaries in terms of patient outcomes and the effectiveness of service delivery

2b. Transitional care – supporting the move from acute hospital care to primary care services

Essential

- Has an understanding of the issues facing individuals as they complete cancer treatment or are discharged from acute hospital follow-up
- Has a knowledge of the wide range of services available to support people living with and beyond cancer outside of the hospital setting
- Understands the roles that primary care services play in supporting people with cancer
- Provides information to ensure that individuals are aware of the changes in care and service provision associated with the transition to care outside of the hospital setting
- Helps individuals navigate the services and resources that are available outside of the hospital setting
- Respects the privacy and confidentiality of individuals as their care is transferred to primary care
- Provides accurate information about individual patients when making referrals within own service and to other agencies

Specialist

As essential, plus:

- Provides information and support to ensure individuals feel fully involved in the changes in care associated with completing cancer treatment or being discharged from acute hospital follow-up
- Provides information and support to primary care staff and other HCPs for ongoing late effects care needed beyond acute care and hospital follow-up
- Supports individuals to develop confidence in their ability to cope with the transition from acute hospital care to self-care
- Assesses the emotional and psychological readiness of individual patients to take more responsibility for their own care, and develops appropriate individualised interventions to support them to do so
- Provides information to ensure that individuals have a good understanding of their diagnosis, treatment, associated late effects and risk of developing late effects, to enable them to take a leading role in their future care
- Supports individuals with complex needs to ensure that they receive appropriate care on completing cancer treatment or on discharge from acute hospital care
- Maintains effective communication between different healthcare providers to ensure that individuals receive appropriate survivorship, late effects and ongoing cancer care
- Takes an active role in working to minimise the occurrence of potential crises eg inappropriate admission to hospital
- Participates in educational programmes to support staff involved in transitional care

Leadership

As specialist, plus:

- Works with other agencies to develop clear pathways and guidelines for the transfer of long-term follow-up to primary services and to different models of follow-up care
- Acts as a specialist resource for local health, social care and voluntary sector services regarding transitional care
- Develops approaches to monitoring transitional arrangements and services to ensure that they meet the needs of service users
- Develops programmes of education to support staff involved in transitional care
- Evaluates services developed to support the transition of patients as they complete cancer treatment or are discharged from acute hospital care in terms of patient outcomes and the effectiveness of service delivery

The transition of children and young people from children's, or teenage and young adult services needs careful planning owing to the specialist needs of this small but significant cohort of patients who may require life-long surveillance or complex care within adult services. More information about both transition and specialist late effects care can be sought from our parallel competency framework (RCN 2011) (http://www.rcn.org.uk/__data/assets/pdf_file/0005/408254/004172.pdf).

DOMAIN 3

**PROACTIVE
MANAGEMENT**

Helping people make informed choices as they live with and beyond cancer.

Essential

- Knows the types of support and assistance that individuals may need at different times in their care pathway and knows how to access them
- Knows the range of resources available for people living with and beyond cancer
- Promotes the participation and inclusion of all service users and ensures that potential barriers are reported to the appropriate personnel
- Acknowledges and respects the decisions made by individuals concerning their health and wellbeing in relation to cancer, cancer treatments, survivorship and late effects care
- Makes appropriate decisions to seek help and report concerns to colleagues when an individual's choices place them at risk
- Has an awareness of the legal frameworks governing cancer and work, such as the Equality Act

Specialist

As essential, plus:

- Responds to individuals' descriptions of their needs, preferences and concerns about their health and wellbeing to ensure that care plans meet their goals and needs
- Enables individuals to reach their own decisions about their health and wellbeing and set their own priorities
- Reviews and adapts care plans with individuals to ensure that they meet their changing needs
- Explains the options that are available to individuals in relation to their care plan to enable them to make informed decisions about their care
- Identifies and explains any benefits and risks arising from decisions about their care to enable individuals to make informed choices
- Provides information and assistance to help individuals access the services and resources they require to implement their decisions
- Identifies factors that can affect an individual's ability to request or access services or to organise support and assistance and takes appropriate action to help them receive the care and services they require (eg knowledge, confidence, physical constraints)
- Identifies external factors that may exclude or prevent individuals from being able to access the range of services and resources available
- Works with other agencies to minimise the impact of negative external factors on services and individual care plans
- Works to ensure that services are inclusive and promotes equal opportunities for access and service provision
- Identifies potential physical, psychological and social problems early and refers patients on for appropriate interventions and services
- Communicates effectively with individuals with complex needs to enable them to make informed choices

Leadership

As specialist, plus:

- Acts as an expert resource for other HCPs when dealing with complex and challenging communication issues (eg when an individual's choices place them at risk)
- Collaborates with a range of individuals, agencies, networks and communities to promote services to help individuals make informed choices about their health and wellbeing when living with and beyond cancer
- Develops systems and processes to identify factors that may exclude or prevent individuals and groups from accessing the range of services and support available
- Takes a leading role in ensuring that factors that prevent or exclude individuals from using services are addressed and minimised



DOMAIN 4
PSYCHOSOCIAL
WELLBEING

Essential

- Demonstrates knowledge of the psychological effects of cancer and its treatment on individuals, particularly in relation to loss of confidence and fear of recurrence
- Understands the psychosocial consequences associated with living with and beyond cancer
- Communicates effectively and appropriately with people of different ages, cultural and socio-economic backgrounds along the cancer journey
- Makes appropriate decisions to seek help where there are concerns about an individual's mental wellbeing
- Uses local pathways to refer individuals with psychosocial support needs to appropriate services
- Understands the wide range of sources of support that are important to individuals living with and beyond cancer eg family and friends, social and leisure activities, religion and spirituality, work
- Has an awareness of legal frameworks governing cancer and work, such as the Equality Act

Specialist

As essential, plus:

- Has a comprehensive understanding of the potential psychosocial consequences associated with living with and beyond cancer
- Applies knowledge and experience of the needs of individuals using cancer, late effects, survivorship and follow-up services to provide psychological support on a wide range of diverse issues
- Supports individual patients in developing coping strategies that are effective for them as they live with and beyond cancer
- Helps patients to develop approaches to monitoring and managing their own mental wellbeing
- Provides advice and interventions that enable individuals to manage the impact of cancer and its treatment on their relationships with those important to them
- Makes appropriate interventions to reduce the potential for individuals to be inappropriately disadvantaged at work by the consequences of their diagnosis and treatment
- Uses different approaches to assessing psychosocial needs eg distress thermometer, SPARC, concerns checklist
- Uses complex strategies to deal with communication issues such as breaking bad news about relapse and development of new late effects
- Identifies when patients have mental health needs that require referral to specialist services and facilitates this process eg psychiatric or clinical psychology services
- Works with other agencies and services to ensure that cancer, late effects and survivorship care is fully integrated into the care plans of individuals with new and pre-existing mental health illness

Leadership

As specialist, plus:

- Demonstrates advanced communication skills eg counselling and motivational interviewing techniques
- Acts as an expert resource for other HCPs when dealing with complex and challenging communication issues
- Develops, implements and evaluates different approaches to assessing psychosocial needs eg distress thermometer, SPARC
- Works with other agencies to develop clear pathways for complex psychosocial support needs for individuals living with and beyond cancer
- Evaluates care and services developed to support psychological wellbeing in terms of patient outcomes and the effectiveness of service delivery

DOMAIN 5

IDENTIFYING HIGH-RISK INDIVIDUALS

Promoting health and preventing ill health among high-risk individuals and groups living with and beyond cancer.

High-risk patients in late effects/survivorship care are those who require close monitoring and complex care plans for a variety of reasons. They include patients who:

- have a high risk of developing late effects complications and require close surveillance;
- require complex physical care/ interventions due to their cancer and its previous treatment (or co-morbidities);
- are finding it difficult to adapt psychologically or socially following their cancer and its treatment; and/or
- are vulnerable or hard to reach and may not attend for monitoring and surveillance or to use the services provided.

5a. Using data to identify high-risk individuals and groups receive services that meet their needs

Essential

- Collects data required for monitoring of individual patients and for service evaluation within survivorship/late effects services
- Understands the ethical and legal issues around data collection and information handling, including confidentiality and consent

Specialist

As essential, plus:

- Has a good understanding of the principles underpinning data and its use, including:
 - the range of qualitative and quantitative methods available and their purpose
 - the concepts of validity and reliability in relation to the design of data collection, collation and analysis
- Contributes to the development of systems of data collection and monitoring to identify patients with increased needs for services, monitors their care needs and evaluates the factors that influence their access to and use of services
- Works with high-risk individuals and groups of service users to promote their inclusion in the development and review of services for people living with and beyond cancer
- Uses specialist knowledge and communication skills to collect data from high-risk individuals and groups using a range of methods eg patient outcome measures, interviews, focus groups and questionnaires
- Interprets and summarises descriptive data relating to high-risk individuals and groups within services for people living with and beyond cancer
- Contributes to the review and development of services for high-risk patients in the light of findings from data collection and analysis

Leadership

As specialist, plus:

- Plays a leading and collaborative role in developing data collection systems for identifying and monitoring high-risk individuals living with and beyond cancer eg ongoing monitoring of individuals, identification of factors associated with high-risk status, exploring experiences of service users
- Has a working knowledge of the strengths and limitations of the different data collection and analysis methods available and ensures methods used are appropriate to the question/subject of investigation and the high-risk client group
- Collaborates with a range of individuals, agencies, networks and communities to ensure that data collected are representative and includes hard to reach individuals and groups
- Uses data appropriately to influence the care of high-risk individuals and groups within services for people living with and beyond cancer
- Presents and explains the findings of data relating to high-risk individuals/groups using language and terminology appropriate to the intended audience (eg service users, MDTs, local network meeting, education of HCPs)
- Collaborates with a range of individuals, agencies, networks and communities to include those from high-risk groups in developing services in response to findings from data collection and analysis

5b. Promoting health and wellbeing among high-risk individuals and groups within survivorship and late effects care

Essential

- Has an understanding of the factors that increase patients' needs for services eg ongoing physical consequences of cancer and its treatment, difficulty with psychosocial adjustment, risk of late effect complications, co-morbidities
- Has an awareness of factors that can influence whether individuals or groups are likely to use services
- Has an understanding of the factors that influence health and wellbeing among groups and individuals with high levels of needs
- Assists families in supporting health promotion and lifestyle changes of people living with and beyond cancer
- Has a good level of knowledge of the range of services available to support individuals across the care pathway eg voluntary agencies, health promotion services and support groups
- Directs individuals and family members to appropriate agencies and information sources that support high-risk individuals within cancer, survivorship and late effects services
- Encourages and enables high-risk individuals to take part in initiatives to review and develop services for people living with and beyond cancer

Specialist

As essential, plus:

- Has a comprehensive knowledge of the range of factors that can result in individuals having an increased need for services for people living with and beyond cancer
- Has an understanding of models and concepts relating to health-related behaviour change and their application to high-risk individuals and groups
- Encourages high-risk individuals to identify and explore factors that affect their own health and wellbeing
- Enables individuals to identify the strengths and weaknesses in their knowledge and skills in promoting their own health and wellbeing
- Provides clear and accurate information to high-risk individuals about actions they can take to improve their health and wellbeing
- Works with high-risk individuals to identify obstacles to their health and wellbeing and to develop appropriate interventions and care plans
- Enables high-risk individuals to reach their own decisions about their health and wellbeing and to set their own priorities
- Encourages and enables high-risk individuals and groups to participate in initiatives to review and develop health promotion and wellbeing services for people living with and beyond cancer

Leadership

As specialist, plus:

- Has a working knowledge of the key concepts associated with health and health promotion and their application to high-risk individuals and groups, including:
 - social constructions of health and illness and how they affect perceptions and beliefs;
 - theoretical models of behaviour change;
 - strategies for promoting health and wellbeing;
 - inequality and discrimination and their impact on health and wellbeing.
- Collaborates with a range of individuals, agencies, networks and communities to promote health and wellbeing among high-risk individuals living with and beyond cancer
- Identifies factors that could act as obstacles to high-risk individuals receiving health promotion and wellbeing support within own specialty and other services
- Collaborates with a range of individuals, agencies, networks and communities to ensure that high-risk individuals have equal access to services that promote health and wellbeing
- Leads in evaluating services to ensure that they meet the needs of high-risk individuals/groups
- Works with others to involve high-risk individuals/groups in the development and evaluation of health promotion and wellbeing services for people living with and beyond cancer

DOMAIN 6

SUPPORTING SELF-CARE, SELF-MANAGEMENT AND ENABLING INDEPENDENCE

6a. Promoting self-management

Essential

- Recognises the contribution of healthy lifestyle behaviours to promoting and sustaining recovery from cancer and cancer treatments
- Assesses the ability and motivation of individual patients to manage self-care
- Identifies health beliefs and lifestyle risks that could influence adherence with care instructions or advice
- Encourages individual patients to make healthy living choices
- Teaches individual patients self-monitoring and self-care on single issues in focused consultations
- Provides encouragement to individuals who are attempting to change or adopt new health-related behaviours and provides positive reinforcement when they are finding it difficult or they are achieving less than they hoped to
- Promotes self-management as far as possible for each patient
- Recognises the barriers to self-management, including loss of confidence, prior ability to manage affairs, cultural issues, support networks
- Involves the family in supporting self-management and self-care where this is appropriate
- Signposts individuals to local services that support healthy living eg exercise facilities, walking groups, adult education classes, smoking cessation groups
- Provides practical and emotional support to encourage individuals to take an active role in communicating with health professionals where this is needed

Specialist

As essential, plus:

- Has an understanding of models and concepts of health-related behaviour change
- Teaches individuals to carry out self-monitoring and self-care and mentors them in the process
- Works in partnership with individuals to develop tailored plans of care to promote healthy lifestyle behaviours that meet their priorities and concerns
- Encourages individuals to identify and explore factors that affect their own health and wellbeing
- Where individuals want to change or adopt new lifestyle behaviours, enables them to develop realistic short – and long-term goals and focused plans for achieving behaviour change
- Works with individuals to identify potential barriers to changing or adopting new lifestyle behaviours and develop strategies to address them
- Identifies and explains any benefits and risks arising from individuals' decisions about their care to enable them to make informed choices

Specialist (Continued)

- Works with individuals to explore ways of overcoming barriers to following care instructions and advice
- Teaches individuals to recognise symptoms that require further advice/ investigation and advises them about the pathways available for accessing appropriate healthcare advice
- Educates individuals about recognising symptoms that require urgent intervention and the pathways for accessing prompt and appropriate healthcare advice

Leadership

As specialist, plus:

- Develops and evaluates strategies and interventions to promote healthy lifestyle behaviours
- Carries out specialist rehabilitation assessments in conjunction with therapist colleagues
- Acts as a resource to other staff supporting individuals with complex needs in relation to adherence with care plans and advice
- Works with other agencies to develop clear pathways for referral to support and information services for people living with and beyond cancer
- Proactively engages in promoting the self-care principle at local, national and international forums
- Creates services that can work in conjunction with other agencies, including primary care and voluntary sector services
- Develops educational programmes to enable individuals to develop the knowledge, confidence and skills to take more responsibility for self-management and self-care and make healthy lifestyle choices
- Evaluates care and services developed to promote self-management in terms of patient outcomes and the effectiveness of service delivery

6b. Providing information to support self-care and self-management and enable independence

Essential

- Has a good level of knowledge of the range of services available to support individuals across the care pathway eg voluntary agencies, health promotion services and support groups
- Directs individuals and family members to appropriate agencies and information sources
- Provides information about the services and support available to support recovery and living well after cancer treatment
- Provides written, online and verbal information to individuals about their condition and treatment
- Evaluates the individual's understanding of information and communicates effectively to correct misunderstandings and give further information when required
- Explains complex medical terminology in lay terms
- Participates in support groups for people living with and beyond cancer
- Offers guidance and support with accessing appropriate online sources of information
- Is aware of local resources to signpost to for advice about finances, return to work and employment issues

Specialist

As essential, plus:

- Acts as a point of contact for own caseload of patients
- Uses specialist knowledge to assess the information and supportive care needs of individuals living with and beyond cancer
- Assists individual patients to evaluate information relating to their own needs and preferences
- Identifies misunderstandings and misinterpretation of information provided and acts appropriately to clarify meaning
- Uses specialist knowledge to provide telephone consultations to individuals as part of services for people living with and beyond cancer
- Understands the concept of the teachable moment and maximises its potential by discussing lifestyle changes when patients are most receptive than at other times on the cancer pathway
- Directs individuals to relevant support/information networks on the wide range of issues that may affect them following cancer treatment, including work and finance matters
- Identifies and signposts individuals to wider sources of support eg online forums, rehabilitation classes

Specialist (Continued)

- Accesses information from a range of resources, and uses them to meet the individual needs of service users
- Critically assesses written information/websites before recommending them
- Contributes to the development and evaluation of patient information resources for people living with and beyond cancer
- Assists in the provision of planned education programmes for individuals using late effects/survivorship services
- Facilitates support groups for individuals using late effects/survivorship services

Leadership

As specialist, plus:

- Works with other agencies to develop information and support to ensure individuals receive information appropriate to their needs
- Leads on the development, audit and evaluation of patient information resources for people living with and beyond cancer
- Organises and plans support groups for individuals living with and beyond cancer

DOMAIN 7

PROFESSIONAL

PRACTICE

AND

LEADERSHIP

7a. Research, audit and service evaluation

Essential

- Collects data required for service evaluations, audits or research within services for people living with and beyond cancer
- Demonstrates an awareness of the principles of consent and confidentiality in relation to data collection, storage and sharing
- Demonstrates an understanding of the principles of clinical research, and can explain to service users the meaning of common terms and concepts (eg placebo, randomisation, qualitative research, patient-reported outcomes, informed consent)
- Accesses appropriate sources of evidence to support their practice eg nursing journals, literature reviews, research articles

Specialist

As essential, plus:

- Carries out service evaluations and audits of key aspects of own practice within services for people living with and beyond cancer eg patient satisfaction, local service standards
- Has a good understanding of the principles underpinning data and its use, including:
 - the range of qualitative and quantitative methods available and their purpose
 - the concepts of validity and reliability in relation to the design of data collection, collation and analysis
- Contributes to the development and completion of service reviews, audits and local research within services for people living with and beyond cancer
- Collaborates with those involved in providing services for people living with and beyond cancer to generate ideas for research, audits and service reviews
- Collects data using a range of methods eg patient outcome measures, technical data (such as results of tests and investigations), patient interviews and questionnaires
- Interprets and summarises descriptive data relating to individuals and groups of patients and local services for people living with and beyond cancer
- Applies principles of ethical practice in relation to research, audit and service evaluation (eg working within local governance systems, informed consent, confidentiality)
- Works with individuals and groups of service users to promote their inclusion in reviews of services for people living with and beyond cancer
- Writes for publication on own specialty
- Presents posters/papers at conferences on own specialty or service review

Leadership

As specialist, plus:

- Has a working knowledge of
 - the range of qualitative and quantitative methods available and their purpose
 - the concepts of validity and reliability in relation to the design of data collection, collation and analysis
- Identifies areas of practice that require review and/or could be the focus of research to develop local services and/or build the body of knowledge on the care of people living with and beyond cancer
- Initiates and guides service evaluations and audits of key aspects of service provision and own practice within services for people living with and beyond cancer
- Initiates, leads and develops service reviews, audits and research on subjects relating to the care of people living with and beyond cancer
- Develops systems for measuring outcomes for individuals, groups and services that enable accurate and meaningful reviews of progress
- Actively involves the range of service users in evaluating services, applying the principles of equality, diversity and anti-discriminatory practice
- Ensures that systems are in place to guarantee that project design and data management and dissemination meet ethical practice standards
- Writes for publication in peer-reviewed journals on own speciality
- Presents posters/papers at conferences on own research/audits
- Develops relationships with other agencies to promote research and enterprise partnerships services for people living with and beyond cancer

7b. Service development

Essential

- Supports other staff in the implementation of services for people living with and beyond cancer
- Contributes to the development of services for people living with and beyond cancer by identifying concerns or gaps in services and sharing them with senior colleagues
- Demonstrates an awareness that the views of service users are important to influence changes in practice
- Engages positively with changes to improve clinical services

Specialist

As essential, plus:

- Teaches and supervises staff in the care of people living with and beyond cancer in a range of settings
- Uses specialist knowledge to contribute to the development of evidence-based policies and procedures for the care of people living with and beyond cancer
- Works with individuals and groups of service users to promote their inclusion in the development of services for people living with and beyond cancer
- Applies the principles of equality, diversity and anti-discriminatory practice to service development
- Represents the local service or own discipline at local strategic meetings
- Contributes to the development of service reports relating to the care of people living with and beyond cancer
- Identifies and highlights gaps in service provision for people living with and beyond cancer
- Contributes to developing, implementing and evaluating service developments

Leadership

As specialist, plus:

- Ensures that services meet the wide range of needs of people living with and beyond cancer, from adjustment to living well after cancer (health promotion), to active surveillance, to complex symptom management
- Directs the development and delivery of local services for people living with and beyond cancer
- Develops services that meet service users' needs, considering a range of potential approaches (eg telephone follow-up, nurse-led clinics, primary care providers)
- Develops evidence-based protocols and guidelines for services for people living with and beyond cancer
- Monitors and evaluates protocols and policies developed for services to support people living with and beyond cancer
- Actively engages service users to obtain their views of service delivery and improvement
- Plays a leading role in the development of business cases and service reports within services for people living with and beyond cancer
- Plays a leading role in evaluating the costs and benefits of providing different models of care and service delivery for people living with and beyond cancer
- Devises and implements systems and methods for measuring the outcomes of services
- Represents services for people living with and beyond cancer or own discipline at network and national meetings
- Influences policies for people living with and beyond cancer at local and national level
- Influences the commissioning and development of cancer services to meet local needs
- Identifies service deficits and develops strategic plans for services for people living with and beyond cancer
- Leads locally on the implementation of national guidance for services for people living with and beyond cancer

7c. Education of service providers

Essential

- Teaches other HCPs in their own service on a one-to-one basis about issues relating to care for people living with and beyond cancer
- Supports more junior staff in the implementation of care for people living with and beyond cancer

Specialist

As essential, plus:

- Teaches groups of HCPs about care issues relating to people living with and beyond cancer in the local service in a range of settings
- Provides formal taught sessions about the care of people living with and beyond cancer on local study days
- Teaches on externally run educational programmes relating to the care of people living with and beyond cancer eg undergraduate and postgraduate training
- Participates in creating and delivering local and national education on the care of people living with and beyond cancer eg study days and conferences

Leadership

As specialist, plus:

- Takes a leading role in developing the skills and knowledge of staff providing care for people living with and beyond cancer in relation to the competences within this framework
- Takes a leadership role on local and network education for other HCPs on the care of people living with and beyond cancer
- Develops education for nurses and AHPs who work in non-oncology primary and secondary care services on cancer care, survivorship issues and late effects
- Develops education to promote an awareness of survivorship and late effects issues among oncology nurses in treatment centres
- Develops 'train the trainer' education to enable the dissemination of knowledge about and skills applicable to the care of people living with and beyond cancer
- Develops educational programmes on the care of people living with and beyond cancer, including survivorship and late effects care, for academic credit in liaison with universities
- Takes a leadership role in the development of national programmes of education on the care of people living with and beyond cancer eg study days and conferences
- Takes a leadership role in developing innovative educational methods to increase awareness and knowledge of the needs and care of people living with and beyond cancer

DOMAIN 8

INTERAGENCY AND PARTNERSHIP WORKING

Essential

- Liaises between service users, relatives and other members of the MDT involved in an individual patient's care pathway to optimise care
- Makes appropriate referrals to other members of the MDT involved in late effects services
- Liaises with HCPs across community and hospital settings and signposts to other healthcare teams as appropriate
- Has a good understanding of the contributions of other health, social care and voluntary sector services in meeting holistic care needs (eg financial, vocational and emotional support)

Specialist

As essential, plus:

- Uses communication and coaching skills to encourage individual patients and their family to be involved in consultations with the MDT and the wider range of care and service providers
- Coordinates MDT interventions relating to a patient's care plan eg discharge and surveillance/survivorship care plans after cancer treatment, community care plans for ongoing care
- Works with health, social care and voluntary sector agencies involved in providing services for people with late effects/survivorship care needs to ensure that individuals receive high-quality, well-coordinated care
- Works with agencies outside of survivorship and late effects services in relation to current and anticipated future needs of individual patients eg employment, financial and education services
- Actively contributes to the development of services for people living with and beyond cancer within the MDT eg late effects, survivorship, health and wellbeing
- As a core member, presents patients at late effects MDT meetings

Leadership

As specialist, plus:

- Coordinates interventions for individuals with complex care needs after cancer and cancer treatment, working with the MDT and health, social care and voluntary sector agencies
- Provides expert advice to other members of the MDT and health, social care and voluntary sector agencies involved in the survivorship/late effects service
- Builds local relationships with those involved in the care of cancer patients eg site-specialist nurse specialists, primary and secondary care MDTs, palliative care teams, social care and voluntary sector agencies
- Promotes inter-professional working to ensure effective communication between all providers and to develop a holistic approach to patient care delivery within the late effects/survivorship service
- Plays a leading role in developing late effects MDT operational policy and activities of the MDT meeting
- Builds partnerships with the health, social care, voluntary and independent sectors to ensure that late effects/survivorship pathways are robust, feasible, and promote quality care
- Works with the MDT and other health, social care and voluntary sector agencies across primary and secondary care services to promote engagement with late effects/survivorship issues early in the patient's treatment journey
- Plays a leading role in local, network and national audits within the survivorship/late effects service

Common Core Competences and Principles

More information can be found from existing guidance:

'A Guide for Health and Social Care Workers Working with Adults at the End of Life' (Department of Health et al., 2009).

Acknowledgements

Key contributors

Clare Warnock

Practice Development Nurse, Weston Park Hospital, Sheffield Teaching Hospitals NHS Foundation Trust

Dr Diana Greenfield

Macmillan Consultant Nurse, Weston Park Hospital, Sheffield Teaching Hospitals NHS Foundation Trust

Professor Sara Faithfull

Professor of Cancer Nursing Practice, School of Health and Social Care, University of Surrey

Feedback

We welcome your constructive feedback on the document. Please contact:

Dr Diana Greenfield

Macmillan Consultant Nurse
Sheffield Teaching Hospitals NHS Foundation Trust.

Email: Diana.Greenfield@sth.nhs.uk
Phone: **0114 226 5592**

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List of additional contributors

Thanks are due to the following for reading and commenting on the final draft: Stakeholders who participated in the evaluation surveys, including the service users, via Cancer Voices.

The managers

Ed Murphy

Senior Development Manager,
Macmillan Cancer Support, South and
West, England

Mary Jo Thompson

Public Health Agency and NI Cancer
Network, Knockbracken Health Care
Park, Belfast

Hayley Williams

Macmillan Survivorship Programme
Manager, Sheffield

The clinicians

Dr Susan Davidson

Consultant Clinical Oncologist,
The Christie NHS Foundation Trust,
Wilmslow Road, Manchester

Dr Gill Levitt

Consultant Paediatric Oncologist,
on behalf of Macmillan

Dr Wendy Makin

Macmillan Consultant in Palliative Care
and Oncology, The Christie NHS
Foundation Trust, Wilmslow Road,
Manchester

The nurses

Those who attended the Nurses'
Stakeholder Day and CCAT Masterclass,
Macmillan UKO, 20 September 2013 as
follows:

Jo Armes

Research Fellow, King's College

Jan Bates

Macmillan Oncology CNS,
Queens Hospital Burton on Trent

Janet Brook

Service Improvement Lead:
Living With and Beyond Cancer,
Addenbrooke's Hospital

Karen Burnet

Lead Breast Care Nurse,
Addenbrooke's Hospital

Clare Byrne

Advanced Nurse Practitioner, University
Hospital NHS Foundation Trust Liverpool

Sandra Campbell

Macmillan Nurse Consultant,
NHS Forth Valley

Nicky Dobson

Teenage and Young Adult Cancer Nurse
Specialist, Addenbrookes Hospital

Sara Faithfull

Professor of Cancer Nursing Practice,
University of Surrey

Sharon Foy

Macmillan Breast Care Nurse Specialist,
The Christie NHS Foundation Trust

Jeannine Georgette

Breast Care Nurse,
Homerton University Hospital

Hannah Greene

Late Effects Clinical Nurse Specialist,
Addenbrookes Hospital

Diana Greenfield

Consultant Nurse & Honorary Senior
Lecturer, Weston Park Hospital

Emma Groves

Macmillan Nurse Community Care
Oncology, BCUHB – Community
Nursing

Enda Hanna

Macmillan Oncology Nurse Practitioner,
Belfast City Hospital

Jane Hopkinson

Professor of Nursing, Cardiff University

Martina Kelly

Upper GI CNS,
Homerton University Hospital

Caroline Lynas

Macmillan Transforming Cancer Follow
Up Project Manager, Ulster Hospital

Tessa Martin

Uro-Oncology CNS,
Royal Berkshire Hospital

Annette Martyn

Macmillan Uro-Oncology CNS,
Western Sussex Hospitals

Denise Moorhouse

Breast Radiotherapy Injury Rehabilitation
Service Manager, Royal National
Hospital For Rheumatic Diseases

Jean Munday

Lead Nurse Endocrinology,
Queen Alexandra Hospital

Helen Newport

Macmillan Lead Nurse/Nurse Manager,
NHS Dumfries & Galloway

Suzanne Nimmo

Macmillan Lecturer,
Edinburgh Napier University

Kemi Ogunyemi

Lead Chemotherapy Nurse,
Royal Free Hospital

Geke Ong

Haematology Clinical Nurse Specialist,
King's College

Julie Orford

Macmillan Lead Nurse,
University Hospital of South Manchester

Sinead Parry

Macmillan Centre Manager,
Queen Alexandra Hospital

Arlene Paterson

Macmillan Advanced Haematology/
Oncology CNS,
Wishaw General Hospital

Barbara Payman

Macmillan Sexuality and Bereavement
Counsellor, Castle Hill Hospital

Pat Pilkington

Macmillan Person Centred Care Project
Manager, Glan Clwyd Hospital

Jane Robson

Teenage Cancer Trust Lead Clinical
Nurse Specialist,
Cambridge University Hospitals

Karen Roberts

Macmillan Reader and Nurse Consultant
in Gynaecological Oncology,
Northern Gynaecological Oncology
Cancer Centre

Kay Rowe

Lung Cancer Nurse Specialist,
Llandough Hospital

Val Russell

Macmillan Neuro Oncology Advanced
Nurse, Oxford University Hospitals NHS
Trust

Claire Taylor

Team Leader, Macmillan Colorectal
Cancer Nurse, St Mark's Hospital

Clare Warnock

Practice Development Sister,
Weston Park Hospital

Lynn Welsh

Macmillan Nurse Clinical,
The Christie at Salford

Isabel White

Clinical Research Fellow in Psychosexual
Practice, Royal Marsden

Cathy Wilson

Head of School, Royal Marsden Hospital

Elaine Wilson

Survivorship Project Manager,
United Lincolnshire Hospitals NHS Trust

Theresa Wiseman

Lead for Health Service Research,
The Royal Marsden

Carly Wretton

Macmillan Haematology CNS,
Northampton General Hospital NHS Trust

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