ACT Government | Canberra Health Services

Model of Care

Cancer Supportive Care

March 2022 V1

Contents

Approvals

Position	Name	Signature	Date

Document version history

Version	Issue date	Issued by	Issued to	Reason for issue

*Once this document has been approved, please remove the DRAFT watermark.

1. Introduction

This Model of Care (MoC) for Cancer Support Care sets out the evidence-based framework for describing the right care, at the right time, by the right person / team and in the right location across the continuum of care. A clearly defined and articulated MoC helps ensure that all health professionals are 'viewing the same picture', working towards common goals and most importantly evaluating performance on an agreed basis.

This MoC:

- outlines the principles, benefits and elements of care,
- provides the basis for how we deliver evidence-based care to every patient, every day through integrated clinical practice, education and research; and
- contains information of patient/client flows (the areas from where patients enter and exit the service) and service co-ordination, that is the linkages required for seamless patient treatment.

A MoC is a dynamic document and will be updated over time to support new evidence and improved ways of working. Any updates will include relevant change management principles and processes to ensure clear engagement and communication.

This MoC should be stored on the Canberra Health Services (CHS) 'Models of Care' intranet site. It will be reviewed and updated regularly through consultation and the relevant communication in line with CHS guidelines once yearly.

2. Principles

Our vision and role reflect what we want our health service to stand for, to be known for and to deliver every day. The vision and role are more than just words, they are our promise to each other, to our patients and their families and to the community. We all have a role to play in delivering on this promise:

- Vision: Creating exceptional health care together
- Role: To be a health service that is trusted by our community

Our values together with our vision and role, tell the world what we stand for as an organisation. They reflect who we are now, and what we want to be known for. They capture our commitment to delivering exceptional health care to our community. Our values:

- We are reliable -we always do what we say
- We are progressive -we embrace innovation
- We are respectful -we value everyone
- We are kind -we make everyone feel welcome and safe.

Our Strategic Plan sets out our path forward as an organisation for the next three years. It is values driven—it outlines how we will deliver against our vision of 'creating exceptional health care together' for our consumers, their families, and carers.

Our Partnering with Consumers Framework provides clear principles for a shared understanding of our approach and what is required from all team members for effective partnerships with consumers and carers in line with our organisational values. The principles have been developed in collaboration with our consumer and carer organisations and underpin this Framework.

3. Benefits to be realised

The Cancer Support Care (CSC) services was established in recognition of the need to provide additional supports for people affected by cancer. From diagnosis through treatment, possible remission, relapse and end of life there are many phases in the journey for the consumer with cancer to become overwhelmed in the system.

The team has advanced knowledge of the specific disease process, treatments, treatment side effects, and other disease related complications, such as financial toxicity, housing, Centrelink processes, Aged care supports, NDIS and grief and bereavement. This specialised knowledge and skills enables them to have an overview of the entire patient journey and a strong understanding of the needs of people affected by cancer.

Education and supportive interventions by the CSC team increases consumers' skills and confidence in decision-making. The CSC team provide care that is coordinated, focused, and supports a holistic patient-centred care model. This approach is fundamental in transitioning consumers from an acute illness mode to a survivorship model during, and at the end of their acute treatment. The CSC team guide consumers through the overwhelming maze of information, appointments, and emotions, from diagnosis through treatment and recovery or palliative care.

A range of benefits associated with CSC services will be monitored

Qualitative benefits:

- Positive patient / family experiences
- Evaluation feedback responses
- Staff experience and culture surveys

Quantitative benefits:

Specific Key Performance indicators include:

- Total number of patients seen by CSC team
- % of patients seen within agreed timeframe
- Number of unplanned readmissions

4. Description of service

The Canberra Health Services CSC team sits within the Division of Cancer and Ambulatory Support (CAS). The service provides consumers with cancer, carers, and their support network with timely access to cancer treatment, symptom management information, support services and referral information.

The CSC team consist of:

Cancer specialist Nurses (CSN)

Cancer Specialist Nurses are senior nurses with a strong background in oncology (medical, radiation, surgical and/or palliative care) and expertise in the cancer they specialise in. CSN work closely with Cancer Specialists (who also sub-specialise to specific tumour groups) within their Multidisciplinary Team, attending clinic appointments with patients and providing further information and support across the entire treatment trajectory.

Cancer Psychosocial team

The Cancer Psychosocial Service is comprised of three different services and includes Social Workers, Psychologists and a Social Work Assistant. Each service provides specialised services within the hospital or community and provides holistic support to patients, families and carers impacted by cancer.

Hospital Based Cancer Psychosocial Team

People with cancer and their families/carers have access to cancer specialist social workers, an adolescent and young adult social worker and psychologist. The team accepts referrals from clients that are currently accessing oncology/haematology and radiation therapy services at the CRCC and oncology/haematology in-patients on the wards of TCH. The Cancer Psychosocial Service acknowledge that patients may have a number of concerns when facing different stages of cancer, including adjustment to the cancer diagnosis and its impact on all aspects of life, recovery, survivorship, and disease progression and for some, end of life care. SW and/or psychologists can address psychosocial concerns through provision of a comprehensive psychosocial assessment and the facilitation of therapeutic interventions that address and manage stress, anxiety and depression in relation to a diagnosis and treatment of cancer.

Social Workers

Social workers use psychosocial assessments to identify psychosocial distress caused by cancer and implement best practice interventions or facilitate access to cancer specific resources and services. The social workers can support patients and their families from an individualised psychosocial approach, within the hospital setting. These interventions may consist of individual counselling services to address emotional adjustment and difficulties, lifestyle changes due to cancer, grief and bereavement issues, practical support, discharge planning, psycho-education and information to patients, family/carers and referrals to health and community organisations and support groups.

Social workers work closely with CSN and other nursing staff to ensure that cancer care incorporates a psychosocial perspective for patients/clients. Communication of issues is conducted through attendance at ward and multidisciplinary meetings, accompanying ward rounds, writing in clinical notes, electronic patient journey board as well as informal discussions. Social workers assist

medical and nursing staff by facilitating family meetings to ensure clear and open communication between the person with cancer, their family/caregivers, and the treating team.

Psychologists

Psychologists from the Cancer Psychosocial Service can diagnose clients with specific types of mental distress and can facilitate inpatient and outpatient clinic-based assessment, counselling, and therapeutic psychological sessions. Cancer specialist psychologists can support people with cancer, their families, and carers. Cancer specialist psychologists can help clients recognise their psychological distresses and educate them of strategies to manage strong emotions. Cancer specialist psychologists can also support people with cancer and their families/carers in managing suicidal ideation, alcohol and/or substance abuse and/or self-harm. If a cancer specialist psychologist recognises that a client may require further support, they may be referred to and Oncology Psychiatrist.

Cancer Counselling Team

The Cancer Counselling Service (CCS) staff consists of both psychologist and Social Work with specific counselling expertise and training. The CCS is a free service offered to people with cancer over the age 16, their partners and caregivers who are receiving cancer treatment within the CRCC. There are two community teams, located at Phillip Health Centre (PHC) and Belconnen Health Centre (BHC). The counsellors work with their clients to alleviate psychosocial concerns through facilitating therapeutic interventions that address management of stress, anxiety and depression in relation to a diagnosis and treatment of cancer. The counsellors in this service focus on adjustment and lifestyle changes due to cancer and survivorship, as well as grief and bereavement counselling. Alongside counselling services, psycho-education and information provision, group programmes, such as mindfulness and post treatment support groups, and referrals to health and community organisations and cancer support groups are also available.

This service may be accessed by people who are receiving private cancer treatment or interstate while residing in ACT; have completed treatment and are bereaved from cancer. This service is also available for clients currently receiving treatment at CRCC who wish to access the service in a community health setting.

Services provided by the Cancer Counselling Team include:

- Supportive counselling regarding adjustment to diagnosis, grief and loss, role and identity changes
- Support when there is a change in disease status
- Support for the psychosocial impact of cancer and strategies to address this
- Carer support
- Transition to end-of-life care
- Therapeutic counselling
- Practical support for financial issues, accommodation, and transport needs
- Information and referral to community services
- Advocacy for patients and their family or carers
- Discharge planning, including family meetings
- Group work

Patient/client journey

Patients may self-refer or be referred to the CSCT service by health professionals, family, carers, and non-government organizations. Referrals are reviewed and prioritised to identify patient needs. The team will use their expertise, knowledge, and training to identify patients who need more, urgent, or ongoing supportive care.

Patients will be made aware of the services available by the CSCT when first orientated to the cancer services at CHS. Clinicians and allied health workers will also work with patients to refer them to the appropriate CSN, SW or psychologist to meet their specific needs.

Patients are not eligible for all services from the CSCT if they are seen in private medical practices and receive their treatment in private hospitals. Cancer Supportive Care team members cannot attend inpatients at hospitals other than CHS.

Eligible patients and their families, both inpatients and outpatients may access the Cancer Supportive Care Team members on both a drop-in basis, and where required, by appointment.

Cancer Psychosocial Service and Cancer Counselling Service clinicians utilise the risk indicator and psychosocial assessment as tools to identify individual's psychosocial needs. Clinicians use a client centred framework when undertaking the assessment and work collaboratively with the client to determine appropriate interventions and additional service required for the person with cancer and their family. The psychosocial assessment is a continual assessment that includes regular reviews to ensure the current needs are met based on current information. While the psychosocial assessment is mostly carried out by the psychosocial clinicians all members of the treating team have a responsibility to contribute to the assessment and review processes.

Referral Process to the CSN

Referrals to the CSN service should be made on the ACT Government Health Directorate Referral Intake Form No. 25063 which is available on the ACT Health Directorate intranet.

Urgent referrals can be made directly to the tumour /age specific CSN or social worker by telephone, email or verbally. The contact list for the team is attached at Appendix 2.

Referrals to the Cancer Supportive Care team can be received from TCH clinicians, external organisations (e.g. external Foundations), from the patient/carer, or from the MDT. Referrals will be directed to the appropriate team member for prioritization. Referrals received for patients under age 26 will be referred to the AYA Cancer Specialist Nurse.

Referral Process to the CCS

Cancer patients may begin to receive psychosocial care at various points of the cancer trajectory, in the outpatient setting, in the community or within the hospital. All patients on Ward 14A/14B can be referred to social work for a psychosocial support via the Patient Digital Journey Board, ensuring adequate information is provided to triage referral. Referrals post discharge from other wards and Outpatient referrals are made to the hospital-based Cancer Psychosocial Service by:

Completion of a Cancer Psychosocial Service referral form for social workers and psychologists

Discussion with social workers/ psychologists at ward meeting / handover

Referrals are made to the community-based Cancer Counselling Service by:

Completion of Community Health Intake Referral (CHI) Form (Health Professionals)

Telephone call to CHI (Client) on (02) 6207 9977

Discharge

If a patient no longer has Supportive Care needs, they will be discharged from the service. Notification to the admitting team will be provided with an invitation to rerefer the patient if they develop further needs.

5. Patient/Consumer Journey

The CSC team provides comprehensive care to referred patients in the inpatient and outpatient settings of Canberra Health Services. The CSC team provide care that is coordinated, focused, and supports a holistic patient-centred care model. The team provides support for patients and carers whilst supporting holistic patient care delivery throughout CHS by the provision of policy, service delivery development, education and mentorship, education, policy, and service delivery development..

Inpatient

Triage of Referrals → Care Provision →Discharge

All referrals are triaged by the referred team – cancer counselling team, cancer specialist nurses or cancer psychosocial team. The psychosocial services are not a crisis intervention service, for clients who are at urgent risk of harm, referral to the Crisis Team.

Care Provision

The teams work with the patient and their carers to navigate the health care system and provide supports to achieve and maintain safe discharge.

1. Prevention and early detection	
The Cancer Supportive Care Team (CSCT) will support the prevention and early detection of cancer in the community through:	
Networking	Developing networks that provide the team with opportunities to inform, educate and support our community on prevention and early detection of cancer.
Health promotion	Through our networks, delivering health promotion activities and education as appropriate.
Model of Care	Promoting the CSCT model of care, and the overarching Optimal Care Pathways, to the primary health care networks and other external stakeholders.
CHS Social Media	Utilising social media, as appropriate and within the CHS guidelines, to promote healthy communities and early detection of cancer.

2. Presentation, initial investigation and referral	
The CHS Cancer Supportive Care Team support the process of referring patients with suspected cancers and subsequent timely diagnosis through:	
Referral Processes	CSCT will work with a single intake model to ensure efficient and effective referrals to cancer services. Referrals to the CSCT can be received at any point in the cancer trajectory, ideally at initial diagnosis. Referrals can be initiated by the CSCT.
Investigations	Working within the multi -disciplinary team to support assessment of the patient's holistic care needs, ensuring timely coordination and prompt follow up.
Patient Engagement	Engaging with patients throughout their interactions with the service and establishment of effective communication with all care providers to support patient centred care.
Access to psychosocial support	Identifying the psychosocial needs of patients, carers and their support network to ensure timely and appropriate access to to support services.

3. Diagnosis, staging and treatment planning	
The Cancer Supportive Care Team supports the process of diagnosis, staging and treatment planning through:	
Education and Information	Providing appropriate and current resources specific to each cancer type to all care providers.
Supporting self-care, health and wellbeing	Promoting self-care and healthy lifestyle strategies that empower patients to enhance their physical, psychological, spiritual, social and information needs.
Engaging with primary healthcare providers	Ensuring primary health care providers receive timely and relevant information on diagnosis, staging and treatment planning and support strategies.
Primary care investigations	Working collaboratively with primary health care providers to initiate timely and appropriate investigations to assist diagnosis.
Treatment planning	Actively work with the MDT to ascertain individual treatment plan.
Communication	Providing care providers, patients and carers with regular and timely communication regarding treatment planning and support.
Carer Support	Ensuring carers and their support network have access to assessment, education, support and resources.

4. Treatment	
The Cancer Supportive Care Team support the process of treatment through:	
Goal Setting	Promoting patient's involvement in determining goals of care.
Treatment options	Providing education and support to patients to enable informed decision making to achieve their goals of care.
Care Coordination	Timely and appropriate assessment and referrals to CSCT and other services as necessary.
Complementary & Alternative therapy	Ensuring patients have the opportunity to discuss and explore complementary and alternative therapies with the treating team. Assisting patients to access appropriate information to make informed decisions.
Treatment planning	Ensuring care providers receive regular and timely communication regarding treatment planning and support.
Supporting self-care, health and wellbeing	Promoting self-care and healthy lifestyle strategies that empower patients to enhance their physical, psychological, spiritual, social and information needs.
Support and communication	Maintaining communication with patients, carers and their support network as well as care providers. Conducting ongoing assessment of support needs.
Clinical trials	Ensuring discussion, information and support to access available clinical trials.
Palliative and Supportive Care	Facilitating appropriate referral to palliative and supportive care early to optimise quality of life.
Advocacy	Advocating for patients, carers and their support network throughout treatment.

5. Care after initial treatment and recovery	
The Cancer Supportive Care Team support the process of care after initial treatment and recovery through:	
Post treatment care planning	Assisting the patient in transitioning back to primary care. Facilitating a treatment summary and follow up care plan that is communicated to the GP and service providers involved in the patient's care. Ensuring the patients, carers and their support network is aware of the plan of care.
Referrals	Ensuring the patient has been referred to or is aware of available services.
Education	Providing education to patients, carers and their support network on the potential ongoing physical and emotional effects of disease, treatment as well as where and when to seek help.
Supporting self-care, health and wellbeing	Promoting self-care and healthy lifestyle strategies that empower patients to enhance their physical, psychological, spiritual, social and information needs.
Carer support and education	Providing relevant information and support to carers and referrals to appropriate community resources.

6. Managing recurrent, residual and metastatic disease	
The Cancer Supportive Care Team support the process of managing recurrent, residual and metastatic disease through:	
Education	Providing education to patient, carer and support network on goals of care, prognosis and treatment options.
Re-entry and engagement	Expediting re-entry into the service. Re-establishing who the members of the MDT are and introducing new members. Ongoing nursing and psychosocial assessments and interventions.
Care planning	Facilitating informed decision making and stablishing agreed goals of care with patients.
Palliative and supportive care	Engaging with palliative care team to facilitate early and timely referrals.
Support and communication	Maintaining communication with patient, carers and their support network as well as care providers.
Research and clinical trials	Conducting ongoing assessment of support needs.

7. End of Life	
The Cancer Supportive Care Team supports the process of end of life through:	
Communication and Support	Maintaining communication with patient, carer, support network and care providers. Conducting ongoing assessment of support needs and referring to appropriate support services.
Education	Providing education to patient, carer and support network on end of life care.
End of life care	Engaging with services who can provide palliative care support to ensure the patient receives appropriate end of life care.
Clinical trials	Ensuring discussion, information and support to access available clinical trials.
Grief and bereavement support	Facilitating referral to psychosocial support for grief and bereavement.

6. Interdependencies

The overall aim of the multidisciplinary cancer meeting (MDM) (Appendix 3) is to enable a formal mechanism for multidisciplinary input into treatment planning and ongoing management and care of patients with cancer. Generally, referrals are generated to the meetings by the medical team to enable confirmation of diagnosis and ongoing treatment recommendations and planning.

The Cancer Supportive care team is an integral member of the MDT and may:

- provide and collate information for the meeting
- participate in the development and implementation the treatment plan
- follow up recommendations and referrals from the meeting
- arrange appointments or further diagnostic tests

- provide further information to patients following communication of the treatment plan by medical officers.

7. Service support

All patients seen by the CSCT are under the care of a Specialist and a wider Multidisciplinary Team. The CSCT team works in partnership with the treating team to manage symptoms and psychological distress associated with a cancer diagnosis. The Service also supports education in the territory regarding cancer prevention strategies, treatment adherence and healthy lifestyle, advance care planning and palliative care.

8. Workforce

The CSCT are available Monday-Friday from 0830 until 5pm (with some differences for part-time staff) (Appendix 4).

9. Accreditation and Training

All new CSCT team members will be provided with local orientation as an essential element to their induction to the service.

Orientation to the CSCT team will include all mandatory training through CHS. It will also include an overview of the work area, gaining access to ICT services and room booking systems.

Quality Improvement: Supporting self-care, health, and wellbeing

The maintenance of staff self-care and wellbeing is fundamental to the provision of Cancer Services. The team supports formal and informal avenues for clinical supervision to support and maintain staff wellbeing. This involves opportunities for debriefing and support, education, and access to self-care resources.

10. Monitoring and Evaluation

Monitoring: Patient Experience through feedback

Morbidity and Mortality Meeting:

Patients who have died within the service are discussed at the monthly M&M meeting. CSCT members involved in the care of any patients for discussion are encouraged to attend the meeting. The review focusses on the leaning from the patient's death including:

- Was the death expected?
- Was the comfort care pathway initiated?
- Was the recommended treatment plan implemented?
- Was the preferred destination of death and care achieved?

Evaluation of the MOC will be achieved by monitoring and auditing the service's performance against specific activities stemming from broad service objectives and methods detailed in the operating guidelines.

11. Records management

Following the relevant consultation, this finalised document and any further updates will be electronically stored on the Canberra Health Services intranet site – 'Models of Care', to ensure accessibility for all staff.

12. Abbreviations

ACT	Australian Capital Territory
BHC	Belconnen Health Centre
CAS	Cancer and Ambulatory Support
CHI	Community Health Intake
CRCC	Canberra Region Cancer Centre
CHS	Canberra Health Services
CSN	Cancer Specialist Nurse
CSCT	Cancer Supportive Care Team
MDT	Multidisciplinary Team
MoC	Model of Care
OCP	Optimal Care Pathways
PHC	Philip Health Centre
SW	Social Work

13. Model of Care Development Participants

Position	Name
CNC Specialist Palliative Care & CSCT, CHS	Erin Wells
CSN Metastatic Breast Cancer	Kerryn Ernst
CSCT	All members
Assistant Director of Nursing, CAS	Cathy Young
Director of Nursing, CAS	Melissa O'Brien

14. Appendix A – Staffing Profile

Position Title	Classification	FTE 2022	Comments
AYA & Sarcoma	RN3.1	1.0	Permanent
Autologous stem cell transplant and plasma cells disorders	RN3.1	1.0	Permanent
Brain & Gynaecological Cancer	RN3.1	1.0	Permanent
Breast Cancer	RN 3.1	1.68	Temporary 3 year rolling contract McGrath Foundation
Metastatic Breast Cancer	RN 3.1	.84	Permanent/McGrath Foundation
Gastrointestinal Cancer	RN 3.1	1.0	Permanent
Head & Neck Cancer	RN 3.1	0.84	Permanent
Haematology	RN 3.1	1.0	Permanent
Lung & Mesothioloma	RN 3.1	1.0	Permanent
Lymphoma	RN 3.1	1.0	Permanent
Melanoma	RN 3.1	0.84	Permanent
Prostate (Surgical)	RN 3.1	0.8	Temporary 3 year rolling funding Prostate Cancer Foundation Australia
Prostate Cancer	RN 3.1	1.0	Permanent/ Prostate Cancer Foundation Australia
Urological Cancer	RN 3.1	1.0	Permanent
Senior Social Worker	HP3	3	Permanent
Social Work Counsellor	HP3	1.4	Permanent
Social Worker	HP2	2.8	Permanent
Social Worker Graduate	HP1	1.0	1 year contract
Psychologist	HP3	1.4	Permanent
Social Work Support	AHA	.4	Permanent