West Midlands Cancer Alliance Personalised Care Standards

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EAG name		
Document Title	West Midlands Cancer Alliance	
Published date	January 2026	
Document Purpose	Developed by Personalised Care Task and Finish Group and wider stakeholders including patient advocates. To provide Trust clinical teams with a set of standards to support the implementation of personalised care as BAU. To support the delivery of the national priorities and objectives for cancer.	
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Review Date:	December 2027	
Approval Signatures:	**Personalised Care Task and Finish Group Chair** 	**Clinical Director, West Midlands Cancer Alliance** 

Document Management

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Revision History

Version	Date	Revision Author	Status	Description i.e. changes made
V0.02	Jan	Personalised Care Task and Finish Group	Draft	First Draft
V0.03	March	Personalised Care Task and Finish Group	Draft	
V0.04	April	Personalised Care Task and Finish Group	Draft	
V0.05	May	Personalised Care Task and Finish Group	Draft	

V0.06	June	Personalised Care Task and Finish Group	Draft	
V0.08	July	Personalised Care Task and Finish Group	Draft	
V0.09	July	Sandra Smith Programme Manager	Draft	
V0.10	September	Personalised Care Task and Finish Group	Draft	
V0.11	September	Sandra Smith Programme Manager	Draft	
V0.12	October	Sandra Smith Programme Manager	Draft	
V0.13	November	Stakeholder Engagement	Draft	
V0.14	November	Stakeholder Engagement update	Draft	
V0.15	December	LWBC Steering Group update	Draft	
V1.0	December	LWBC Steering Group update	Final Draft	
V1.2	December	Text minor amendments	Final Draft	

Approved by

This document must be approved by the following people:

Governance	Description	Who	Date
LWBC Steering Group	Approved	LWBC Steering Group Vice Chair	15.12.2025
WMCA Clinical Cabinet	Approved	Clinical Cabinet	14 January 2026

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Executive Summary

The West Midlands Cancer Alliance (WMCA) Personalised Care Standards for Cancer outlines a comprehensive, person-centred approach to supporting individuals diagnosed with cancer through an assessment and care planning approach. With cancer prevalence expected to rise significantly, with over 135,000 people projected to be living with and beyond cancer in the West Midlands by 2030, this standard responds to the urgent need for proactive, holistic care aimed at enhancing patient wellbeing.

Background

The number of people living with a cancer diagnosis in the UK is set to double to more than 4 million by 2030[1]. Due to developments in diagnosis and treatment of the disease cancer survival rates have doubled in the last 40 years. There are currently 2.5 million people living with cancer in the UK. This means more people are living with the disease, its side effects, and the consequences of its treatment for many years.

In England, the average general practice has 280 patients living with cancer and 140 patients diagnosed within the past five years, 70% of people with a diagnosis of cancer are living with at least one other long-term condition which may impact on their holistic needs once they get a cancer diagnosis .[2] A personalised approach to care and support planning, using a Holistic Needs Assessment (HNA), ensures people's needs can be fully identified and appropriate support planned.

6.5 million people live in the West Midlands, and 600 cancer cases are diagnosed per 100,000 people every year – this is set to increase as our population ages. By 2030 there will be some 135,000 people living with and beyond cancer in the West Midlands. This is due to a number of factors, including rising incidence related to lifestyle factors and our ageing population, but also higher rates of early diagnosis and better treatments meaning that people are living longer following a cancer diagnosis. Macmillan Cancer Support advocates that people living with cancer receive a HNA and a Personalised Care and Support Plan (PCSP). It's their individual guide through their cancer journey, from diagnosis onwards.

This document has been developed by WMCA Personalised Care Task and Finish Group to support the services to focus on the whole person and whole pathway, with a personalised care approach in cancer for adults.

Introduction

What is Personalised Care?

- Personalised care is a key focus of the *NHS Long-Term Plan* (2019), focused on giving people more control over their health and ensuring tailored support, especially those diagnosed with cancer.

- The Long-Term Plan states that every cancer patient will have access to personalised care, including a HNA, PCSP, and appropriate information and support, in line with the comprehensive model for personalised care.[3,4]
- Personalised care tools are seen as essential for guiding patients through the complex journey from diagnosis onwards, ensuring their individual needs are recognised and met at every stage.

Health Inequality

All patients should be offered an HNA in a format that is accessible, and provision made for patients in an appropriate language format including braille to meet their requirements.

Scope

The Personalised Care Standards document shall include Holistic Needs Assessment, Personalised Care and Support Planning and End of Treatment Summaries. The Personalised Care Standards document will not include Cancer Care Reviews (CCR), Prehabilitation & Physical Activity, Health & Well-Being Information & Support. The latter shall be addressed with the listed Standards for Cancer Care review (CCR), Pre-hab and Physical Activity, HWBiS, and the Community Prehabilitation transformation project work). Teenagers and young adults will have an age appropriate HNA completed rather than the standard one as per the NHS England (2023) service specifications

What is a Holistic Needs Assessment?

- A HNA is an assessment consisting of a checklist or series of questions about all areas of the patient's life, to assist in the patient's ongoing care and support needs.
- This can be administered either by a paper copy or electronically (eHNA)

The HNA Guideline process

- The HNA should take between 30 minutes to 1 hour to complete but can take as long as needed by the patient.
- A HNA should be conducted by a member of the cancer/inpatient team and the person responsible for the care of the patient and the patient themselves.
- The HNA should be conducted at an appropriate time or after 4 weeks following the patient being informed of their diagnosis, but a HNA can be offered at any stage in the patient's care pathway and the HNA can be updated to document any new concerns a patient may have.
- As the patient needs change over the course of the care pathway a new HNA may be required.

HNAs are completed by the patient in conversation with the appropriate Health Care Professionals.
This could be:

- Clinical Nurse Specialist (CNS) or
- Advance Clinical Practitioner (ACP)
- Allied Health Professionals (AHPs),
- Trained Cancer Support Worker (CSW), Cancer Care Navigator (CCN) to ensure consistency and quality across cancer pathways.
- Palliative Care Team

The document is called a holistic needs assessment because any area of a patient's life that has been affected by cancer can be discussed. A HNA is not only about the physical symptoms of cancer or the side effects of treatment.

These concerns can be:

- physical
- emotional/psychological
- practical
- financial
- social
- family and relationship
- spiritual
- lifestyle or information needs

What happens at a HNA discussion?
The HNA is a tool used to identify concerns that matter most to a patient. This can help to decide what to discuss and talk about and issues that are most important for the patient during the assessment.

The HNA Conversation

- The HNA conversation should be based upon the needs of the patient. If the patient has complex or multiple needs (to be decided upon by the clinician) then this should be undertaken by a CNS/ACP/AHP. A CCN/CSW will in most cases be able to complete a HNA but should be guided by their clinical team.

- The HNA conversation or follow up call should ensure privacy.

- The HNA may be completed by hospital or General practice staff.

- The HNA can be completed over the phone. It can also be completed online in a video call (virtually). The patient can tell the person completing the HNA what they would prefer.

- Ideally a patient should be offered an informal HNA at diagnosis (after the patient has been informed of their diagnosis), this may be to address immediate concerns regarding (e.g. finances), but should have a formal HNA offered at around 4 weeks after diagnosis, (Dependent on patient needs and ongoing investigations)

- The HNA can also be offered at any time in the patient's pathway e.g. during treatment after treatment, dependent on patient needs.

- Patient concerns should be documented in the patients care plan if the patient raises concern after the HNA has been completed.

- The patient's needs may change over time; another HNA may be required at another time. Patients should be given the contact details for the cancer team.

- The HNA completion shall be recorded via Somerset. Some providers may record the results on Somerset or their own clinical portal, or both.

- It is important for Trusts to have a mechanism to identify the level of patient concern that is recorded and discussed with the patient. Trusts must have an escalation process in place for patients who have expressed their concerns that is completed within the HNA.

- Staff completing HNAs should have proficiency in cancer pathways, effective communication skills, and knowledge of available support services.

- A structured training framework is recommended to maintain quality and standardisation.[1]

This framework and standardisation of competence for HNA completion is the responsibility of the organisations. It is recommended that CCNs or CSW's are given time to observe multiple HNAs being undertaken, along with being observed by either a more experienced navigator or a personalised care team member. The navigator must also adhere to the organisations escalation process and know when to escalate to their CNS or Clinical support team.

Both the HNA and care plan should be logged on both somerset and or the Trusts clinical portal. The information may be brief on somerset to allow for more in-depth information on a clinical portal.

If issues and or concerns are resolved at the point of the HNA completion this should be

What is a Personalised Care and Support Plan (PCSP)?

- The PCSP explains how the patient will be supported now and in the future.
- It also lists services the patient may want to use. The Cancer team should give the patient a copy so they can share it with other healthcare professionals.
- A PCSP is created in collaboration between the patient and healthcare professional to manage the patients concerns

The PCSP guideline process

- The cancer team should write the care plan for the patient, based on any concerns they have discussed as part of the HNA.
- When completing the HNA the person will agree on the best ways to manage the patients needs and concerns during the discussion.
- The patient will be given a copy of the care plan.
- A copy of the care plan may be sent or given to:
  - The patient's GP, so they know their concerns and what help is planned.
  - Other members of the patient's healthcare team, to help them plan or improve their care.
- Specialist support services – for example, a dietitian or counsellor.[1]

[1] Macmillan Cancer Support

- A patient may have multiple care plans throughout their pathway and needs will be evolving.

The Personalised Care and Support plan

During the discussion, the person completing the HNA will agree on the best ways to manage the patients' needs and concerns. They may write down what has been agreed with the patient in the care plan or personalised care and support plan.

PCSP- may also be written as a letter. The cancer team may write it during the discussion with the patient, or they may make notes and send it to the patient afterwards.

The care plan will record:

- The main concerns the patient talked about
- Suggestions and actions to help the patient manage their concerns.
- Services that may be able to support the patient, and any referrals they make
- What is already being done to help, for example, the services the patient is already using?
- Information about who to contact if the patient needs more help.
- The details of other health and social care professionals that the patient has agreed to share the information with.[1]
- Care Plan Template example

What care and support plans include

Care and support plans include:

- what's important to you
- what you can do yourself
- what equipment or care you need
- what your friends and family think
- who to contact if you have questions about your care
- your personal budget and direct payments (this is the weekly amount the council will spend on your care)
- what care you can get from your local council
- how and when care will happen

If you're a carer, it will also include:

- respite care options so you can take a break
- details of local support groups
- training, such as how to lift safely

End of Treatment Summary (EoTs)/Treatment Summary (TS)

A treatment summary is completed at the end of each stage of treatment (e.g. after surgery, chemotherapy, radiotherapy, immunotherapy or best supportive care (BSC) planning (e.g. stent insertion). This is a short document completed by the healthcare team, often the CNS, which states information about the diagnosis, side effects of treatment, signs and symptoms of recurrence and who to contact with any concerns. It is then shared with the patient and their primary care team to inform them of any recommended actions to take place in General Practice. The GP can then update the records and use the document as a basis for conducting the Cancer Care Review.

The EoTs/TS should include.

1. Diagnosis and staging
2. Summary of all treatment to date
3. On going follow up plan.
4. Request for GP/General Practice actions.
5. Signs and symptoms to report to the specialist team.
6. Red flag symptoms that require the patient attend A&E
7. Symptoms of late effects to look out for
8. Health and wellbeing support and information
9. Important contacts for the patient
10. Referrals made or advice given on other services
11. Any other useful sources of information

- The patient will be given a copy of their treatment summary and will also send one to the patient's GP.

The timing of issuing an EoT/TS

- The EoTs/TS should be provided whenever treatment has completed or ended, ensuring that the patient and primary care providers receive timely and relevant information.

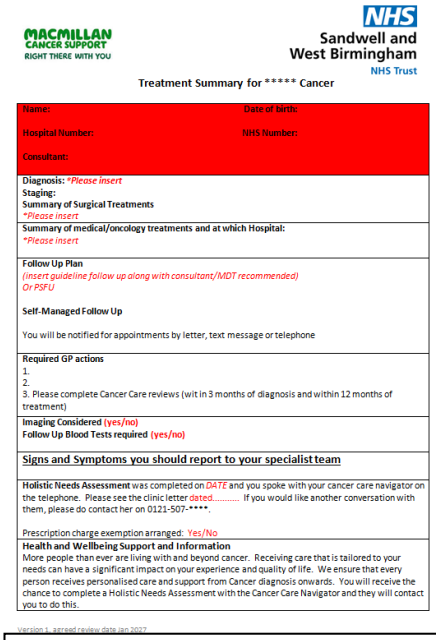
The responsibility for completing EoT/TS documents.

- Should lie with the CNS, treating consultants or surgeons to ensure accuracy and continuity of care and should be accessible for all teams.

All cancer pathways should be issued with an EoT and or TS, the content should be tailored to the specific treatment pathway and individual patient's needs.[1]

- Where Personalised Stratified Follow Up (PSFU) guidance is being followed, patients should be appropriately clinically assessed and offered the option of PSFU.

Treatment summary example



MACMILLAN CANCER SUPPORT
RIGHT THERE WITH YOU

NHS
Sandwell and West Birmingham
NHS Trust

Treatment Summary for *** Cancer**

Name:	**Date of birth:**
Hospital Number:	**NHS Number:**
Consultant:	

Diagnosis: **Please insert*
Staging:
Summary of Surgical Treatments
**Please insert*

Summary of medical/oncology treatments and at which Hospital:
**Please insert*

Follow Up Plan
(insert guideline follow up along with consultant/MDT recommended)
Or PSFU

Self-Managed Follow Up

You will be notified for appointments by letter, text message or telephone

Required GP actions
1.
2.
3. Please complete Cancer Care reviews (wit in 3 months of diagnosis and within 12 months of treatment)

Imaging Considered (yes/no)
Follow Up Blood Tests required (yes/no)

Signs and Symptoms you should report to your specialist team

Holistic Needs Assessment was completed on *DATE* and you spoke with your cancer care navigator on the telephone. Please see the clinic letter dated..... If you would like another conversation with them, please do contact her on 0121-507-****.

Prescription charge exemption arranged: Yes/No

Health and Wellbeing Support and Information
More people than ever are living with and beyond cancer. Receiving care that is tailored to your needs can have a significant impact on your experience and quality of life. We ensure that every person receives personalised care and support from Cancer diagnosis onwards. You will receive the chance to complete a Holistic Needs Assessment with the Cancer Care Navigator and they will contact you to do this.

Version 1, agreed review date jan 2027

Health and well-being events are set up by SWB Trust for everyone who has had a cancer diagnosis. There will be clinical and non-clinical staff at the event and you will be provided with health promotion information and information about activities going on around Sandwell and West Birmingham. This event is designed to be a relaxed and informal event. Your Cancer Care Navigator will invite you to the event when you speak with them.

If you would like to be invited to one of the events or monthly groups, please call or email the LWBC (details below)

Important contacts for queries or concerns

CNS Team	**Living with and Beyond Cancer Team (LWBC)** Phone – 0121 507 3817 Email – swbh.livingwithandbeyondcancer@nhs.net

Other useful information sources
World Cancer Research Fund
www.wcrf.org
Macmillan Cancer Support
www.macmillan.org.uk
Tel: 0808 808 0000 (8am-8pm everyday)
****** insert cancer site specific information**

Version 1, agreed review date jan 2027

Referral to a Tertiary Centre

Tertiary center offering specialised treatments should provide a TS or discharge letter containing key information related to the treatment.

Personalised Stratified Follow Up

There is currently EAG approved PSFU WMCA guidance for Prostate, Breast, Colorectal, and Endometrial cancers. Where PSFU guidance is being followed patients should be appropriately clinically assessed and offered the option of PSFU.

Trusts must have:

- The four priority PSFU pathways Prostate, Breast, Colorectal and Endometrial cancers implemented and fully operational.
- Remote Monitoring System (RMS) in place and fully operational.
- Regular reporting on access to PSFU for patients
- Report on the number of patients on the PSFU pathways per Trust per tumour site

References

1. Macmillan Cancer Support What is a Holistic Needs Assessment (HNA)? | Macmillan Cancer Support
Macmillan: The burden of cancer and other Long-Term Health Conditions (April 2015) https://www.macmillan.org.uk/documents/press/cancerandotherlong-termconditions.pdf
2. Public Health England, Cancer in the West Midlands, Protecting and improving the nations health. Published: August 2017 Cancer in the West Midlands
3. NHS (2019). NHS Long Term Plan. [online] Available at: https://www.longtermplan.nhs.uk/.
4. Personalised Care Institute (2024). A Manifesto for Putting Personalised Care at the Centre A New Dawn for the NHS. [online] Available at: https://www.personalisedcareinstitute.org.uk/wp-content/uploads/2024/12/Report_-A-manifesto-for-putting-personalised-care-at-the-centre-1.pdf

Resources
West Midlands Cancer Alliance Academy - for training resources
Cancer Academy - West Midlands Cancer Alliance

Appendices

Appendix 1
TYA HNA

University Hospitals Birmingham NHS
NHS Foundation Trust

West Midlands Teenage & Young Adult Service

TYA MDT Psychosocial Holistic Needs Assessment (HNA),
Any incomplete forms will be returned.

Any queries should be directed to the QEHB TYA CNS Team via:
Main Office (Monday to Friday): 0121 371 6237

Demographics (or patient sticker)	Name: DOB: Hospital number: Preferred Pronouns: ***(For example he/him; she/her; they/them)*: ……** **Would prefer to self-define: ……** **Prefer not to disclose:** ☐ Address: Telephone number: Email address: Preferred method of contact: **Phone** ☐ **Email** ☐ **Other** ☐ **Please specify:** <u>NOK Details</u> Name: Relation: Contact number:
Diagnosis and Treatment summary.	Diagnosis: Consultant: Site Specific team details: Date of diagnosis: Treatment plan: Treatment start date: Is the patient on a trial? **Yes:**☐ **No:**☐ If yes, which one:
Physical needs I.e. symptoms, fatigue, pain, swelling, oral health, diet, cough, weight loss, nausea and vomiting, bladder / bowel, sensory impairments. Mobility.	PMH: Presenting symptoms: Current needs:

Appendix 2 KPI's

Personalised Care data field	Target/ KPI
HNA Offered	**85%**
HNA Completed /accepted	**65%**
PCSP completed	**70%**
EoTs	**85%**
Priority Pathways implemented (yes /no)	
Breast	
Colorectal	
Endometrial	
Prostate	