# SOCIAL PRESCRIBING FOR CANCER PATIENTS

A guide for Primary Care Networks In partnership with



Personalised Care Institute



# This resource has been developed in association with the Personalised Care Institute.

The Personalised Care Institute (PCI) is accountable for setting the standards for evidence-based training in personalised care in England and has developed the first ever personalised care curriculum.

The PCI is a collaborative organisation with more than forty partners from across health and care and works together with these partners to develop, accredit and deliver high quality personalised care training, aligned to the personalised care curriculum.

Via a dedicated virtual training hub the PCI offers health and care staff across all sectors to access the very latest in personalised care training and development.

For more information and to access the training hub, please visit **www.personalisedcareinstitute.org.uk** 



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## What is Social Prescribing?

The five-year framework for GP contract reform published in 2019 emphasized the importance of multidisciplinary working to deliver personalised care to people within primary care. For the duration of the contract, Primary Care Networks will receive reimbursement funding for social prescribing link workers to support patients across the network. This commitment will enable social prescribers to become an integral part of the core general practice model across England, and is an essential way to ensure that people are able to access the support needed as and where suits them. Macmillan Cancer Support has developed this toolkit to provide Primary Care Networks and social prescribing link workers with information, tools and resources to support them in their role.

Social prescribing takes into account the multiple determinants contributing to a person's health including social, financial and environmental factors. Social prescribing programmes link and support people to access personal networks, as well as linking to practical and emotional support within communities and the voluntary sector. Social prescribers work with people to identify needs that are having a negative impact on their quality of life and to agree plans through direct practical support or, more often, signposting or referring to other professionals or services who are well placed to meet these needs.

The aim of social prescribing models is to help people live their lives as well as possible, with a focus on supporting them to take control of and to improve their health, wellbeing and social welfare. Individual needs vary which means some people may only need limited contact with the social prescriber however for others, more regular contact and review/follow up might be necessary.

#### Social Prescribing can:

Help people identify needs that are currently affecting their lives, as well as empowering them to identify potential issues and to work through solutions. Supporting self-management and the development of coping skills for people with long term conditions is an essential element of what social prescribing can achieve working with the medical professionals involved in a person's care.

As well as the benefits to the individual, there is evidence from the University of Westminster that supporting an individual through social prescribing can reduce GP attendances by an average of 28% and A+E attendances by an average of 24%, demonstrating statistically significant drops in referrals to hospital.

The below infographic from the Richmond Group demonstrates what they consider to be the five essential elements of social prescribing.

#### A transfer of resources



From the statutory sector to the voluntary, community and social enterprise (VCSE) sector, in parallel with these connections. This is essential for the sustainability of these approaches.

#### Community-building service development



With attention given to building on existing assets, generating social capital and creating local responses to unmet needs and goals.

#### A person-centred approach



With appropriate time given to conversations focused on how people want their lives to be, what strengths they have, and what goals they can work towards to live as independently as possible.

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#### Connections



To personal and community networks as well as to practical and emotional support within communities and the voluntary sector.

#### Buy-in from referring professionals



With recognition that collaboration and communication across and within sectors is a necessity and may require additional link workers, which is a skilled role that must be appropriately paid.

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## Working together

These roles are more than signposting and actively support people to focus on what matters to them, what a good life looks like and help to build confidence and resilience to enable self-management as appropriate. These roles often support people to navigate care between professionals and to access support for their holistic needs. The individual and the social prescriber can co-produce a simple personalised care plan that outlines their needs and expectations, what they can do for themselves and what assets are available to them. This could be either in the community or through the networks they already have.

This involves:

- Conversations
- · Assessment and Care Planning
- Navigation
- Support
- Information

Key principles of social prescribing and things to consider in implementation (BritainThinks (2017). *Social prescribing in Somerset: Research commissioned by the Richmond Group*)

- · It is tailored to the individual
- · There is a personal relationship at the centre of the service
- · It offers support with emotional and social needs
- · It enables people to make changes in their own lives
- · It feels positive and solution-focused

It is not:

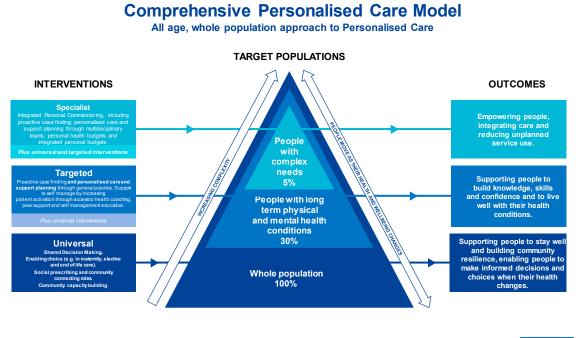
- an alternative to social work, social care or occupational therapy
- an alternative to properly funding and supporting these essential eligibility-based services or other health services including mental health provision
- · a cheaper alternative to statutory services
- new

It is important to understand that community assets will need to be nurtured and invested in so that there are resources and support available to meet people's needs. Many successful schemes also either invest in, or work with others to build up community resources with continuous asset mapping being key to a programme's effectiveness. Some social prescribing roles also involve building and developing community resources.

## **Universal personalised care model**

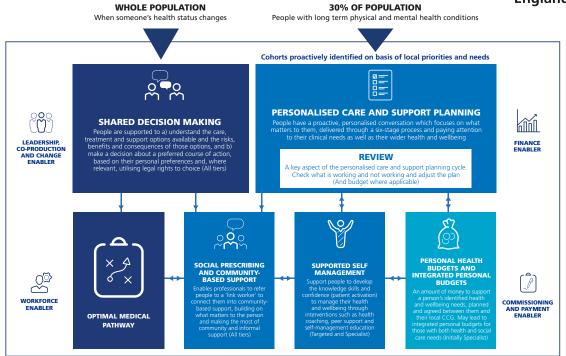
Social prescribing should be offered at a population level and is only one part of personalised care. It should be thought about in the context of the whole operating model and how your Primary Care Network (PCN) will deliver on all aspects of personalised care.

Below is the NHS England comprehensive model of personalised care which may be helpful when considering how a social prescribing service at network level fits with the wider health and social care system in your area.



## Personalised Care Operating Model



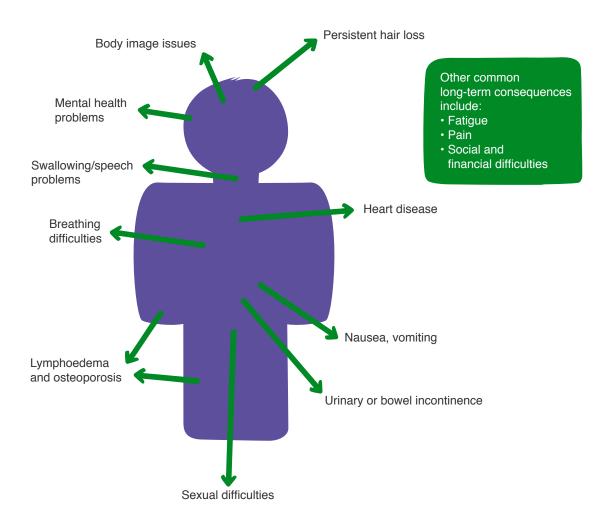


## Social Prescribing in supporting people living with cancer

Macmillan Cancer Support recognises that Social Prescribing is an essential enabler to the delivery of integrated personalised care for people living with cancer. Our Macmillan GP community may be able to provide training at a local level to support social prescribers in delivering personalised care for people living with cancer. If this is something you would be interested in finding out more about please <u>email us</u>.

Support for people living with cancer within the community is becoming ever more relevant as people are living longer following a diagnosis. This is leading to a shift in the perception and management of cancer which is increasingly being seen and treated as a long-term condition for a growing number of people. This shift coupled with the understanding that 70% of people living with cancer will also have another long-term condition strengthens the need for support within primary and community care.

People living with cancer have varied needs and cancer can affect all aspects of your life, from relationships to work or finance. Cancer can have a huge emotional impact on the individual and those around them.





The <u>Holistic Needs Assessment</u> is an intervention used to identify what issues a person living with cancer might be facing at different points in their cancer experience. These needs may be physical, emotional, practical or financial. Offering a social prescribing service to people living with cancer can help to address these needs around the time of diagnosis, throughout treatment and also, essentially, when the active treatment period is over. This is a time where an individual's needs may change and structured follow up may stop.

Understanding what support and services are available locally is vital and appropriate asset mapping may be necessary either at network or CCG/Local Authority level to ensure details are thorough and up to date.

Macmillan cancer support has developed various services, tools and resources to support people living with cancer. Some of these offers are listed on <u>page 33</u> and can be utilised alongside locally available services and support.

<sup>&</sup>lt;sup>1</sup> Macmillan Cancer Support. <u>Throwing light on the consequences of cancer and its treatment</u>. 2013 (1 in 4 people using estimated prevalence of 2.5 million)

<sup>&</sup>lt;sup>2</sup> Macmillan Cancer Support. *Hidden at Home – The Social Care Need of People Living with Cancer.* 2015.

<sup>&</sup>lt;sup>3</sup> Pitman A, et al. *Depression and anxiety in patients with cancer*. BMJ 2018; 361:1415.

<sup>&</sup>lt;sup>4</sup> Macmillan Cancer Support. *No Small Change: Time to act on the financial impact of cancer.* 2012.

How could a Social Prescribing service provide support to people living with cancer? People living with cancer can experience a wide range of unmet needs, many of which may not require support from a clinician. To demonstrate this and the tremendous impact that a social prescriber can have when utilised fully we have included a case study below.

We would like to thank the team at Knowsley CCG and the individual affected for sharing this case study.

#### Case study

Sarah is a 42-year-old with no partner living with a ten-year-old daughter and a seven-year-old son. Sarah has recently been diagnosed with stage 3 breast cancer. Sarah's GP automatically referred her for a holistic needs assessment (HNA) with the local Macmillan Navigator, which revealed the following concerns:

- 1. For two years the family has not had access to a cooker and has survived on microwave meals from Farm Foods.
- 2. Sarah had no bed, slept in a chair and as a result was not sleeping well.
- 3. Sarah worried about the debt she had accrued and feared that the cancer would stop her from working.
- 4. Sarah did not know how she would get to her hospital appointments.
- 5. Sarah was very anxious about how the diagnosis would affect her children.
- 6. Sarah wanted to give up smoking because of her diagnosis.
- 7. Sarah felt isolated, she was struggling to get to grips with her diagnosis and hospital appointments.
- 8. The Navigator also identified potential literacy problems as Sarah missed her first Chemotherapy appointment and had a poor understanding of her diagnosis and treatment.

Following this conversation, an HNA and resulting Care Plan were completed and attached to Sarah's file within EMIS Web. The issues identified through the HNA and resulting action undertaken by the social prescriber are outlined overleaf.

Need identified by HNA	Intervention initiated by the Navigator*
No Cooker for over two years	Knowsley Housing Trust Purchased a new cooker for Sarah
Sleeping in a chair	A grant for a new bed through "Person Shaped Support" was obtained
Financial Problems	A phone call was facilitated with Macmillan for benefits/debt review and rent payments through Tenants Extra Support Scheme
Transport problems	Appointments were rearranged so that a friend could drop Sarah off and pick her up outside of school times
Not Sleeping	As well as the new bed, some relaxation information given and Sarah was booked onto the next Mindfulness course run by her GP Practice
Worried about the children	Free passes were arranged for the family from the local gym and holiday clubs were organised for the half-term. Possibility about referral to CAMHS if necessary was discussed with Sarah
Smoker	Appointment made for that afternoon with smoking cessation at Sarah's GP Practice
Feels semi isolated and increased anxiety	Review of medications by practice pharmacist, discussed free local community classes, breast cancer support groups, free holistic therapies' and lunches
Missing Chemotherapy appointments	Arrangements made through the Navigator and CNS to ring Sarah the day before her chemo as a reminder
Literacy problems	Navigator is still testing to see if high anxiety or literacy issues are contributing to understanding and compliance with appointments/working with others, this will be further assessment at Sarah's 12-week HNA review

\*This role is described as a 'Macmillan Navigator' locally however, the individual undertaking this role may be referred to as a Social Prescriber or Social Prescribing Link Worker elsewhere.

#### Unmet needs of people living with cancer and support available

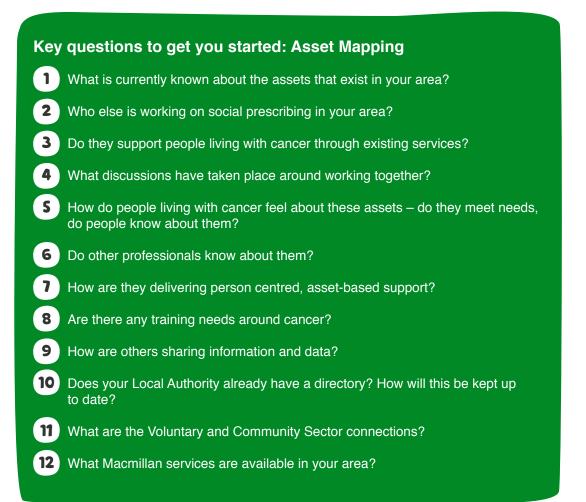
Many of the needs exemplified through Sarah's story are common needs experienced by people living with cancer. Some of these needs and guidance on how to find available support are explored below:

- We know that <u>almost a quarter of people</u> living with cancer are suffering from loneliness as a result of their cancer. As well as directing people to local opportunities such as community groups or volunteering/buddying services, the Macmillan Online Community can be a way for people to connect with others who have had a similar experience.
- As mentioned above, many people will have significant psychological needs after a cancer diagnosis. People living with cancer who experience these needs should be made aware of local support that is available face to face. In addition, or in place of this, some may benefit from online information and support or from speaking to someone on the <u>Macmillan Support Line</u>.
- As highlighted, the negative financial impact of cancer can be a difficult and unexpected consequence of receiving a cancer diagnosis for some people living with cancer. There should be local services available to provide support in addition to speaking to a <u>Macmillan Welfare Rights Adviser</u> by calling 0808 808 00 00.
- Getting back to work after a cancer diagnosis can be difficult but we know that <u>87% of people</u> living with cancer who were employed at the time of receiving a diagnosis would like to return to work. Over half of people living with cancer don't know where to go to get help with this and a social prescriber could provide vital support. Get Macmillan's '<u>Work Support Route</u>' guide and <u>Top Ten Tips for Primary Care Professionals</u> to help with these discussions.
- <u>Appropriate advice and support</u> regarding physical activity can be essential for people living with cancer from the time of being diagnosed, through treatment and recovery and to prevent effects of treatment and recurrence of cancer. It is important to understand where people living with cancer can be signposted or referred to locally and to understand the benefits that this could bring.

#### **Asset Mapping**

Having an up to date awareness and directory of services and support that are available in your area is essential for a successful social prescribing service. Asset mapping involves identifying any services, support or networks already available locally for people living with cancer, or that can be expanded to include cancer care. These services need not be cancer-specific but simply responsive to the needs of people living with cancer. Asset mapping may already be underway at a broader scale within your area, likely spanning multiple networks.

Any social prescribing, navigating and connecting model will need to build on the assets that exist locally which is why it's key that this activity is one of the first steps in mobilising a social prescribing service. Asset mapping is also an ongoing process which needs continuing resource and infrastructure in order for it to be effective. This is where digital platforms such as <u>Elemental</u> or <u>Health Unlocked</u> can provide an innovative solution to ensuring ongoing service improvement.



### **Tools and Resources**

- 1. How to access Cancer Care Review templates within each Primary Care IT System
- 2. How to carry out an effective Cancer Care Review
- 3. How to find the Cancer Care Review Information sheet and one pagers
- 4. How to access the electronic Holistic Needs Assessment
- 5. How to access palliative care templates within each Primary Care IT System
- 6. How to access Macmillan information and resources for Primary Care
- 7. How to access Macmillan's Ten Top Tips Series
- 8. How to sign up for Macmillan's Quarterly Primary Care update newsletter
- 9. Work and Cancer
- 10. Finance and Cancer
- 11. Local Services
- 12. Macmillan Support Line Services
- 13. Macmillan's Online Community
- 14. How to order Macmillan resources
- 15. Accessing a Macmillan grant for patients

#### 1. How to access Cancer Care Review templates within each Primary Care IT System

A Cancer Care Review (CCR) as part of QOF should be offered to every patient within three to six months of being told they have cancer. This should be a holistic conversation that covers clinical, practical, emotional, psychological and financial (where appropriate) aspects of the person's cancer care. The GP Contract Framework for 2019/20 details that this conversation should be face to face where possible with the offer of a follow up in person if initially a telephone call is preferable. Updated guidance also encourages the use of a structured template such as Macmillan's integrated Cancer Care Review template to ensure an individual's health and support needs are addressed. Macmillan has worked with the three main GP IT providers to integrate a standardised, national template in to EMIS Web, TPP SystmOne and INPS Vision.

#### **EMIS Web**

Follow this pathway within your EMIS Web system to access the Cancer Care Review template: EMIS Library > EMIS Protocols > Third Sector Partnerships > Macmillan/Cancer Support > Macmillan Cancer templates

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#### **TPP SystmOne**

Follow this pathway within your TPP SystmOne system to access the Cancer Care Review template: System > Resource Library > type 'macmillan' as the key search term.

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#### 2. Information on how to carry out an effective Cancer Care Review

Carrying out an effective CCR relies on a few key aspects which ensures both you and the patient get the most out of the session. Images of the Macmillan guidance can be found below, but to access the PDF version, use the following link:

www.macmillan.org.uk/healthcare-professionals/news-and-resources/guides/ten-tips-primarycare-cancer-care-reviews

## 3. How to find the CCR Information sheet and 'eHNA concerns' one pagers

At the end of the Cancer Care Review templates, there are information sheets available for the primary care professional to discuss with the patient and print out. This information includes one pagers for the most common concerns arising from holistic needs assessment conversations (eg fatigue or trouble sleeping) and an overarching information sheet on how to access further support from Macmillan. All of these information sources have been designed for patients to be able to take away with them with minimal printing required from the practice.

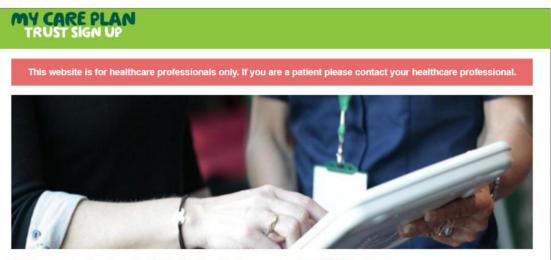
For EMIS they are under the 'Useful Links' page, for SystmOne they are under the 'Links and Info' tab, and for Vision they are under the 'References' tab. The front page of the Macmillan Support and Information one pager can be seen to the right. This one pager details how to access Macmillan Support over the phone, online or through our printed information with the second page going on to detail specific information that may be useful at this point in the patient's cancer treatment.



#### 4. How to access the electronic Holistic Needs Assessment (eHNA)

The <u>Holistic Needs Assessment</u> (HNA) is used to assess the physical, psychological, social and spiritual needs of the patient and supports a personalised care approach. You may wish to ask the patient to complete an HNA or electronic HNA prior to meeting with them. This way, they can work through the concerns checklist at their own pace allowing them to consider each aspect as needed. You could ask that they bring their completed checklist to the planned consultation, or submit it via the system if using eHNA, to enable you to focus the conversation on what matters most to them at that point in time. To sign up for the electronic version of the HNA, please see https://ehna.mycareplan.co.uk/sign-up.

If you have any questions or would like to request an electronic agreement rather than signing a paper copy, please email **ehna@macmillan.org.uk**. Once the agreement has been signed, you will be set up as a user on the system and will receive a Site Setup Guide to support you in getting ready to use the eHNA and testing that it is all working as it should.



Welcome to electronic Holistic Needs Assessment (eHNA) sign up

This website will let you sign your organisation up to use the Macmillan eHNA. You should only use this website to sign up if your organisation has taken the decision to use the eHNA, and you have been nominated to complete this process on its behalf.

You'll need to provide the name of your organisation, your own contact details, and contact details for the person who'll be signing the contract. You won't be able to complete this application unless you're able to provide all of this information.

Full instructions are given on the next page.



#### 5. How to access palliative care templates within each system

#### **EMIS Web**

We have worked with EMIS Health to develop an updated palliative care template, which enables you to code relevant information directly into the patient notes.

To access the template in EMIS Web, please follow this pathway:

EMIS Library > EMIS Protocols > Third Sector Partnerships > Macmillan/Cancer Support > Macmillan Cancer templates

#### SystmOne template

We have now built the updated palliative care template in TPP SystmOne. This template is available to all TPP users via the Resource Library.

To access the template, please follow this pathway:

#### System > Resource Library (keyword search is Macmillan)

We are working with GP IT providers to replicate this template in other systems. To stay up to date with developments in this area, please visit our <u>Primary Care Webpage</u> and check the 'End of Life Care Quality Improvement Resources' tab.

#### Palliative care searches

We have worked with EMIS Web to develop automated palliative care searches. These searches support the use of Module Four of Macmillan's Quality Toolkit for <u>cancer care in</u> <u>Primary Care</u> and enable practices and networks to gather a baseline of current activity. You can run these searches at the start of an end of life care quality improvement initiative, and can then re-run them after implementation, to demonstrate its impact.

#### **EMIS searches**

To access the searches in EMIS, please follow this pathway:

EMIS Library> READ Searches> EMIS Clinical Utilities> Third Sector Partnerships> Macmillan Cancer Support> Quality tool kit> End of Life Care QI Searches

The SNOMED converted versions of these will sit in EMIS Library> SNOMED Searches> EMIS Clinical Utilities> Third Sector Partnerships> Macmillan Cancer Support> Quality tool kit> End of Life Care QI Searches.

#### **TPP SystmOne Searches**

To access the searches in TPP SystmOne, please follow this pathway:

System > Resource Library (keyword search is Macmillan)

#### End of Life Care Quality Improvement

Macmillan has developed resources to help primary care professionals implement end of life care quality improvement projects, in response to the 2019/20 GP contract changes to QOF. These resources can be used at practice or network level and have been developed to meet the specifications set out for the 2019/20 QOF Quality Improvement Project.

## Quality toolkit for cancer care in primary care (module 4)

This module builds upon our existing toolkit. It focuses on end of life care quality improvement in the context of the 2019/20 QOF contract.

## End of life care network guide

This guide draws insight from our work in end of life care, and the innovative work of Macmillan GPs. The guide provides Network Leads with an introduction to end of life care, resources to support you, and case studies of UK quality improvement initiatives.

#### 6. How to access Macmillan information and resources for primary care

Macmillan has produced a number of toolkits, guidance documents and online training modules to support Primary Care Professionals as they connect with cancer patients from early diagnosis through to after treatment, and at end-of-life. To access these resources you can visit our <u>GP webpage</u> or our <u>Practice Nurse webpage</u> and share with colleagues.

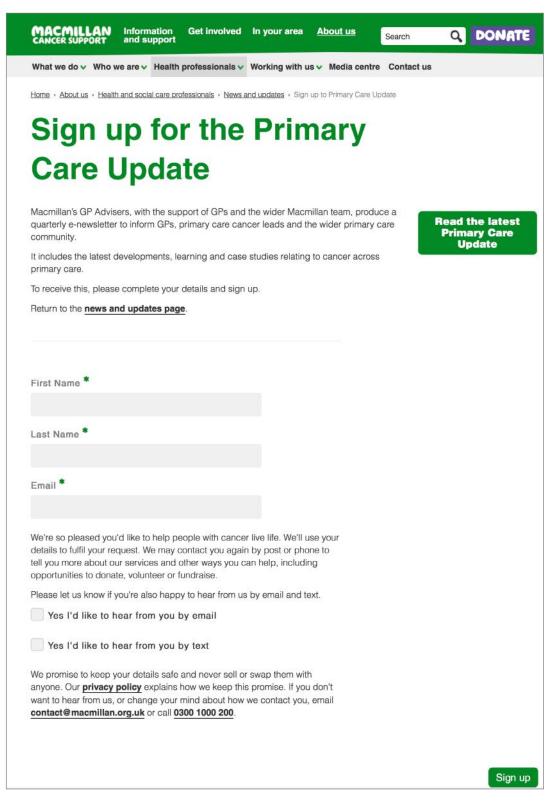
#### 7. How to access Macmillan's Ten Top Tips Series

Macmillan GP advisers have collaborated with members of the Macmillan primary care community to develop a '10 top tips' series of downloads. The PDFs offer practical hints, tips and information on a variety of different primary care situations and scenarios. The link to access these documents can be found Doctors <u>here</u>, Nurses <u>here</u>.



## 8. How to sign up for Macmillan's Quarterly Primary Care update newsletter

Macmillan GPs, with the support of the wider Macmillan team, produce a quarterly e-newsletter to inform GPs, primary care cancer leads and the wider primary care community on what's new in cancer. It includes the latest developments, learning and case studies relating to cancer across primary care. The link for the sign up can be found <u>here</u>:



#### 9. Work and Cancer

#### Making work *work* for people with cancer

Signpost your patients to Macmillan's Work Support Service for guidance on employment issues. This is a new telephone service to help people make informed decisions around staying in or returning to work following a cancer diagnosis. The document is available in a PDF version or hard copies can be ordered through the Macmillan website.

#### Work Support Route Guide

This booklet provides professionals with information to help them to best support people affected by cancer, regardless of their work-related concern. It suggests relevant questions, recommends responses and lists further sources of support, so that they can be given the guidance they need.

#### **11. Finance and Cancer**

#### Money worries, how we can help

A one-page document with helpful hits and tips to help ease money worries for people affected by cancer.

#### **10. Local Services**

#### Macmillan Support in Your Area

Macmillan has an online support tool which allows both healthcare professionals and people affected by cancer to identify Macmillan services in their area. This can include information and support services, drop-in services and local living well or rehabilitation groups. The link for the page can be found <u>here</u>.

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#### **11. Macmillan Support Line Services**

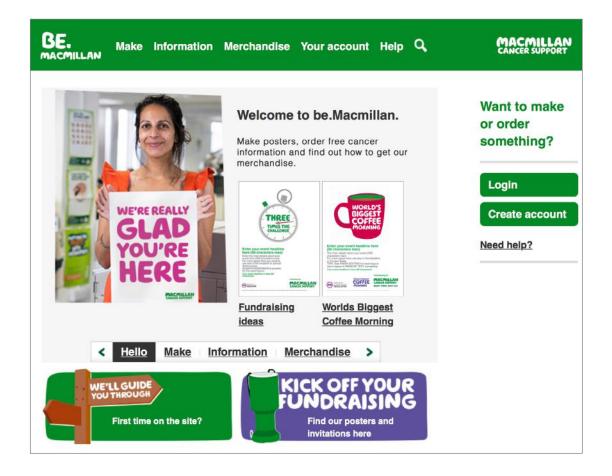
The Macmillan Support Line is available 7 days a week from 8am to 8pm and can be contacted at 0808 808 00 00. For more information regarding the support line and what it can offer, please click <u>here</u>.

#### 12. Macmillan's Online Community

The Macmillan Online Community is a 24/7 peer support network with groups dedicated to specific cancer types, treatment, family and friends and even a light relief group called 'Laughter is the best medicine'. There is a plethora of areas for all people affected by cancer and the site gets over 100,000 visits a week, it is the biggest community of its kind in Europe. The link to access the site can be found <u>here</u>.

#### 13. How to order Macmillan resources

Macmillan has a wide range of resources to help Healthcare Professionals and people affected with cancer such as toolkits and information sheets. Patients or professionals can create an account and order as much information as required which will be sent out free of charge. Click <u>here</u> to access the resources and create an account.



#### 14. Accessing a Macmillan grant for patients

The Macmillan grant is a means tested grant and therefore a patient applicant would need to be assessed to qualify. This process is usually done by a benefits advisor or through the Macmillan Support Line. If the person qualifies for a grant, the benefits advisor or the Macmillan helpline would complete an application form with additional medical information completed by the CNS or the GP.

Grants can be accessed via the Macmillan Support Line, a Macmillan Information and Support Centre, a Macmillan Professional or through local cancer centres. Further information on the financial support that Macmillan provides can be found <u>here</u>.

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Guidance on how as a professional you can apply for a grant on behalf of your patient can be found <u>here</u>.

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#### **Patient Resources**

These are resources that you can highlight to your patients where appropriate. All of the below can be viewed online as a PDF, or ordered online for free from be.Macmillan. Additionally, you and your patients are able to make your own be.Macmillan accounts and search for any other resources you might need <u>here</u>.

#### Learning network

NHS England has set up an online learning platform to share the latest resources and encourage collaboration. To join the platform, please contact **england.socialprescribing@england.nhs.net** 

Below is a summary of key documents and resources:

- <u>NHSE Information and support for Social Prescribers</u>
- Elemental's Guide to Social Prescribing for PCNs
- What is social prescribing The Kings Fund (02 February 2017)
- Making Sense of Social Prescribing University of Westminster
- · Spotlight on the Ten High Impact Actions Royal College of GPs
- A guide to implementing social prescribing in London Healthy London Partnership
- <u>A review of the evidence assessing impact of social prescribing on healthcare demand and cost implications</u> University of Westminster
- Westminster Social Prescribing Network
- <u>Richmond Group Somerset social prescribing work</u>

## Appendix

#### Useful codes to record referrals to Social Prescribing:

Referral to social prescribing service **8T09** Social prescribing declined **8IEp** Social prescribing for mental health **8BAf** Social prescribing offered **9NSE** 

#### **Durham Joining the Dots Case Study**

#### Background/Support/Actions

Client came to Macmillan Joining the Dots as first point of support. The support I was able to offer included arranging transport and attending the four chemotherapy sessions with the client. This was because there were no family members able to attend and the client was scared to go on their own. I also arranged the transport for the 20 sessions at James Cook and supported by attending the follow up tests and scans. Throughout this I have supported the client with emotional support during this very difficult time in their life, as they felt they didn't want to 'bother' family members who had their own lives to deal with. I meet with the client most weeks to see how they are doing and to provide practical solutions to problems.

I was able to refer the client to Macmillan Welfare Rights which meant that they were able to get support applying for Attendance Allowance and a Macmillan Grant. Thanks to this the client received over £800, as the Attendance Allowance was back dated to when I submitted the request, and a grant for clothing and fuel was approved. I also arranged for a Blue Badge.

The client started having dizzy spells and fainted at home, so I contacted the GP and requested a home care assessment and also requested a Macmillan Nurse to contact her. Whilst waiting for the home care I arranged for a wheelchair from the British Red Cross to assist the client getting around their home, this was with the client until their NHS chair arrived. The client later told me that they had stopped going into the kitchen as they were scared to stand up, so the wheelchair means they can use their kitchen again and prepare basic meals.

Due to their medication the client was also in pain with constipation. They mentioned this to their GP but weren't given anything for it. The client was in increasing pain so after I contacted Macmillan asking for advice on their behalf, the client gave me permission to speak to their GP. The GP had not been fully aware of the extent of the pain (of 9 days duration), and that afternoon they arranged a prescription and the client was feeling better in a couple of days.

Requesting a Macmillan Nurse to contact this client is a big step for them, as when we first met the client declined the offer as they linked Macmillan Nurses with end of life, due to our conversations they don't think that any longer.

For more information on the Macmillan Joining the Dots Service please visit our webpage www.joiningthedots.info

#### **Client Quote/Feedback**

Throughout all of this journey the client has said many times how much they appreciated the support I was able to give them, especially the referral made to Welfare Rights. However, for me the biggest moment was when I arrived with the temporary wheelchair, Betty started to cry and gave me a hug saying "thank you so much, I really don't know what I would have done without you".

At Macmillan, we give people with cancer everything we've got. If you're diagnosed, your worries are our worries. We will move mountains to help you live life as fully as you can.

And we don't stop there. We're going all out to find ever better ways to help people with cancer, helping to bring forward the day when everyone gets life-transforming support from day one.

We'll do whatever it takes. For information, support or just someone to talk to, call **0808 808 00 00** or visit **macmillan.org.uk.** 

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