HSE

nccp National Cancer Control Programme

Cancer Survivorship Patient Pathway

A National Framework

The Cancer Survivorship Patient Pathway provides a framework to improve survivorship services for cancer patients and their families and give guidance for consistent development into the future. It was truly a collaborative effort. It became clear from many conversations with clinical staff in cancer centres and stakeholders that some direction and guidance regarding cancer survivorship care and its implementation across services was needed. This framework brings together the expertise of people currently working in cancer services across sectors, international and national evidence and the patient voice. We have tried to be ambitious on behalf of patients and families and include elements that will need to be built to be fully realised. This will be the work now and in the future. The NCCP and clinical services will work together under the stewardship of the next National Cancer Strategy to ensure the capacity and expertise exists to deliver this in all sectors. As with any publication there have been many authors but I would like to thank and recognise in particular Clare Leatham who has led on this work, also Bernie O'Loughlin, Cathleen Osborne and Terry Hanan who have lent their considerable knowledge, experience and expertise to the final pathway. My hope is that this framework provides the practical and necessary guidance to continue to grow and improve services for cancer patients and their families, directly enhancing their quality of life, which is always our aim.

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Acknowledgement

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Executive Summary

People living with and beyond cancer often experience ongoing physical, psychological, social and practical challenges that can persist long after treatment ends. To address these needs, the NCCP has developed the Cancer Survivorship Patient Pathway. This national framework supports the delivery of consistent, high-quality survivorship care for adults across acute and community settings.

High-quality survivorship care is essential to support people as they adjust to the impacts of cancer and its treatment. The National Cancer Strategy[1] highlights the need for improved supports, investment and greater recognition of the complex challenges faced by individuals living with and beyond cancer.

The pathway is structured around four pillars - Point of Contact, Education and Information, Needs Assessment and Care Planning, and Support Programmes, Places and People. Together, these aim to improve quality of life, strengthen coordination of care, and ensure access to appropriate supports from diagnosis onwards.

Introduction

The NCCP's vision for survivorship care in Ireland is to help people live well after a cancer diagnosis by providing early, coordinated, multidisciplinary support across acute and community services. Through ongoing engagement with acute hospital cancer centres, services consistently highlighted the need for clear and practical guidance on how best to support people living with and beyond cancer.

In response, the NCCP has developed the Cancer Survivorship Patient Pathway, a practical, service-focused framework informed by best evidence and extensive consultation. This framework responds directly to the gap identified by services. The pathway sets out four core pillars of support to enable consistent delivery of high-quality survivorship care and improve patient experience and outcomes.

The pathway is intended primarily for healthcare professionals across acute, primary and community settings who play a central role in delivering and coordinating survivorship care. Components can be integrated into existing services and pathways and delivered by different members of the multidisciplinary team at various points along the cancer journey.

Scope and Definitions

Cancer survivorship begins at the time of diagnosis and continues until end-of-life. For the purpose of this document people who have had a cancer diagnosis and treatment are referred to as cancer survivors or as living with and beyond cancer. This includes people with incurable cancer who live with cancer but not generally those receiving end-of-life care, who are supported through separate palliative care pathways[2].

Nationally and internationally there is increasing focus in understanding and addressing the needs of people living with cancer and their rehabilitation after cancer and its treatments. Needs can vary according to:

- stage of survivorship
- age of the patient
- cancer type and associated treatment effects
- co-morbid illnesses

These needs are related to the difficulties often experienced by people affected by cancer. Cancer survivors can have unmet physical, psychological, information or supportive care needs[3].

Advances in cancer treatment mean that many individuals now live for extended periods with cancer as a long-term condition. Their care needs and goals may differ significantly from those diagnosed with early-stage disease. People living with advanced or metastatic cancer can have complex care needs, and may receive continuous, recurrent, or intermittent treatment without an expectation of cure. They can remain on treatment for long periods of time without progression. For this group, whilst the needs are the same, the delivery is different and time is of the essence. A sense of urgency focuses on minimising the impact of cancer and its treatment by optimising quality of life and ensuring timely access to appropriate supports alongside ongoing treatment[2].

Purpose, Audience and How to Use

The Cancer Survivorship Patient Pathway provides guidance to support healthcare teams to identify, assess and address the evolving needs of people affected by cancer from diagnosis onward. It sets out the core components of survivorship care and practical actions to support implementation.

Many elements of survivorship care are already in place within existing services but may not be formally identified as such. There is a need to align existing services under a survivorship framework. By incorporating the core components into existing care pathways, healthcare providers can ensure that people with cancer receive comprehensive, person-centred support that empowers them to take an active role in their own health and well being. This framework reinforces that survivorship care is a shared responsibility across the entire multidisciplinary team in both acute and community settings, rather than resting on any single individual. It encourages a collaborative approach, ensuring that all relevant services are considered and integrated into patient care.

Evidence and Alignment

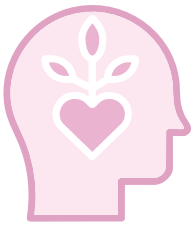
The Cancer Survivorship Patient Pathway is grounded in national and international best practice and reflects both evidence and lived experience. Development of the pathway was informed by:

- national and international models of survivorship care
- a scoping review of current survivorship care models
- a scoping review of cancer survivorship in the acute sector services in Ireland
- a national cancer survivorship needs assessment
- consultation with individuals with lived experience of cancer, subject matter experts and multidisciplinary stakeholders, including the NCCP Survivorship Steering Group and the Department of Health's Cancer Patient Advisory Committee

This approach ensures that the pathway is evidence based, person-centred and grounded in the realities of service delivery in Ireland.

Why Cancer Survivorship Matters?

Advances and investment in early detection, targeted treatments, and new therapies have led to more people than ever before living with or beyond an invasive cancer diagnosis. By the end of 2022, around 221,000 people in Ireland were living with a diagnosis, which represents a 50% increase over the previous decade. This number is expected to double over the next 25 years[4].



The National Cancer Strategy[1] emphasises the importance of developing comprehensive survivorship supports to meet the needs of those living with and beyond cancer and recommends significant investment in survivorship services.

Educating people living with and beyond cancer about the potential challenges and connecting them with appropriate, reliable, trusted support services, is essential to improving quality of life. People with supports are more likely to better self-manage their health, which also facilitates more efficient use of healthcare resources.

Common unmet needs across cancer types and treatments include:

- physical needs, such as pain, fatigue, and sleep disturbances.
- psychological needs, including the fear of recurrence, distress, sexuality related needs.
- psychosocial needs, including information gaps, the need for increased information from health professionals, financial hardship and challenges related to employment and return to work.

Effective survivorship care can mitigate many of these needs; the essential components of which include[5]:

- prevention of recurrent and new cancers, and of other late effects.
- surveillance for cancer spread, recurrence, or second cancers.
- intervention for consequences of cancer and its treatment.
- coordination between specialists and primary care providers.

In addition, a number of elements of high-quality survivorship care include:

- monitoring and intervention as needed for physical, psychological and social needs.
- encouragement of self-management with support.
- information and health education.
- familial genetic risk assessment if indicated.
- guidance on work and financial issues.
- guidance on cancer prevention and maintaining a healthy lifestyle.

Since publication of the National Cancer Strategy[1], significant progress has been made to strengthen cancer survivorship supports in Ireland across acute and community settings. These developments include expanded psycho-oncology services, implementation of stratified self-managed follow-up models, development of evidence-based survivorship programmes, and investment in community cancer support infrastructure. A summary of key national survivorship developments to date is provided in Appendix A.

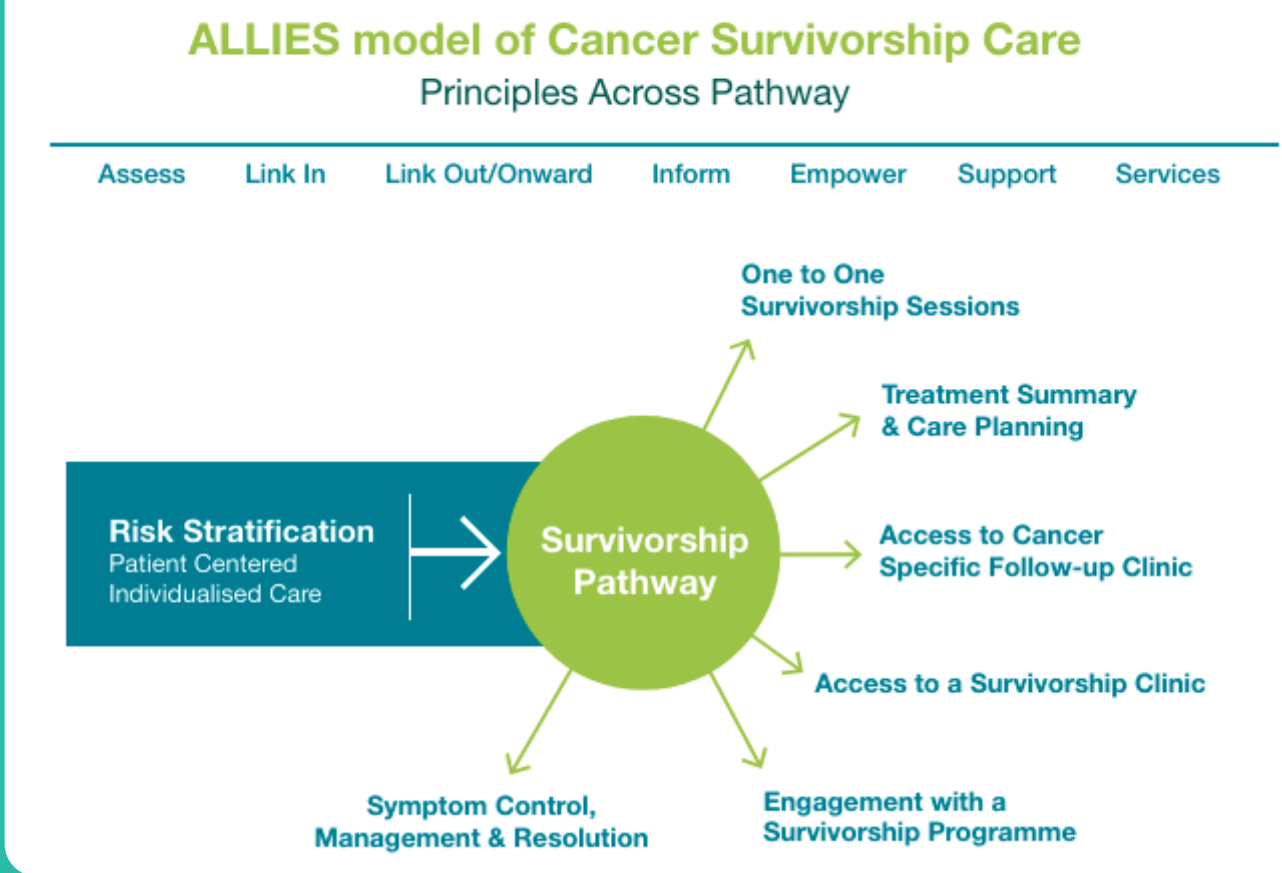
Models of Care

There is broad international consensus that the traditional hospital-based follow-up models are no longer sustainable, given the increasing number of cancer diagnoses and growing complexity of care needs.

Newer models of survivorship care move beyond a sole focus of surveillance for recurrence. They seek to improve quality of life, functional outcomes, patient experience, long-term health outcomes and survival rates of people diagnosed with cancer. They also emphasise the benefits of utilising a framework that is applied in clinical settings to improve the quality of comprehensive cancer care[6]. Effective models include shared care with primary care, nurse-led follow-up and supported self-management pathways[7]. A scoping review of cancer survivorship in the acute sector services in Ireland[8],[9] highlighted the need for system-wide change to respond to growing survivor numbers.

The ALLIES model of care provides the initial guidance for the development of survivorship services and supports and continues to underpin this pathway. This model of care is a principle-based approach which promotes assessment, linking in and out and onward, information, empowerment, and timely access to support and services.

Figure 1. ALLIES Model of Cancer Survivorship Care.



Implementation Principles

The Cancer Survivorship Patient Pathway provides a roadmap for the continuous improvement of cancer survivorship care across Ireland. It supports a gradual shift towards more co-ordinated, person-centred and comprehensive survivorship care across acute and community settings.

The following principles underpin implementation of the pathway:

- Survivorship care begins at diagnosis and should be integrated from diagnosis onwards, tailored to individual needs and circumstances.
- Implementation should be phased, flexible, and iterative, recognising local context as services can vary in readiness and capacity.
- Not all services will have all components in place initially; incremental improvement is expected over time.

- Pathway components should be aligned with and embedded within existing care pathways, such as Stratified Self-Managed Follow Up and relevant accreditation standards.
- Survivorship care is a shared responsibility across the multidisciplinary team and across acute, primary and community sectors.
- Different components may be delivered by different professionals at various points in the cancer journey (for example, SACT education, prehabilitation, or return-to-work support).

- Effective implementation relies on clear communication, smooth transitions of care, and consistent signposting to appropriate supports and services.

Services are encouraged to use this framework to map current provision against the four pillars, identify gaps, and prioritise actions to strengthen survivorship care locally.

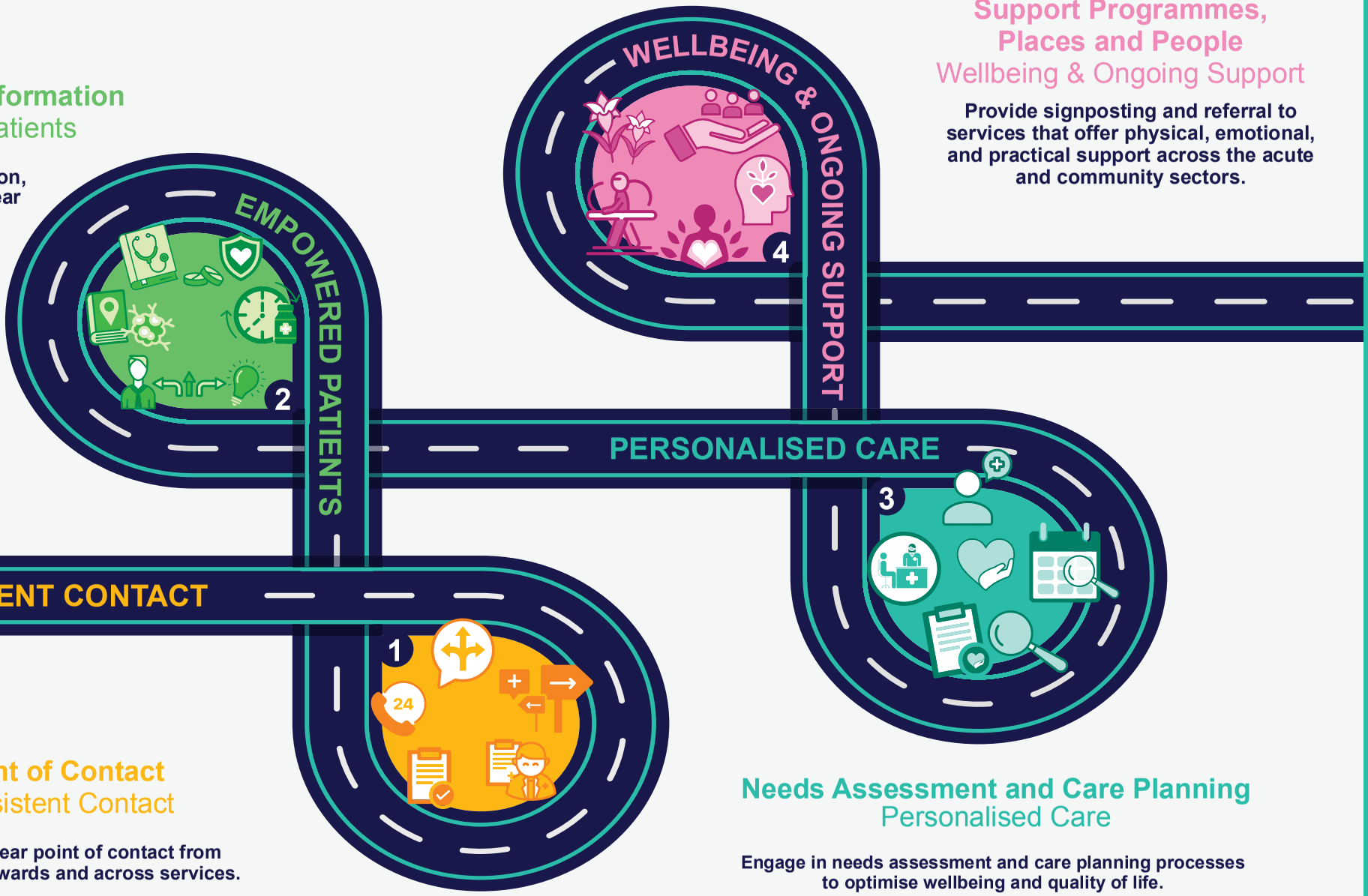
Cancer Survivorship Patient Pathway

Education and Information
Empowered Patients

Provide education, support and clear information.

Support Programmes, Places and People
Wellbeing & Ongoing Support

Provide signposting and referral to services that offer physical, emotional, and practical support across the acute and community sectors.



Point of Contact
Consistent Contact

Ensure a clear point of contact from diagnosis onwards and across services.

Needs Assessment and Care Planning
Personalised Care

Engage in needs assessment and care planning processes to optimise wellbeing and quality of life.

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Cancer Survivorship Patient Pathway

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1 Point of Contact - Consistent Contact

- Introduce key contact person and share contact details
- Support Patient inclusion in decision making
- Provide clear support options and out-of-hours contact details
- Signpost to support services
- Explain re-access pathways

2 Education and Information - Empowered Patients

- Provide tumour specific information and education
- Discuss treatment options, clinical trial and late long term side effects
- Promote self-care and self-management through education, advice and support
- Educate on signs and symptoms of recurrence, survivorship services and re-access information
- Educate on secondary cancer prevention, health promotion, and wellbeing

3 Needs Assessment and Care Planning - Personalised Care

- Use screening tools including holistic needs assessment and a distress screening tool
- Complete personalised care planning with patient
- Review treatment summary and care plan and follow up surveillance schedule with patient
- Share treatment summary and care plan with the patient and the GP
- Refer for assessment to Health and Social Care Professionals as required

4 Support Programmes, Places and People - Wellbeing & Ongoing Support

- Signpost to Community Cancer Support Centres and Services, and Daffodil Centres
- Encourage participation in prehabilitation, rehabilitation, and physical activity programmes
- Refer to Psycho-oncology and psychosocial services as required
- Promote survivorship programmes and late and long term effects services
- Encourage engagement in risk reduction behaviours and cancer screening programmes

Note: Most elements outlined in this pathway are intended to provide general guidance and support service planning and are relevant across the entire cancer care continuum. Clinical judgment should be used to determine the most appropriate time for each element to ensure the patient receives the supports that they need.

Cancer Survivorship Patient Pathway

The Cancer Survivorship Patient Pathway is structured around four pillars of survivorship care, applied from diagnosis and throughout the cancer trajectory. This is a high-level framework supported by examples of practical applications.

Pillar 1:
Point of Contact

Pillar 2:
Education and Information

Pillar 3:
Needs Assessment and Care Planning

Pillar 4:
Support Programmes, Places and People

Pillar 1: Point of Contact – Consistent Contact

Purpose:

To ensure that every person with cancer has a clear, consistent and accessible point of contact from diagnosis onwards and across services. The point of contact supports co-ordination of care and timely access to care and support, provides personalised support and education, and symptom management. The point of contact can be in the acute or community setting.

Overview and Key Components:

Clear and consistent communication is central to effective survivorship care. Individuals should be introduced to their key contact person from diagnosis onwards and provided with clear contact details. Individuals should know who their main point of contact is, how to contact them, and what type of support they can expect at each stage of the pathway.

The named point of contact may change over time as individuals transition between services, treatment phases and settings. Responsibility for ensuring a clearly communicated handover rests with the service.

In most cases, the point of contact is a specialist nurse associated with the tumour site or treatment modality. However, the role may also be fulfilled by other appropriately designated professionals in acute, primary or community settings[9] (e.g. Acute Haematology Oncology Service Nurse, GP).

Key elements of the point of contact include:

- Introduction of a key contact person from diagnosis onwards and provision of clear and accessible contact details, including guidance for out-of-hours or urgent concerns.
- Supporting patient inclusion in decision-making by facilitating communication and shared understanding.
- Providing essential information and education.
- Signposting to appropriate survivorship services, community cancer support centres available in their locality and national services.
- Ensuring individuals understand support options available and how to access them.

- Explaining re-access pathways, including when and how to seek advice or review if concerns arise.
- Supporting coordination of care across acute, primary and community services.

A consistent point of contact improves confidence in care and supports smoother transitions across the pathway.

Local Considerations: Roles and Responsibilities

- Services should have local policies and processes in place to ensure that individuals are informed of who their current point of contact is and how and when to reach them.
- Changes in point of contact should be clearly communicated to the individual at transition points.
- Out-of-hours and urgent contact details should be clearly explained and accessible.
- The re-access pathways should be clearly documented and understood within the services.
- Effective communication between services is essential to ensure a smooth handover, continuity and consistency of point of contact across the pathway.
- Effective communication ensures that the person understands their care plan, potential late effects and available survivorship services.

Examples in Practice

- A clinical nurse specialist is introduced as the primary point of contact at diagnosis, providing contact details and explaining when and how to seek advice.
- During systemic anti-cancer (SACT) treatment, responsibility for the point of contact would transition to a treatment-specific service, with clear explanation of additional support options such as the Acute Haematology Oncology Nursing service.
- An individual completing active treatment is informed of their new contact arrangements for follow-up and surveillance, including re-access pathways.
- The GP remains an accessible point of contact throughout the pathway, supported by clear communication from acute services.

Checklist:

- [ ] Is a key point of contact introduced from diagnosis?
- [ ] Are contact details clearly provided, including out-of-hours guidance?

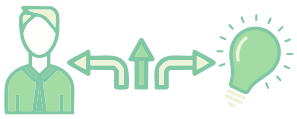
- [ ] Do individuals understand who their current point of contact is at each stage of the pathway?
- [ ] Are changes in point of contact clearly communicated during transitions?

- [ ] Are individuals actively signposted by their point of contact to relevant supports, including local cancer support centres, with a clear explanation of how to access them?
- [ ] Are re-access pathways explained and understood?

Pillar 2: Education and Information - Empowered Patients

Education and Information

Providing clear, timely and tailored education and information from diagnosis onwards is central to empowering people to live well with and beyond cancer. This includes preparing individuals for potential late and long-term side effects, supporting self-management, enabling individuals to manage their long-term health, and signposting access to appropriate supports. This pillar emphasises open communication and the delivery of comprehensive, appropriate, and timely information and tailored educational programmes to ensure high-quality survivorship support.



Purpose:

To ensure that individuals with cancer receive clear, timely and tailored education and information that supports informed decision-making and prepares them for living with and beyond cancer. This includes building awareness of the supports, programmes and services available in their local community and nationally. This is supported though embedding open communication that empowers individuals to actively participate in their care from diagnosis into long-term follow-up.

Overview and Key Components:

Education and information are central to empowering individuals throughout their cancer pathway. From diagnosis onward, individuals should receive information that is relevant to their cancer type, treatment and stage of survivorship. This evolves as their needs change. Education should prepare individuals not only for treatment, but also for potential late and long-term effects, follow-up arrangements, survivorship supports and re-access pathways. This includes ensuring individuals are aware of the range of community-based and voluntary supports available, such as Community Cancer Support Centres (CCSCs) and nationally delivered survivorship programmes. Information should be delivered in a way that supports understanding, shared decision-making and self-management.

Key elements of this pillar include:

Provision of tumour-specific, plain-english information and education tailored to individual needs, including:

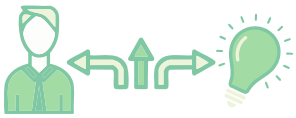
- Pre-treatment information and planning.
- Discussion and education of treatment options available, including potential risks, benefits, and clinical trial opportunities where relevant.
- Education on the side effects, long-term and late effects of cancer and its treatment.
- Promotion of self-care and self-management, supported by appropriate education, advice and support.
- Education on signs and symptoms of recurrence (Red Flags).
- Clear explanation of follow-up and surveillance schedules and re-access pathways.
- Education on secondary cancer prevention, health promotion and wellbeing.
- Use of materials/documents that are suitable to meet the needs of a diverse population, including translation of materials into languages commonly spoken by the population served.
- Information on available survivorship services, community based supports and nationally delivered evidence based survivorship programmes.

Local Considerations: Roles and Responsibilities

- Education should be delivered in a way that reflects the HSE Making Every Contact Count (MECC) approach, embedding supportive health and wellbeing conversations into routine care where appropriate.
- Information and education should be patient-focused, accurate, up-to-date, evidence based and delivered in accessible formats.
- Education should be time appropriate and repeated as often as needed to support understanding.
- Follow-up care and surveillance should be standardised.
- Healthcare Professionals delivering education should be supported to provide consistent messages aligned with national guidance (e.g. complete the relevant HSE e-learning programmes such as ‘Reducing Cancer Risk’).
- Services should ensure materials are available to support education related to survivorship and self-management.

Examples in Practice

- At diagnosis, an individual receives evidence-based tumour-specific written information such as the booklets provided by the Irish Cancer Society (ICS), alongside verbal explanation and discussion from the team.



- Education is provided to prepare individuals for treatment and potential side effects. This may include nurse-led education within the oncology service, alongside information on survivorship programmes such as the Life and Cancer – Enhancing Survivorship (LACES) programme, to support preparation for living well with and beyond cancer.

- Services engaging in the development of personalised patient pathways, and using nationally agreed pathways, for example Stratified Self-Managed Follow up, supporting quality of life in survivorship and the efficient running of cancer services.
- Individuals are educated about signs and symptoms of recurrence or progression, including clear guidance on “red flags”, what to look out for and when and how to seek advice.

- Information is provided on evidence-based survivorship programmes, such as Cancer Thriving and Surviving (CTS), to support self-management and wellbeing.
- Smoking cessation is actively encouraged and supported, with referral to the HSE QUIT programme where appropriate as part of secondary prevention and health promotion.

Checklist:

- ☐ Are healthcare staff aware of current services available so that they can signpost individuals to them?
- ☐ Is clear, timely, and tailored information and education provided from diagnosis onwards?
- ☐ Is information appropriate to the tumour type?
- ☐ Are treatment options including clinical trials, where relevant, discussed?
- ☐ Are potential late and long-term effects of cancer and its treatment discussed (e.g. lymphoedema, menopause, fatigue, sexuality, cognitive effects, and others)?
- ☐ Is education provided to support self-management and wellbeing?

- [ ] Are the sign and symptoms of recurrence clearly explained?
- [ ] Is information being repeated as necessary and time allowed to process information and ask questions?
- [ ] Is a pre-treatment education session offered?
- [ ] Are follow-up and re-access pathways understood?
- [ ] Are survivorship services and supports consistently signposted?
- [ ] Is education delivered in accessible, understandable formats?
- [ ] Is information provided regarding secondary prevention and relevant cancer screening programmes?
- [ ] Is there a Stratified Self-Managed Follow Up pathway available that can be discussed with the individual?

Pillar 3: Needs Assessment and Care Planning – Personalised Care

Needs Assessment and Care Planning

Needs assessment and care planning are essential to delivering personalised survivorship care. Needs assessment and care planning processes aim to optimise wellbeing and quality of life during and after cancer treatment. This includes prompt recognition of needs (holistic), surveillance for new or recurrent cancers, surveillance and assessment of long-term and late effects and promoting engagement in preventative and positive lifestyle behaviours.

Purpose:

To ensure that the individual needs of people affected by cancer are identified and addressed through structured needs assessment and a personalised care-planning process. The focus is on helping people to live as well as possible after a cancer diagnosis.

Overview and Key Components:

This pillar focuses on optimising quality of life and overall wellbeing for individuals following a cancer diagnosis. This is achieved by proactively assessing needs and co-ordinating appropriate support at key points such as diagnosis, post-treatment, and transition phases. Needs assessment and care planning incorporates surveillance for new or recurrent cancers, surveillance and assessment for long term and late effects and promoting engagement with positive lifestyle behaviours that support health and wellbeing.

This pillar supports the systematic use of assessment tools and care planning processes to identify needs, guide appropriate interventions, and support shared understanding between individuals and healthcare providers.

Key elements include:

- Use of screening and assessment tools, including a Holistic Needs Assessment (HNA), and where appropriate condition/tumour specific or distress screening tools, to identify needs at key points along the pathway (see Appendix B1).
- Completion of personalised care-planning that is informed by assessment of needs.
- Development, review and sharing of a Treatment Summary and Care Plan (TSCP) with the individual and their GP to support continuity and co-ordination of care (see Appendix B2).
- Follow-up care should be standardised and national guidance should be used when available.
- Ongoing review of needs at key transition points across the pathway.
- Access to functional and psychosocial support services, referral for assessment by Health and Social Care Professionals, psycho-oncology or other specialist services, based on identified needs where required.

Needs assessment and care planning should not be a single event. It is a dynamic and ongoing process. It is revisited at key transition points such as diagnosis, changes in treatment, completion of active treatment, and entry into long-term follow-up or surveillance.

Local Considerations: Roles and Responsibilities

- Needs assessments should be offered at baseline and revisited at key transition points using validated tools. This may be co-ordinated through the named point of contact.
- Assessment results should be discussed with the individual and inform care planning.
- Ensure there are local processes in place for delivering the Holistic Needs Assessment and that healthcare staff are aware of these.
- Provide and encourage the use of a patient passport where available for patients to bring to hospital and use to record their care.
- Roles and responsibilities for completing and sharing Treatment Summary and Care Plans should be clearly defined and documented in local policies.
- Where available, adherence to the nationally developed minimum dataset for a Treatment Summary and Care Plan is recommended.
- Consider how information will be collected at key junctures in the person's healthcare journey to capture relevant information to facilitate the creation of the Treatment Summary and Care Plan.

- Information systems should support timely capture and sharing of relevant information.
- A designated person may be in place to ensure that relevant information is electronically captured, for example at multidisciplinary team meetings. They or another designated person may check that the data is accurate. This supports the completion of a Treatment Summary and Care Plan.
- Develop or adopt a Treatment Summary and Care Plan template to suit local hospital systems and processes.
- Services should ensure clear pathways for referral to Health and Social Care Professionals and other supports identified through assessment.

Examples in Practice

- A person completes a HNA at the end of active treatment, identifying fatigue, anxiety and concerns about returning to work. These needs are discussed with a nurse specialist, incorporated into a personalised care plan and referrals for support are made.
- A tumour specific Health Concerns Questionnaire (HCQ), such as prostate specific questionnaire in Stratified Self-Managed Follow up, is used alongside the standard HNA, identifying red flags for the individual to discuss with their team.
- A review is scheduled with an individual at a time point when they have completed active treatment and are due to start long-term follow-up, to review the completed Treatment Summary and Care Plan. The TSCP is reviewed with the individual, ensuing a shared understanding of what follow-up involves, as well as the signs and symptoms of recurrence, modifiable risk factors, healthy living, and supports available locally, and how and when to re-access care.
- Distributing a Patient Passport, such as the NCCP Colorectal Patient Passport, at their first appointment when they receive a diagnosis, with instructions to bring it to each visit. During follow- up the patient records the details of their treatment and appointments.

Checklist:

- [ ] Is a HNA or another validated needs assessment offered at diagnosis and at key transition points?
- [ ] Is care planning completed with the person, and needs reviewed and discussed with them?
- [ ] Is a Treatment Summary and Care Plan developed and shared with the person?
- [ ] Is a meeting arranged with the individual to review the information on the Treatment Summary and Care Plan?
- [ ] Are GPs included on shared documentation and do they receive copies of the Treatment Summary and Care Plan?
- [ ] Are there local policies in place for the creation and delivery of the Treatment Summary and Care Plan?
- [ ] Are there processes in place to ensure data is collected in a timely manner to support the creation of a Treatment Summary and Care Plan?
- [ ] Are follow-up and surveillance plans clearly explained?
- [ ] Are there local policies in place regarding needs assessments?
- [ ] Are patient passports shared with individuals and its purpose explained?

Pillar 4: Support Programmes, Places and People – Wellbeing and Ongoing Support

Support Programmes, Places and People

Purpose:

To ensure that people affected by cancer have access to appropriate functional, psychosocial, emotional and practical supports throughout and beyond cancer treatment. These supports are essential to maintaining or improving quality of life, supporting recovery and helping people cope with treatment and live as well as possible with and beyond cancer. This pillar focuses on access to supports informed by the assessment of needs.

Overview and Key Components:

This pillar highlights the role of specialist functional and psychosocial support services for individuals living with cancer and their families. It emphasises effective signposting to services that provide physical, emotional, and practical support across both acute and community settings. Utilising these supports throughout the cancer journey can substantially improve quality of life both during and after cancer treatment.

Not every person will require every service, but awareness of available supports and ability to access them when needed is critical. Availability of support services across acute settings, primary care, and community settings can vary by location.

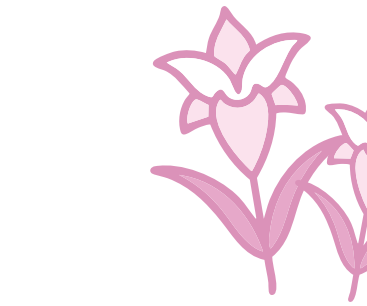
A multidisciplinary team approach is central to the delivery of survivorship supports. This includes Health and Social Care Professionals, whose expertise contributes to assessment, intervention and ongoing management across treatment, prehabilitation and rehabilitation, long-term survivorship and palliative care. Access to relevant professional expertise, where available, may include Dietetics, Medical Social Work, Physiotherapy, Occupational Therapy, Speech and Language Therapy, Psycho-Oncology, Nursing, and Palliative Care, supporting comprehensive and person-centred survivorship care.

Key elements include:

- Signposting and referral to Community Cancer Support Centres and services including ICS Daffodil Centres to provide information, psychosocial support and practical assistance, and access to support groups.
- Encouragement and support to participate in prehabilitation, rehabilitation and physical activity programmes, recognising the important role in improving physical function in cancer recovery and quality of life.
- Access and referral to Psycho-oncology and other psychosocial support services.
- Encouragement to participate in national evidence-based survivorship programmes, such as:
  - Life and Cancer - Enhancing Survivorship (LACES)
  - Cancer Thriving and Surviving (CTS)
  - Menopause and Cancer (EMPOWER)
  - See Appendix A4 for more details
- Referral to late and long-term effects services addressing cancer and treatment effects such as fatigue, lymphoedema, cognitive changes, menopause and psychosocial distress.
- Support for health promotion, wellbeing and secondary cancer prevention, including encouragement of risk reducing behaviours and participation in appropriate cancer screening programmes.

Local Considerations: Roles and Responsibilities

- Services should ensure timely access to relevant Health and Social Care Professionals, and rehabilitation services with multidisciplinary interventions for people affected by cancer.
- Referral pathways, guidance and appropriate assessment tools will ensure patients are directed to the relevant services.
- Multidisciplinary working is essential to ensure supports are coordinated and responsive to individual needs.
- Support options should be routinely discussed during clinical consultations using clear referral guidelines and assessment tools and consistent signposting across acute, primary and community settings.
- Services should maintain up to date knowledge of local and national supports and ensure effective communication and handover between services.



- Local policies for referral to cancer rehabilitation services within and outside of the hospital setting are recommended to streamline the process and ensure consistent, equitable care.
- Support for managing late and long-terms effects of cancer such as fatigue, cognitive impairment and psychological distress should be provided
- Effective links and referral pathways should exist within and between acute, primary and community care settings. Clear referral pathways and open communication is required across all services.

Examples in Practice:

- A person who is experiencing the effects of menopause as a result of their cancer treatment can be referred to the Empower Menopause and Cancer survivorship programme in their local Community Cancer Support Centre.
- A person is signposted to their local Community Cancer Support Centre at diagnosis or at any stage of their treatment for access to psychosocial supports, survivorship programmes, support groups, information, financial and practical advice.

- A person experiencing anxiety and low mood following a cancer diagnosis is referred to the hospitals Psycho-oncology MDT. The severity of need experienced by the person dictates the level of intervention and expertise required. This ranges from offering information and advice on psychological wellbeing to specialist psychological interventions and psychiatric support offered though the Psycho-oncology MDT.
- A person preparing for major cancer surgery is referred to a prehabilitation programme which may include a tailored exercise and nutrition plan and are later supported by physiotherapy-led rehabilitation.
- A person undergoing radiotherapy for head and neck cancer is referred to dietetics and/or speech and language for swallowing difficulties and weight loss.
- A person experiencing cognitive fatigue following treatment is referred to occupational therapy for targeted assessment and intervention.
- A person is signposted to their local ICS Daffodil centre at the end of their active treatment for information on accessing LACES survivorship workshop.

Checklist:

- [ ] Is access to functional, psychosocial and practical supports available across the pathway?
- [ ] Are needs identified through assessment, actively used to inform referrals and signposting?
- [ ] Are individuals supported to access appropriate prehabilitation and rehabilitation services and physical activity programmes where appropriate?
- [ ] Is there timely access to Health and Social Care Professionals?
- [ ] Are support services routinely discussed during clinical consultations?
- [ ] Are there strong links and referral pathways to Community Cancer Support Centres and survivorship programmes?
- [ ] Are health promotion, wellbeing and secondary prevention supports actively encouraged?
- [ ] Is smoking cessation offered pre-treatment and at relevant timepoints?
- [ ] Are there criteria and clear referral pathways to the Psycho-oncology MDT?
- [ ] Are there local policies and referral pathways in place for all relevant support services?

Appendices

Appendix A: Key Developments in Cancer Survivorship Care in Ireland

This appendix provides a non-exhaustive summary of key national developments that have informed and supported the evolution of cancer survivorship care in Ireland. These developments reflect progress across policy, service models, programmes and community-based supports, and underpin the Cancer Survivorship Patient Pathway.

A1. Policy and Strategic Frameworks

National Cancer Strategy 2017–2026

The National Cancer Strategy emphasised the importance of developing survivorship care to support people living with and beyond cancer and recommended targeted investment in survivorship services.

NCCP Survivorship Programme

The NCCP Survivorship Programme was established to lead and coordinate survivorship initiatives nationally, informed by emerging evidence, patient experience and service need.

National Cancer Survivorship Needs Assessment

National assessments of survivorship needs highlighted persistent unmet physical, psychological, social and informational needs across cancer types and stages, informing service development and prioritisation.

A2. Models of Care and Service Developments

ALLIES Model of Cancer Survivorship Care

The ALLIES model (Assess, Link in and Link out and onward, Inform, Empower, Support) is a principles-based approach to survivorship care and has informed the development of survivorship services and frameworks in Ireland.

Best Practice Guidance for Community Cancer Support Centres (2022)[10]

The NCCP Best Practice Guidance (BPG) is a guide developed to support Community Cancer Support Centres (CCSC) in how they govern, manage and deliver their services. It brings together learning and agreed good practice across four key areas: delivery of core services, governance, adherence to professional conduct and ethics, and impact monitoring and service evaluation. As part of the BPG, CCSCs take part in a self-assessment and peer-review process, which shows how they meet and apply the guidance in practice. The BPG helps CCSCs reflect on their current practice and identify where improvements may be needed. For patients, it offers assurance that CCSCs are safe, well-governed and focused on delivering high-quality, person-centred care.

Psycho-Oncology Model of Care for Adults (2020)[11]

The model of care is a multi-faceted approach, which spearheads both the development of multidisciplinary Psycho-oncology teams in cancer centres as well as development of the Alliance of Community Cancer Support Centres, emphasising the importance of an integrated patient pathway. It further promotes an integrated patient pathway for psychosocial and psychological support, so that no matter what point of the cancer trajectory the patient is at, they should be able to access the professional support they need.

Cancer Survivorship Stratified Self-Managed Follow up Framework (2023)[12]
Stratified self-managed follow up pathways have been developed and implemented for prostate cancer, with expansion into breast cancer. This approach empowers patients to self-manage and enables appropriate redirection of patient from routine hospital-based follow-up with clear re-access pathways and supported self-management.

A3. Community Supports
The Alliance of Community Cancer Support Centres and Services (The Alliance)
Community Cancer Support Centres (CCSCs) within the NCCP Alliance provide free supportive services and programmes to individuals affected by cancer, including patients, their families and carers. These centres offer a range of supports, including core services such as information provision, psychological support, physical activity and survivorship programmes, as well as access to complementary therapies and supportive activities, including yoga, relaxation classes and peer support groups. Practical supports, such as financial advice, are also available to assist individuals in managing the wider impact of a cancer diagnosis.

The NCCP provides activity-based funding to support core services delivered by organisations within the Alliance. It supports the development of integrated care pathways between Community Cancer Support Centres, hospitals and primary care services through the implementation of NCCP Best Practice Guidance, the advancement of evidence-based survivorship services, and enhanced professional collaboration. The aim is to ensure that all those affected by cancer in Ireland, including individuals with a diagnosis, their families, carers and supporters, can access appropriate, high-quality support in the right place and at the right time. Such support is readily accessible, delivered by appropriately qualified practitioners and free at the point of service.

Directory of Community Cancer Support Centres & Services, Ireland
The directory is a list of the support services available in the Community Cancer Support Centres.

Alliance Newsletter
News for the Cancer Support Community is a monthly newsletter which provides information and a compendium of survivorship initiatives available, including programmes and educational opportunities for healthcare professionals and patients and families and promotes cancer survivorship research.

A4. Evidence Based Survivorship Programmes.
Life and Cancer – Enhancing Survivorship (LACES):
This workshop allows patients to access appropriate information and signposting to improve their quality of life after cancer. The focus is on health and wellbeing, enhancing the use of community supports and survivorship programmes.

Cancer Thriving and Surviving (CTS):
This six week programme helps patients with the transition from active treatment to living well with and beyond cancer. It is based on a rehabilitation best practice model, focusing on self-management with information and support.

Children's Lives Include Moments of Bravery Programme (CLIMB®):
This programme is for children aged 6 to 12 who are experiencing the impact of a parent's cancer diagnosis. The programme aims to build upon the child's strengths and increase their ability to cope with stress associated with the parent's illness.

EMPOWER Menopause and Cancer programme:
This programme is for women impacted by menopause following cancer treatment or surgery. Expert contributors cover topics including how to manage menopause symptoms, the losses associated with menopause, intimacy and sexuality.

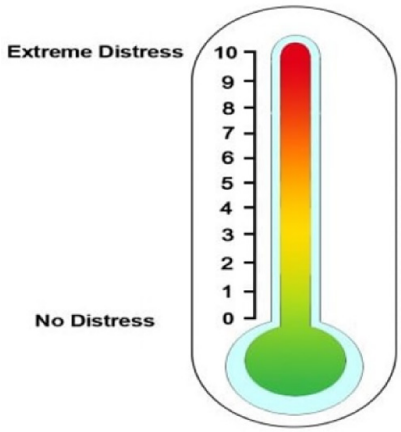
Appendix B: Needs Assessment National Templates

B1. Holistic Needs Assessment (HNA):

An assessment tool used to identify all of a persons needs during and after cancer treatment. It includes an assessment of physical, emotional, practical, financial and spiritual needs and is used to promote self-management and wellbeing and is suitable for use across all cancer types.

For each item below, please select yes or no if it has been a concern for you during the last week, including today. You will have an opportunity to speak about your concerns with your healthcare team.

Date	Practical Concerns	Yes	No	Physical Concerns	Yes	No
	Caring responsibilities			High temperature		
Name	Housing or finances			Wound care		
	Transport or parking			Passing urine		
Hospital Number	Work or education			Constipation or diarrhoea		
	Information needs			Indigestion		
Please select the number that best describes the overall level of distress you have been feeling during the last week, including today:	Difficulty making plans			Nausea and/or vomiting		
	Grocery shopping			Cough		
	Preparing food			Changes in weight		
	Bathing or dressing			Eating or appetite		
	Laundry or housework			Changes in taste		
	Smoking habit			Sore or dry mouth		
	Substance use			Feeling swollen		
	Family Concerns			Breathlessness		
	Relationship with children			Pain		
	Relationship with partner			Dry, itchy or sore skin		
	Relationship with others			Tingling in hands or feet		
	Fertility concerns			Hot flushes		
	Emotional concerns			Moving around or walking		
	Loneliness or isolation			Fatigue		
	Sadness or depression			Sleep problems		
	Worry, fear or anxiety			Communication		
	Anger, frustration or guilt			Personal appearance		
	Memory or concentration			Other medical condition		
	Hopelessness			**Any other concerns:**		
	Sexual concerns					
	Spiritual concerns					
	Regret about the past					
	Loss of meaning/purpose in life					
	Loss of faith or other spiritual concern					



B2. Treatment Summary and Care Plan (TSCP):
Contains information about the person's cancer diagnosis, their cancer treatment and their follow-up care, as well as information on signs of recurrence and maintaining a healthy lifestyle. It is recommended as a tool to communicate and co-ordinate survivorship care and contains information on signs and symptoms to watch out for as well as modifiable risk factors and advice for staying healthy, and maintaining psychological wellbeing.

Patient details			
Name:		DOB:	
Address:			
Hospital number:		Hospital:	
Consultant:		Hospital phone number:	
Key contact (CNS/CSW):		Phone number:	
General Practitioner:		Phone number:	
Diagnosis Details			
Cancer type:			
Date of Diagnosis:		Stage:	
Surgery Details			
Surgery Type(s):		Date(s) of Surgery:	
Surgeon:			
Radiation Therapy Details (if applicable)			
Radiation type:		End date:	
Hospital:		Radiation Oncologist:	
Hormone Therapy Details (if applicable)			
Complications / Other relevant information			
Follow Up Care Plan Details			
Clinic Appointment / Tests Schedule:			
Self-managed pathway (if applicable):			
Drug Name:		End date:	
Hospital:		Duration:	
Systemic Therapy Details (if applicable)			
Regimen/ Drug Name:		End date:	
Hospital:		Medical Oncologist:	

Patient Information:

Post Treatment Advice

If you experience any of the following symptoms, please notify your Clinical Nurse Specialist, Healthcare Team or GP

- [Enter Symptom]
- [Enter Symptom]
- [Enter Symptom]
- [Enter Symptom]
- [Enter Symptom]

Lifestyle Advice

You can lower your risk of developing a new cancer by following some simple lifestyle advice:

- Avoid smoking or using tobacco products
- Have a healthy diet & be a healthy weight
- Be physically active
- Avoid alcohol & recreational drugs
- Avoid too much sun & make sure you are SunSmart
- Recommend keeping vaccinations up to date
- Get screened for cancer by taking part in organised population breast, cervical and colorectal screening programmes

Psychological Well being

Psychological well being is important for everyone. A diagnosis of cancer can lead to psychological distress. This can occur anytime - at diagnosis, during treatment or after discharge.
It can affect your ability to cope.

For more information on local supports refer to: www.hse.ie/thealliance

Please seek medical advice if you have ongoing:
• **Fatigue • Body image concerns • Difficulty coping • Anxiety or depression • Any other worries**

LACES Programme

The Life and Cancer – Enhancing Survivorship (LACES) programme is for patients who have finished treatment or who are on maintenance therapy. The 2½ hour workshop can help you to live well, feel your best, physically and emotionally and find out more about good support services available to you. Cancer nurses deliver the workshops online and face to face in some Daffodil Centres.

To join a workshop, email patienteducation@irishcancer.ie

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