Healthcare Improvement Scotland

Service Summary: Single Point of Contact

Executive summary

This summary has been produced by Healthcare Improvement Scotland to support the scalability assessment by providing an accessible overview of the information collated from service profiles of the Single Point of Contact (SPoC) services. This report provides:

- An overview of the key information collected in the service profiles
- Analysis of the similarities and differences between services
- Themes identified from analysis of the service profiles and aggregate summary of profiles, which indicate barriers and enablers to implementation of SPoC.

Since 2021, Scottish Government have provided funding totalling 5.1 million over four years. This has supported 12 pilot projects for SPoC within 10 NHS Scotland health boards and one regional cancer network. Each health board has one SPoC project apart from NHS Greater Glasgow and Clyde which has two separately funded projects for specific tumour pathways (Gynaecological and Lung). The West of Scotland Cancer Network has one service which funds SPoC staff for four health boards in the West of Scotland, focused solely on post-treatment follow up.

Roles

Investment in SPoC has been primarily for NHS Scotland Agenda for Change (AfC) Band 4 navigator (delivery) staff. Some sites have committed to ongoing funding of the pilot projects. This has allowed those areas to appoint staff to permanent posts. This has been identified as an enabler to successful planning and recruitment.

Despite a variation in job title, the core tasks of the SPoC navigator remain similar across services. The core description of the role is to triage calls, direct queries to clinical support where appropriate and respond to non-clinical queries. In practice, this involves a mixture of administrative and healthcare support worker tasks.

See Appendix 1 for further detail on the variation in roles and responsibilities of SPoC staff reported by services.

NHS SCOTLAND

Service Offering

SPoC navigators provide a mixture of support to patients throughout the cancer journey. This support can be:

- Administrative & logistical
- Social & emotional
- Informational

SPoC services support patients at various timepoints in the cancer pathway. Most services begin at diagnosis and conclude at end of treatment. NHS Borders and NHS Western Isles services start earlier in the pathway, from referral to end of treatment. NHS Fife, NHS Grampian and NHS Greater Glasgow and Clyde (Lung) support only from referral through diagnosis. The West of Scotland Cancer Network supports follow up only.

SPoC support is provided across all tumour pathways in 3 out of the 11 funded health boards (NHS Borders, NHS Fife and NHS Western Isles). An additional three of the funded health boards deliver SPoC support across seven or more pathways. Support is most limited in sarcoma/bone pathways.

See Appendix 2 for a detailed report of pathway coverage and contact type per site.

Integration with other services

SPoC services were specifically asked about interactions with Rapid Cancer Diagnostic Services (RCDS) and Improving the Cancer Journey (ICJ).

The cancer action plan states *"Improving the Cancer Journey (ICJ) helps us keep the person with cancer and their family or supporters at the centre of their care. The service integrates psychosocial care into the cancer pathway and, through the holistic needs assessment and care planning process, individuals can access timely support that is relevant, appropriate, and sufficient for their needs."*

Patients referred to RCDS have non-specific symptoms (such as fatigue, nausea and weight loss) that do not meet existing Scottish referral guidelines for suspected cancer. RCDS offers Primary Care a fast-track diagnostic pathway that is different from urgent suspicion of cancer pathways. SPoC has limited interaction with RCDS. At the time of writing, not all sites have ICJ services. Where ICJ services do exist, SPoC and ICJ typically interact to support patients.

Where SPoC-ICJ interaction exists, the roles of each are distinct between clinical pathway support (SPoC) and support to access community services (ICJ).

Key variables in SPoC-ICJ interaction between services are:

- Who refers. In some services, the SPoC refers directly to ICJ whereas in others the clinical nurse specialist (CNS) carries out the referral. In one board, the SPoC signposts patients to the ICJ and does not interact with ICJ directly.
- Basis for referral. Most services with SPoC-ICJ interactions refer or signpost all patients, with a minority using criteria-led referral to manage limited ICJ capacity.

See Appendix 3 for further detail on RCDS and ICJ.

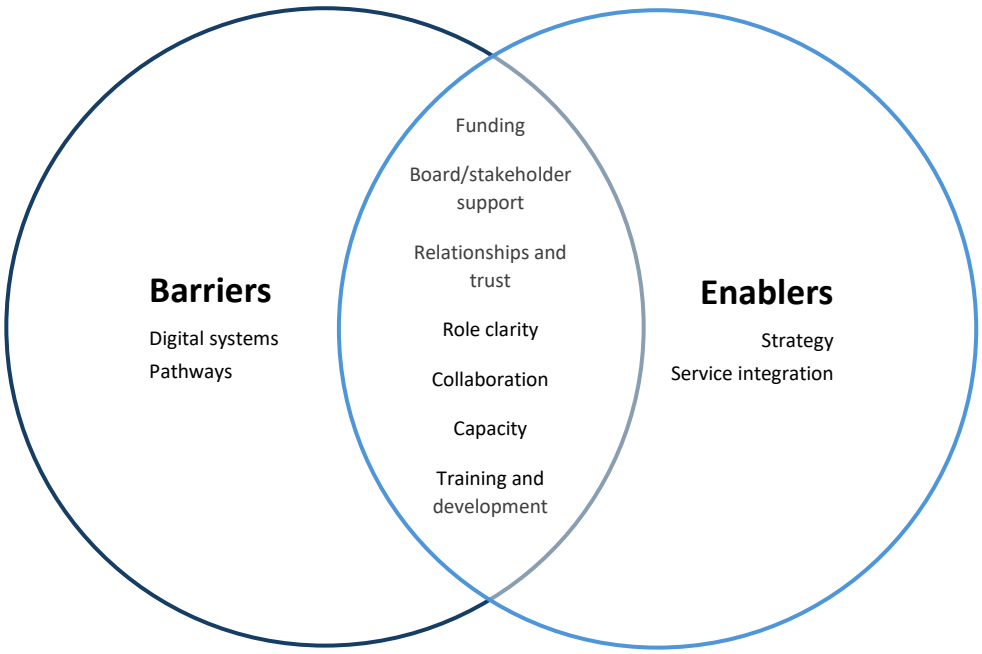
Key learning from implementation

The most collected measures from services are:

- Patient/carer experience (7 sites)
- No of patient contact/calls (10 sites)
- Call reason (including action/outcome) (6 sites)

Information on barriers and enablers to implementation of SPoC was collated from the site profiles and analysed to develop 11 key themes. Seven of the themes presented both barriers and enablers depending on context. The other four themes were either exclusively enablers or exclusively barriers.

Figure 1.0 Themes presenting barriers/enablers to SPoC derived from service information



See Appendix 4 for examples of barriers and enablers associated with each theme and examples from service experiences.

Appendix 1: Roles

Funding for SPoC has primarily been for direct support roles and was allocated as outlined in service models described in the initial bids from teams. Services have distributed this funding in slightly different ways to cover a range of roles from NHS Scotland Agenda for Change (AfC) band 3 to band 5.

Healthcare support worker (NHS Scotland AfC Band 3)

The navigator role in NHS Western Isles was originally specified as a band 3 Healthcare Support Worker role. This is in the process of being regraded to band 4.

NHS Western Isles reported HCSW responsibility for attending Near Me appointments with patients and carrying out prehab assessments. This may be particularly reflective of the island context.

Navigator (NHS Scotland AfC Band 4)

The core role for SPoC is the band 4 navigator role, which has been given varying titles:

- Cancer Care Coordinator (NHS Borders & NHS Dumfries & Galloway)
- Patient Navigator (NHS Fife, NHS Lothian & NHS Tayside)
- Cancer Support Worker (NHS Highland)
- The job title for the WoSCAN navigator role varies depending upon the health board but generally uses the term 'Support Worker' e.g. in NHS Greater Glasgow and Clyde, it is Prostate Cancer Support Worker; in NHS Ayrshire & Arran it is Urology Oncology Support Worker.

Despite the variation in job title, the core tasks of the navigator remain similar. The core description of the role is to triage calls, direct queries to clinical support where appropriate and respond to non-clinical queries. In practice this involves a mixture of administrative and support worker tasks.

Most services report a combination of:

- Logistical & administrative support by helping patients to navigate the service, coordinating appointments, receiving and interpreting information and arranging access for patients such as to transport and interpreters
- Social & emotional support by directly communicating with patients and providing referrals to community resources
- Informational support by providing standard advice in relation to elements of investigation and treatment

These patient-facing elements are also supplemented by information gathering and coordination on behalf of patients and clinicians.

The most common tasks across services are:

- Appointment checking and rescheduling
- Responding to transport queries
- Signposting to other support (third sector/community organisations)
- Providing emotional support
- Referring to Improving the Cancer Journey (ICJ) where ICJ services are established

SPoC navigators also provide advice and information to patients on topics related to their treatment, including:

- Responding to concerns about side effects
- Explaining investigations (e.g. MRI, CT scans)
- Providing vaccination advice
- Providing standard advice and guidance on a range of topics, including diagnostic tests, symptom management, medication & treatments

NHS Lothian's model differed from the others as it identified primarily administrative tasks for the navigator, which may be associated with lower job satisfaction. It may be useful to investigate this further.

Additional SPoC funded staffing

- Band 5 Cancer Pathway Navigator (NHS Borders)
- Band 5 Supervisor (NHS Lothian)
- Clinical advisor, band not provided (NHS Lothian)

Other staffing

In several cases, SPoC services are supported by additional roles not funded through SPoC:

- Macmillan Cancer Information and Support Service Manager (NHS Borders)
- Nurse Consultant (NHS Grampian)
- Clinical Service Manager (NHS Dumfries & Galloway)
- Cancer Audit and Performance Manager and Cancer Transformation Manager (NHS Fife).

Staff development

Not all services provided information about training and development. The staff in post have varied backgrounds, which has informed their development needs. Primarily, services referenced Macmillan modules when describing the training provided. NHS Fife used the same training and development package as the RCDS navigators.

Other development activities (often supplementary to Macmillan) included:

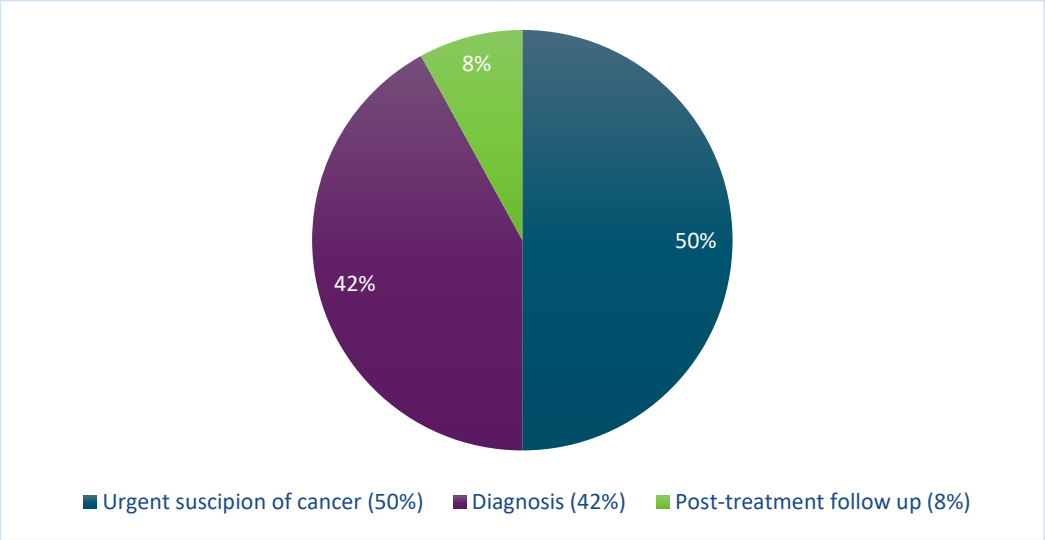
- Shadowing the CNS (NHS Dumfries & Galloway, NHS Grampian)
- Shadowing across different tumour groups to understand pathways (NHS Grampian)
- Support Workforce Learning Week, held by NHS Education for Scotland in 2022. This training was aimed at support workers in nursing, midwifery, AHP, business and admin and estates and facilities roles. (NHS Dumfries & Galloway)
- Training on solutions-focused coaching (NHS Highland)

Appendix 2: Service Offering

Point of referral

Services accepted referrals from different points in the cancer pathway. Some services started when an urgent suspicion of cancer (USC) referral was made by GPs whereas other started from the point of diagnosis or from follow up. Figure 2.0 shows the split of points of referral to SPoC amongst services.

Figure 2.0 Commonality of points of referral to SPoC



There is almost an even split between SPoC services which take patient referrals from Urgent Suspicion of Cancer pathways (USC) and those which take referrals at the point of diagnosis only. WoSCAN is the only service which focuses on post-treatment follow up support.

What part of the pathway does SPoC support?

Figure 3.0 SPoC pathway coverage by site

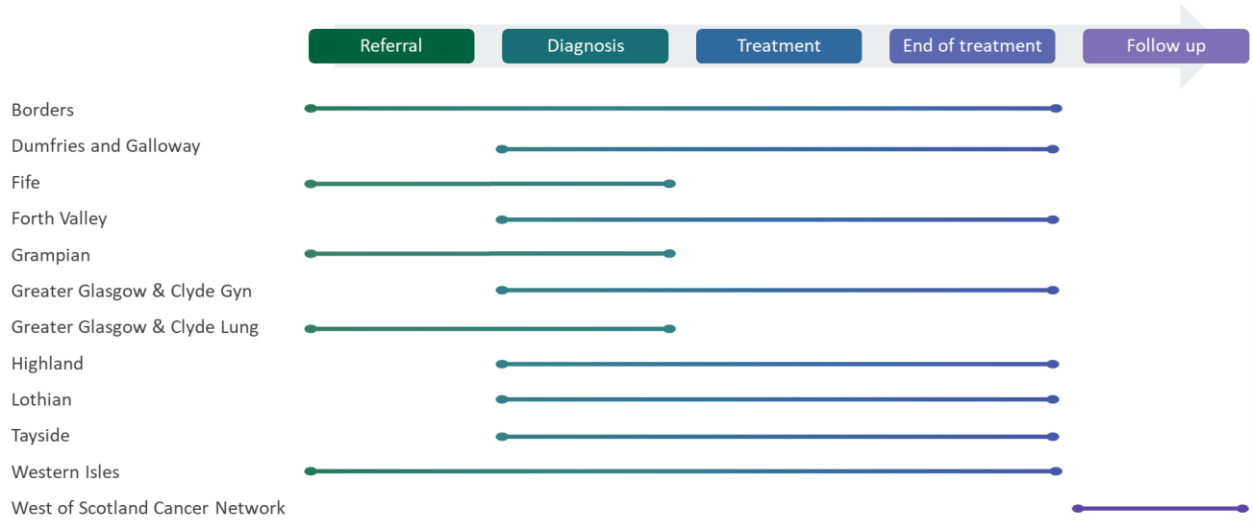


Figure 3.0 summarises the pathway coverage by service. Some services include support for multiple tumour type pathways, which is detailed in table 1.0 below. Most services begin at diagnosis and conclude at end of treatment. Borders and Western Isles services start earlier in the pathway, from referral to end of treatment. NHS Fife, NHS Grampian and NHS Greater Glasgow and Clyde (Lung) support only from referral through diagnosis. West of Scotland Cancer Network (WoSCAN) supports follow up only.

What tumour pathways does SPoC support?

Excluding WoSCAN from the analysis, six of the funded health boards deliver SPoC support across seven or more tumour pathways. Support is most limited in sarcoma/bone pathways. Reporting of a specific Neuroendocrine pathway was low, but it is likely that some services support neuroendocrine cancers as part of other tumour pathways.

Table 1.0 indicates which tumor pathways SPoC services currently support at each funded site.

Table 1.0 Tumour pathways supported by SPoC services

Site	Gyn	Haem	Lung	Urology	Breast	Head and Neck	Colorectal/ HPB/ Upper GI[1]	Skin/Derm	Neuro	Sarcoma/ bone	Neuroendocrine
NHS Borders	•	•	•	•	•	•	•	•	•	•	•
NHS Dumfries & Galloway			•	•	•[2]		•[2]				
NHS Fife	•	•	•	•	•	•	•	•	•	•	
NHS Forth Valley		•	•	•	•	•	•	•			
NHS Greater	•										

Glasgow and Clyde (Gyn)											
NHS Greater Glasgow & Clyde (Lung)			•								
NHS Grampian	•	•[3]	•[3]	•[3]	•[3]	•[3]	•	•	•[3]	•[3]	
NHS Highland	•	•	•	•	•	•	•	•	•		
NHS Lothian	•		•	•	•	•	•	•	•		•
NHS Tayside				•			•[4]				
NHS Western Isles	•	•	•	•	•	•	•	•	•	•	
WoSCAN				•							

[1] Colorectal, hepatobiliary and upper gastrointestinal tumour types were grouped for data collection. Distinct data for each tumour type separately is not currently available. Service may not cover all three types.

[2] Phasing in

[3] Inbound only

[4]Upper GI only

Further points to note:

- WoSCAN is a specialist service supporting prostate cancer pathways across multiple locations.
- NHS Tayside focuses their service on people with advanced disease.
- NHS Fife provides additional support to people on some pathways and at some stages to target efforts where it is most likely to make a difference for patients.

Contact type

Services reported a variation of ways in which SPoC staff interacted with patients. Table 2.0 organises the services by the type of contact between SPoC navigators and patients.

Table 2.0 Types of contact between SPoC services and patients

Contact type	Services
Proactive outreach* to patients	NHS Borders NHS Fife

		NHS Grampian (Dependent on tumour pathway)
	Initial outbound contact to patient followed by inbound/outbound contact	NHS Highland NHS Western Isles NHS Greater Glasgow and Clyde (Lung)
	Primarily or exclusively inbound contact from patient	NHS Dumfries & Galloway NHS Lothian NHS Tayside NHS Greater Glasgow and Clyde (Gyn) NHS Forth Valley

*Proactive outreach may be targeted at specific points in the pathway.

Holistic Needs Assessment

Only NHS Borders currently carries out Holistic Needs Assessment (HNA) within the SPoC service. It is first offered at diagnosis, with uptake by approximately 1 in 3 patients.

HNA is otherwise carried out by ICJ services, where they are in place. Views about the desirability of shifting the HNA from ICJ to SPoC were mixed, noting the HNA offered the potential for developing the relationship with patients, but that ICJ has existing skills and contacts relevant to the HNA. ICJ has received greater investment and training to carry out HNA, resulting in greater capacity where ICJ services are in place.

Appendix 3: Integration with other services

Rapid Cancer Diagnostic Service (RCDS)

RCDS is a fast-track diagnostic pathway to investigate patients with non-specific symptoms (such as fatigue, nausea and weight loss) that do not meet existing Scottish referral guidelines for suspected cancer. RCDS offers Primary Care a fast-track diagnostic pathway that is different from urgent suspicion of cancer pathways. SPoC tends not to interact with RCDS, either because there are no RCDS services in the board area or because SPoC and RCDS intervene at different points on the patient pathway.

Patients on the RCDS pathway are supported by SPoC in Borders and Fife.

Improving the Cancer Journey

The cancer action plan states "*Improving the Cancer Journey (ICJ) helps us keep the person with cancer and their family or supporters at the centre of their care. The service integrates psychosocial*

care into the cancer pathway and, through the holistic needs assessment and care planning process, individuals can access timely support that is relevant, appropriate, and sufficient for their needs."

Most, but not all, board areas have ICJ services however staffing varies. SPOC-ICJ interaction is highly variable. Where both services are present, a number of approaches were reported:

- SPoC supporting patients through clinical elements of the pathway, referring to ICJ for support in the community (NHS Tayside).
- No SPoC-ICJ interaction. In two services (NHS Dumfries & Galloway, NHS GGC (Lung)) the CNS refers to ICJ rather than SPoC making the referral. In one board (NHS Lothian), SPoC signposts patients to ICJ rather than referring directly.
- SPoC supporting earlier in the pathway with ICJ supporting post-treatment (NHS Fife).
- SPoC and ICJ work collaboratively. Due to limited ICJ capacity in a small number of boards, a set of criteria have been established for referral to ICJ at points in the cancer journey where it is likely patients would most benefit. For certain cancers, all patients will receive a referral at some point in the cancer journey (NHS Forth Valley).

SPoC-ICJ integration is currently under development in NHS Borders and NHS Western Isles.

Sites reporting no interactions with ICJ are: NHS GGC (Gyn), NHS Grampian, NHS Highland & WoSCAN.

Where SPoC-ICJ interaction exists, there is consistent distinction between the roles of each. Clinical pathway support is provided by SPoC whereas ICJ provides support to access community services.

Key variables relating to SPoC-ICJ interaction are:

- Who refers. In some services, the SPoC refers directly to ICJ whereas in others the clinical nurse specialist (CNS) carries out the referral. In one board, the SPoC signposts patients to the ICJ and does not interact with ICJ directly.
- Basis for referral. Most services with SPoC-ICJ interactions refer or signpost all patients, with a minority using criteria-led referral to manage limited ICJ capacity.

Other teams or services

Services reported interactions with other teams including:

- The waiting times team
- Other regional boards (to facilitate treatment across boundaries)
- Radiology
- GPs
- District nurses
- Third sector providers (e.g. Macmillan, Maggie's, Hospice)

Reports of interactions with other teams are highly clustered. SPoC services within a small number of boards (NHS Borders, NHS Fife, NHS Forth Valley, NHS GGC (Gyn)) reported a high degree of connection with other teams, while most services reported none.

Appendix 4: Key learning from implementation

Measures

The most collected measures were:

- Patent/carer experience (7 sites)
- No of patient contact/calls (10 sites)
- Call reason (including action/outcome) (6 sites)

No other measures are being collected by more than three sites.

Barriers and Enablers

Information on barriers and enablers to implementation of SPoC was collected via the site profiles. Responses were collated and analysed to develop themes. Tables 4.0 and 5.0 below show the themes and examples of how they present enablers and barriers. Most themes appear in both tables as they had both benefits and challenges associated with them.

Barriers

Table 3.0 Barriers to SPoC implementation

Theme	Barriers	Service experiences
Funding	Non-recurring funding; fixed-term contracts	Non-recurring funding meant that contracts for SPoC posts were fixed term in some boards. Services highlighted that this negatively impacted the pace of service development, continuity of support to the CNS and staff turnover.
Board / stakeholder support	Changes in board leadership	One service noted that there was significant change to board leadership during the development period for SPoC, which resulted in a lack of visibility of the project.
Relationships and trust	Clinician reservations about new service model; challenging patient perceptions; relationships with referrers; change of culture	Several services highlighted that clinicians were initially wary about handing their patients over to a new service. Time had to be spent building relationships and trust. Some services also noted that patients perceived the loss of direct contact with their CNS as a negative, especially existing patients. Patients also expressed confusion over the difference in role between SPoC and ICJ. Teams had to spend time building patients' understanding and trust in the service. Relationships with referrers were also highlighted as a barrier as one service noted that GPs were not adhering to referral guidance therefore more time

		needed to be spent building relationships with referrers.
Role clarity	Varied interpretation of the navigator role; inappropriate use of the service; variation in job titles; determining admin/clinical balance; unclear person specification	There was no clear framework or blueprint for what SPoC should be when it was introduced therefore services had different models and ways of working. Several services raised issues about the role of SPoC and the varied interpretations of what it should be. Clinicians and patients at some services felt that it was unclear which team should be doing what, and when. Although the navigator is a non-clinical role, a small number of teams had a clinically trained person in post therefore finding a balance between admin and clinical work was a concern. Occasionally, patients also phoned the service inappropriately e.g. because they could not get an appointment with their GP. Teams had to spend time raising awareness of the service and improving understanding of their role.
Collaboration	Multi-disciplinary leadership; cross-sector working; unique geographical challenges	One service highlighted that it was difficult to bring together leads from multiple disciplines to collaborate on the development of the service however they have now agreed to meet on a regular basis. Some services also worked across sectors and one team highlighted the difficulties of securing engagement and agreement across multiple sets of clinical leads, lead nurses and clinical service managers due to the differences in set-up of teams, clinics and processes. One service also highlighted a barrier to collaborating with other services because their service had unique challenges associated with delivering healthcare in an island community.
Training and development	Limited capacity to conduct training	One service noted that training and development was difficult due to CNSs experiencing high demands and having little time to conduct training for SPoC staff.
Capacity	Increasing demand; lack of physical space; lack of absence cover; staffing instability	One service noted that referrals and diagnoses were increasing, and pathways were becoming more complex. This meant that capacity in the department was reducing and even though SPoC was releasing clinical hours, it did not appear to have influenced waiting times.

		One team also expressed a desire to move to a hub model which would allow them to provide a more flexible service but they currently lack the physical space to do so. Staffing was also raised as a barrier and multiple services experienced challenges with staffing which meant capacity was reduced for periods of time and there was no cover for absences leading to inconsistency.
Digital systems	Access permissions; reluctance to digital working; IT delays	One of the services highlighted that having no access to certain systems was a barrier to SPoC implementation. They expressed a need to have access to book scans for patients which is something that will be discussed in future. Another service provided digital only follow-up for patients but felt that clinicians were wary of handing patients over to a digital service as they were concerned patients wouldn't receive the appropriate level of care. Their service also experienced delays due to IT issues and patients had to be managed manually until the live environment was deployed.
Pathways	Complex pathways; waiting times; availability of other services	Where pathways were more complex, one service highlighted that this was a barrier to providing the proactive SPoC service they did for other tumour pathways. Some pathways also had longer wait times from the multi-disciplinary meeting confirming diagnosis to the time of the patient being informed which meant the SPoC team were not able to plan when to call patients. Availability of other service such as community phlebotomy influenced SPoC implementation. One team highlighted that patients needed access to PSA testing in the community in order for their service to work which was challenging as they worked across sectors with varying availability of community phlebotomy.

Enablers

Table 4.0 Enablers of SPoC implementation

Theme	Enablers	Service experiences
Funding	Board commitment to longer-term investment;	In boards where permanent funding of SPoC roles was agreed, recruitment and retention were made easier. One service also reported that CNS

	permanent funding of SPoC posts	engagement was improved once it was clear the roles would be embedded in the team permanently.
Board / Stakeholder support	Supportive board leadership; clinical leadership	Where board leadership were engaged with the project and could see its benefit, the profile of SPoC was raised. Some boards also reported that clinical teams were highly engaged with the process which was valuable for support and direction.
Relationships and trust	Good CNS/Navigator relationship; clinician trust; openness to change	Several services reported that clinician trust was essential to allow patients to be supported by the service. Good CNS relationships meant that the roles and expectations of the navigators were clear, and a supportive team culture was created. In one board, consultants also provided scripts and helped to develop processes which made the team feel valued and reduced waiting times for results for patients.
Role clarity	Clear person specification; clinical background	Two services highlighted the importance of choosing the right person for the SPoC role. The time spent clarifying the role meant that the right person was appointed, and staff turnover was low. This meant patients were provided with a consistent service. In one board, the person appointed had a clinical background which the service felt was beneficial to building relationships and trust in the service.
Collaboration	Engagement with stakeholders; collaborating with other boards; merging services; MDT integration	Some services collaborated with key stakeholders to design and deliver their SPoC model, including key contacts in primary and secondary care, which helped to integrate SPoC into existing pathways and secure buy in. One service felt that collaborative delivery with other organisations was key to driving and sustaining momentum of the project. Another felt that drawing on the experiences of other services who were more established was beneficial to developing their own processes. One board merged their central referral unit and SPoC into one hub which they reported was efficient for patients' progress through pathways and ensured robust business continuity. SPoC was also integrated into an existing Macmillan service at one board which was beneficial as they had a good understanding of where funding could add value. One service noted the benefit of SPoC staff being involved in MDT and surgical planning meetings. They reported that this allowed navigators to be proactive in providing support to patients as they were aware of surgical wait times and notified early of new patients being referred to the service.

Training and development	Training and input from clinical staff; shared locations; time with community services	Training provided by clinical staff was often seen as valuable, as was ongoing support, particularly from CNSs. Some services highlighted the benefit of SPoC staff sharing an office with, or being located close to, clinical staff. They reported that it improved access to support and knowledge. One service also advised that SPoC staff spent time with community services such as Cancer Information Support Centre, Citizens Advice and carers hubs, as part of their induction. This enabled them to better understand the roles of the services and build good relationships.
Capacity	Reducing CNS workload	SPoC releases clinical time for CNSs which one service reported to be an enabler for SPoC implementation as the help was positively received by clinical staff.
Strategy	Alignment to board strategy	Alignment to board strategy was highlighted as an enabler by multiple services as it helped to secure engagement from stakeholders.
Service integration	Dedicated support for integration; alignment to existing governance structure; phasing in approach	Multiple services felt that having a dedicated role to lead the implementation of SPoC was fundamental to the success of integrating the service. Others highlighted that reporting through existing governance structures was key to ensuring that senior leadership were engaged. Having oversight from established management also helped with integrating SPoC due to their knowledge and skills. Overall, a good management structure was seen as valuable. One service used a phasing-in approach whereby SPoC was introduced to pathways in succession over a period of six months which allowed for testing.

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www.healthcareimprovementscotland.org

Edinburgh Office
Gyle Square
1 South Gyle Crescent
Edinburgh
EH12 9EB

0131 623 4300

Glasgow Office
Delta House
50 West Nile Street
Glasgow
G1 2NP

0141 225 6999