LUNG CANCER NURSING UK

NAVIGATE, FACILITATE, ADVOCATE:

A Professional Development Framework for Lung Cancer Navigators/Coordinators

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"The lung cancer navigator or clinical care co-ordinator role is now a vital and established part of the team. This has enhanced the service given to patients throughout their pathway and treatment and improved patient experience. The role helps free up valuable lung cancer nurse specialist time and enables nurses to manage an ever-increasing workload, better.

When a navigator is in post, patients get a quicker response to enquiries and have extra support in very difficult and challenging circumstances. Every team should have at least one navigator post, if not more!"

Jackie Fenemore
(LCNUK chair 2019 - 2022)

ABOUT LUNG CANCER NURSING UK

Lung Cancer Nursing UK was established in 1998 as the National Lung Cancer Forum for Nurses (NLCFN). In 2019, to celebrate its 20th anniversary conference, the NLCFN announced a new name, Lung Cancer Nursing UK (LCNUK), along with a new website (www.lcnuk.org) intended to improve understanding of the expertise and professionalism of Lung Cancer Nurse Specialists (LCNSs) among healthcare professionals and policymakers.

LCNUK aims to provide networking and support to nurses specialising in the care of people with lung cancer. Any nurse specialist who spends more than 50 per cent of their working week or clinical activities in caring for patients with lung cancer is eligible for membership. Towards the end of 2023 LCNUK made the decision to invite Lung Cancer Navigators/Coordinators to join its membership as a way of recognising the role they play in delivering best practice lung cancer care and the support they provide to LCNSs.

Over the last 20 years, LCNUK has supported its members in four key areas:

- **Clinical**: providing clinical support, sharing information, knowledge and best practice to improve the care lung cancer patients receive.
- **Developmental**: keeping our members up to date on the latest lung cancer news and developments, and encouraging regional participation in LCNUK.
- **Educational**: creating a forum to share and disseminate new developments, skills, treatments and practice through educational programmes, events and publications. Encouraging members to be involved in and lead lung cancer-related research and audit.
- **Professional**: encouraging networking, championing and campaigning for recognition of the role, raising voices on clinical and strategic issues, and representing UK LCNSs in national and international bodies.

ABOUT THIS DOCUMENT

This document was produced by a working group comprising LCNSs and Navigator/Coordinator members of LCNUK. This working group comprised LCNSs and LCNUK committee members Julia McAdam, Karen Macrae and Jane Weir, as well as Navigators/Coordinators Amanda Abbott, Louise Blow, Alisha Gray, Larissa Griffiths, Alison Spray and Karen Whiteside. The working group was responsible for the inception of the document, reviewing relevant exemplars and supporting literature, generating content, consulting with and reviewing all feedback from the wider community, and all editorial decisions. The final document was approved by the Lung Cancer Nursing UK Steering Committee. As this is a new document, we will keep it under review and expect to revisit it 12–18 months after publication.

We are grateful to everyone who contributed ideas and views as part of this project.

INTRODUCTION

Lung Cancer Navigators/Coordinators are part of the wider cancer care team, and they act as a single point of contact and support for people living with cancer and their relatives and carers. Although we understand that people within this role are sometimes called Cancer Care Coordinators, Support workers or Assistant Practitioners (as a few examples), for the purposes of this Framework the role will be referred to as Lung Cancer Navigator/Coordinator, as this seems to be the most consistent name used. However, whatever the name – it is a key role which patients and LCNSs alike appreciate and value.

Lung Cancer Navigators/Coordinators work closely with the LCNSs to provide high-quality, patient-centered care for patients with a lung cancer diagnosis. Under the direction, guidance and supervision of the LCNSs, the Navigators/Coordinators are there to help coordinate care and support patients through clinical investigations, diagnosis, cancer treatment and beyond. A Lung Cancer Navigator/Coordinator plays a vital role in:

- supporting patients through every stage of their cancer journey;
- acting as a liaison between patients, families and the healthcare team;
- ensuring that patients receive comprehensive, timely and well-organised care; and
- alleviating the workload of the LCNSs, allowing them to focus more on direct patient care and patients with more complex needs.

The roles of a Lung Cancer Navigator/Coordinator and a LCNS often overlap. While there are distinct responsibilities for each, there needs to be clear boundaries to ensure safe, coordinated and streamlined patient care. It is crucial to understand where responsibilities begin and end. Whilst a Lung Cancer Navigator/Coordinator plays an essential role in improving the patient experience by providing guidance, resources and support, they must work within their limitations. By maintaining these boundaries, they can provide high-quality care while protecting our well-being and ensuring the best possible outcomes for our patients.

This Professional Development Framework has been written by a Navigator/Coordinator project group with the support of a LCNS team. The Framework has been based on the LCNUK Professional Development Framework for LCNSs.

This Framework is intended to guide Lung Cancer Navigators/Coordinators, their line managers and employers on the core skills, knowledge and training that they will gain and demonstrate as they progress in the role.

The Navigator Framework will be used to:

- define a navigator in the context of the lung cancer setting;
- outline the role and its responsibilities;
- raise awareness and profile of the role with healthcare professionals and patients;
- educate on the benefits and achievements the role can bring;
- support the role becoming a recognised profession; and
- determine what qualifications/training are required for the role (including signposting to recommended education and training schemes where they are available) and what NHS banding is appropriate.

The Navigator's Framework project forms part of the wider Navigator's Programme run by LCNUK, and the project group is accountable to the LCNUK committee.

We are grateful to the LCNSs, other healthcare professionals, academics and advocates who contributed to the development of this document.

As a membership organisation and a charity, LCNUK will continue to champion the needs and hopes of lung cancer patients and the importance of a sustainable, supported and rewarded LCNS workforce so crucial to their care.

LUNG CANCER NURSING UK NAVIGATOR FRAMEWORK WORKING GROUP

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Jane Weir	Nurse Consultant Lung Cancer, Manchester University NHS Foundation Trust
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USING THIS DOCUMENT

This document has been designed to be used by:

- **Those aspiring to become a Lung Cancer Navigator/Coordinator** to understand the qualifications and, hence, the training or professional development they may need to complete to secure a Navigator/Coordinator role, and the skills and capabilities they will be using to support patients and services in the role.

- **Existing Lung Cancer Navigators/Coordinators** with differing experience, time in the role and at different levels, to aid them in:

  - Considering their priorities for professional development, and where they want to focus to develop in their practice as a Lung Cancer Navigator/Coordinator;
  - Supporting conversations with managers about their training needs and career goals;
  - Job matching and making a case for promotion, where Navigators/Coordinators are operating at a higher Agenda for Change band or level.

- **Line managers**, in aiding conversations with their staff members about their current competencies, their priorities for their professional development and their career goals – both as part of, and outside, annual appraisals.

- **Employers**, to understand in more detail the roles that their Lung Cancer Navigator/Coordinator workforce will be playing in individual (and often complex) case management, pathway management, service design and delivery, and research, and to support them in determining the Lung Cancer Navigator/Coordinator resource needed to meet the needs of the lung cancer population.

- **Policymakers**, to bring to life the multiple and varied contributions that Lung Cancer Navigators/Coordinators make to improving service delivery and patient outcomes and experience, and the critical importance of the Navigator/Coordinator workforce if we are to meet the Government's new 10-Year Health Plan: Fit for the Future ambition to increase lung cancer screening and detect thousands more cancers earlier each year.

THE PATIENTS WE SUPPORT

The new NHS 10-Year Health Plan: Fit for the Future states:

> ***"OVER 70% OF LUNG CANCERS ARE CAUSED BY SMOKING"***

To tackle this and the challenge it presents to the NHS, the plan commits to the following:

> ***"THROUGH OUR UPCOMING NATIONAL CANCER PLAN, WE WILL INCREASE ACCESS AND UPTAKE OF SCREENING SERVICES. USING THE NHS APP, WE WILL MAKE IT EASIER FOR PEOPLE TO BOOK APPOINTMENTS. WE WILL FULLY ROLL OUT LUNG CANCER SCREENING FOR THOSE WITH A HISTORY OF SMOKING, WHICH WE EXPECT WILL DETECT 9,000 CANCERS EARLIER EACH YEAR"*** [1]
>
> THE 2025 NHS 10-YEAR HEALTH PLAN: FIT FOR THE FUTURE

Every year approximately 49,200 people in the UK will be told that they have lung cancer.[2] It is a devastating diagnosis that turns their world upside down. With the new NHS 10-year Health Plan and its commitment to increase screening for lung cancer, this number is likely to increase.

The risk of lung cancer increases with age. More than four in 10 (45%) lung cancers are diagnosed in people over the age of 75,[2] many of whom will have other comorbidities.

Lung cancer is often but not always closely linked with deprivation. Lung cancer incidence rates in England in females "*are 174% higher in the most deprived quintile compared with the least, and in males are 168% higher in the most deprived quintile compared with the least*".[2] This reflects higher rates of smoking – the biggest risk factor for developing lung cancer (72% of lung cancer in the UK is caused by smoking) – and greater occupational exposure to carcinogens (13% of lung cancer is caused by workplace exposures).[3] We also know that patients with lower socio-economic status receive less treatment and have worse short-term and long-term outcomes compared with more affluent patients.[4]

We also continue to see a rise in case numbers of people with lung cancer who have never smoked (9.5% in 2022[5] to 9.6% in 2023[6]). There is much research and interest in this group of patients who sometimes have different support needs. As an organisation, LCNUK is supporting current research being undertaken in this area to improve our knowledge.

Of the 18,653 patients included in the 2025 National Lung Cancer Audit report (1 January – 31 December 2023), 50% were alive at 1 year.[6] According to Cancer Research UK, one in 10 (9.5%) people diagnosed with lung cancer in England survive their disease for 10 years or more, it is predicted.[7]

Huge efforts are being made to encourage people to be aware of changes and come forward with possible symptoms so that cancers can be detected earlier. However, most lung cancer patients present when their cancer is at stages 3 or 4, harder to treat and outcomes are poorer.[8] This means that most people diagnosed with lung cancer may have shorter prognoses and need more intensive support from nurse specialists

with the support of Lung Cancer Navigators/Coordinators and multidisciplinary teams (MDTs) over a rapid timeframe than those with other common cancers.

While later-stage lung cancers are usually incurable, advances in treatment have given us more therapeutic options to slow progression or manage symptoms, meaning many people can still live well and for longer after diagnosis. These changes to treatments – coupled with our increasing understanding of lung cancer biomarkers and their implications for treatment efficacy – are also changing the support that LCNSs and Lung Cancer Navigators/Coordinators are providing to patients.

Treatment to prevention

The new NHS 10-year health plan: Fit for the Future has committed to rolling out lung cancer screening for those with a history of smoking. It is estimated that this will detect an additional 9,000 cancers earlier each year. This in combination with the awareness raising and advances in treatment mentioned above, sets to tackle the challenges faced by lung cancer patients but increasing the number of early-stage diagnoses and provide them with all possible opportunities for a better outcome.

Anyone living with lung cancer is a unique person with individual needs, hopes and fears. Each one deserves to be listened to and heard, and to have high quality information, treatment, support and advocacy. Each one deserves to have the best possible support, whether that be from a LCNS, Lung Cancer Navigator/Coordinator or member of the MDT, and someone there to ensure they have effective, coordinated care every step of the way.

THE FOUR PILLARS OF THE ROLE

Coordination
Coordination is an integral part of a Lung Cancer Navigator/Coordinator's role, ensuring patients on the cancer pathway have a seamless transition of care from the initial suspicion of cancer through investigations, diagnosis, treatment and follow-up care. The key aspects of coordinating is organising and collaborating with various healthcare services, departments and professionals to ensure patients receive timely and effective care; working with a multidisciplinary team including doctors, nurses, radiologists and other healthcare professionals to create a treatment plan for patients; and coordinating care with other Trusts to ensure that patients receive the right care at the right time, minimising delays to ensure a smoother pathway and a better experience for patients.

Advocate
A Lung Cancer Navigator/Coordinator is a healthcare worker who advocates and helps guide patients through the complex process of investigations, diagnosis and treatment. They act as a liaison between the patient and the healthcare teams, ensuring that the patients understand the many different diagnostics they will be referred to and make sure they have all the information they need to support them on their journey. Navigators/Coordinators offer emotional support to patients and their families, helping them feel more empowered and less overwhelmed, playing a vital role in reducing barriers to care and ensuring that patients receive timely, efficient and personalised care. They help simplify the healthcare journey for patients, especially at such a challenging and emotionally taxing time. They offer guidance and reassurance, ensuring patients don't feel lost or unsupported during their journey. They are also able to escalate patients' needs to LCNSs for further assessment of concerns and needs.

Information
Lung Cancer Navigators/Coordinators play a crucial role in informing both patients and their families about the lung cancer pathway and ensuring patients and their families are well informed throughout the investigation, diagnosis, treatment process and further follow-up post treatment. Navigators/Coordinators help patients and families connect with cancer support groups where they can share experiences and find emotional support from others going through similar experiences and ensuring they have access to the resources and services they require.

Facilitator
The Navigator/Coordinator role requires a combination of clinical knowledge, organisational skills and emotional intelligence. The facilitator aspect of the role not only involves guiding patients through the lung cancer pathway but also improving care processes, advocating for patients' needs and being a source of support for both healthcare teams and patients. This requires a facilitator style that emphasises clarity, patience and empathy, actively engaging with patients, listening to their concerns and making sure their voices are heard within the healthcare team. Navigators/Coordinators often work within large healthcare systems which can be difficult to navigate. A strong facilitator in this role will possess the skills to identify and overcome barriers to care, whether they are logistical, financial or systemic. Facilitators in this position are skilled problem-solvers who think creatively to help patients overcome barriers to treatments and care.

A summary of the key components of these four pillars can be found in Figure 1.

Figure 1: Components of the Lung Cancer Navigator/Coordinator role

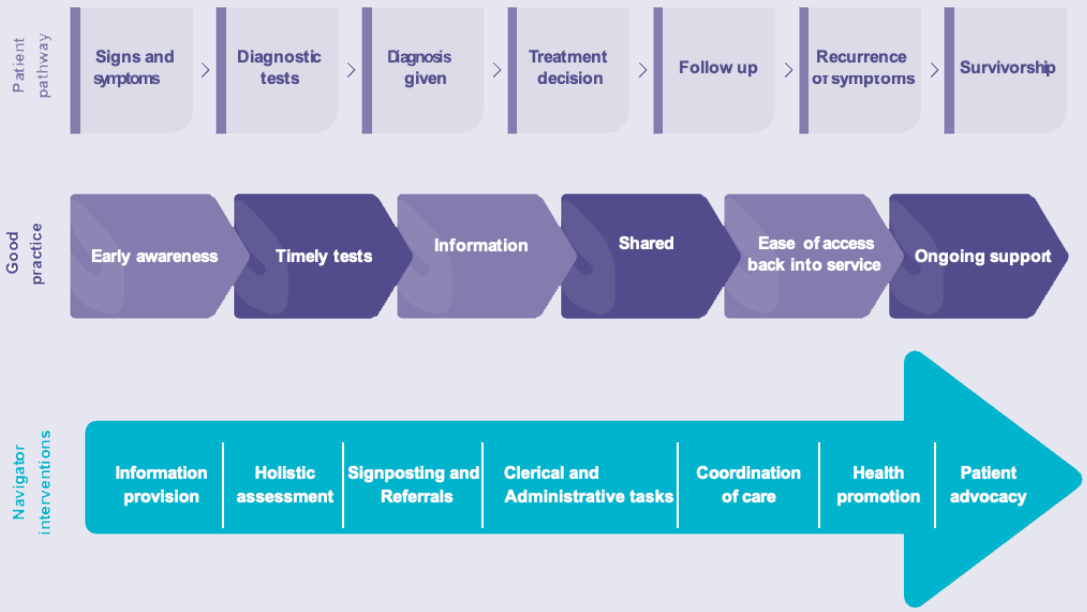
MANAGING THE PATIENT PATHWAY

The role of a Lung Cancer Navigator/Coordinator is still relatively new. There is no unified job description of the role, and it can vary depending on individual hospital Trust needs. The role of a Navigator/Coordinator is to facilitate patients' investigations including collaborating with other areas/Trusts to ensure movement through the pathway in a timely manner and beyond, depending on Trust policy, and improving the lung cancer diagnostic pathway in terms of tracking every stage of the pathway, patient outcomes and experience, service delivery and system efficiency.

The Lung Cancer Navigator/Coordinator role constantly evolves. They are continuing to learn, develop and adapt their skills and communicate effectively with others – both patients and colleagues.

The critical role of a Lung Cancer Navigator/Coordinator at the different points of the pathway is set out in Figure 2.

Figure 2: Lung Cancer Navigator/Coordinator role at different points of the pathway



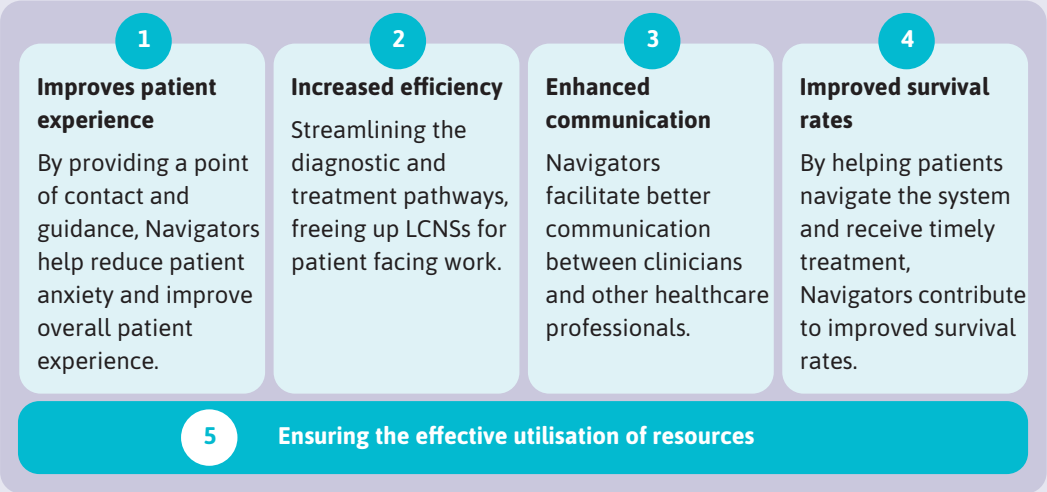
ACCESS TO A LUNG CANCER NAVIGATOR/COORDINATOR IS CRITICAL TO PATIENT SAFETY, OUTCOMES AND EXPERIENCE

The importance of patients having access to Lung Cancer Navigator/Coordinator support from the earliest possible stage is very beneficial to both patients and their families. The pathway Navigator/Coordinator will support the patient once they have been referred for investigations and stay with them up to the point of diagnosis. Each pathway Navigator/Coordinator will work in a slightly different way in different Trusts.

Why does access to a Lung Cancer Navigator/Coordinator matter?
Put simply, LCNUK feels that *"patients with a Lung Cancer Navigator/Coordinator working alongside a LCNS are more likely to get access to treatment with clear consequences for their chances of survival as well as a more positive experience of care if they are supported by a Lung Cancer Navigator/Coordinator"*.

The benefits of the Lung Cancer Navigator/Coordinator role are outlined in Figure 3.

Figure 3: Benefits of the Lung Cancer Navigator/Coordinator Role:



LUNG CANCER NAVIGATOR/COORDINATOR INTERVENTION ACROSS THE PATIENT PATHWAY

For Lung Cancer Navigators/Coordinators, their involvement starts even before patients are referred. Many Lung Cancer Navigators/Coordinators are informed of a patient when the radiologist reports an abnormal result and go on to organise blood tests, CT scans, MDT discussions and Fast Track (FT) appointments. Lung Cancer Navigators/Coordinators are constantly monitoring FT (also known as urgent suspected cancer appointment (USCO)) referrals from GPs and, when a suspected cancer diagnosis is discussed with the patient at FT appointment, a LCNS should be there to guide them through the investigation process, explain what tests they need and support/advise them along the way. The Lung Cancer Navigator/Coordinator registers these patients in a database and sets about coordinating this complex combination of diagnostic tests under the guidance of the LCNS and respiratory physicians, recording activity and tracking the patients, identifying barriers to care and blocks in the pathway and working with the patient and wider healthcare teams to overcome these. The cancer pathway can be complex, lengthy and disjointed, involving a wide variety of healthcare professionals in a range of care settings/Trusts, so it is important that the Lung Cancer Navigator/Coordinator develops and maintains good communication across sites and with a variety of clinical and non-clinical colleagues.

Collaborating with the wider MDT team, the Lung Cancer Navigator/Coordinator works closely with the Respiratory Administrators, Consultant Secretaries and MDT coordinators (also known in some areas as cancer trackers). It is important that these roles compliment each other, but with clearly defined boundaries to avoid confusion and duplication of work. A clearer definition of the cancer tracker's role is very different in that they:

- sit within the cancer information teams;
- have no patient contact; and
- concentrate on tracking the pathway in line with the cancer waiting time standards, data collecting and uploading to the appropriate national database*.

*England = NHS England COSD, Northern Ireland = Cancer Register (through Queens University), Scotland = Scottish Cancer Registry and Intelligent Service (SCRIS), Wales = National Cancer Data Standards (Lung).

The Lung Cancer Navigator/Coordinator will organise calls/appointments for patients to complete Electronic Holistic Needs Assessments and develop a personalised care plan. This helps build a good relationship with the patient whilst actively participating to explore the management of their health and well-being within the context of their whole life and family situation, in turn overcoming barriers to care. Personalised Care and Support Planning (PCSP) helps people living with cancer to take an active and empowered role in the way their care is planned and delivered, with interventions and care tailored around the things that matter most to them (Macmillan Cancer Support).

Care coordination is crucial to patients' outcomes and experience of care. Many patients will have complex needs and other conditions to manage alongside their lung cancer treatment. Lung Cancer Navigators/Coordinators are involved in supporting patients with fitness for and living well on treatment, for example signposting pre-habilitation, smoking cessation and giving low level dietary support. They are also responsible for:

- facilitating referrals to external services such as Benefits Advisors, Council Blue Badges, Wheelchairs and Complementary Therapies; and
- keeping on top of the day-to-day office administration tasks such as stock/supply of patient information leaflets.

LCNSs and Lung Cancer Navigators/Coordinators actively participate in the MDT meetings where patients' pathways and treatment options are discussed. The Navigator/Coordinator proactively identifies information about the patient, results and appointments to prepare the LCNSs in acting as an advocate for the patient when treatment option decisions are made.

After completion of active cancer treatments, patients continue to be monitored in ongoing surveillance scanning to ensure they remain cancer-free and to ensure signs of recurrence are identified early. The Lung Cancer Navigator/Coordinator may be additionally responsible for tracking and ensuring that the ongoing surveillance scans are arranged in a timely manner within their agreed surveillance regime set out by the treating consultant and protocols.

Away from the coordination of the pathway, other responsibilities may include organising public awareness campaigns to raise awareness of signs and symptoms of lung cancer and working with the LCNSs to promote early diagnosis. They might also contribute to the development and analysis of results from the patient surveys, so we are proactively utilising the feedback from patients' experience to develop and change the way they do things.

LCNSs take leadership roles in service delivery, redesign and improvement. The Lung Cancer Navigator/Coordinator supports the LCNS in this, as together we are well placed to identify where services can be adapted or introduced to better meet patients' needs and make efficiencies. We contribute to audit and reporting of patient outcomes and experiences of care. Examples of the ways in which LCNSs innovate to change practice for the better can be found in LCNUK's Good Practice Guide.[9]

QUALIFICATIONS, SKILLS AND COMPETENCIES NEEDED BY A LUNG CANCER NAVIGATOR/COORDINATOR

At LCNUK we believe that the Lung Cancer Navigator/Coordinator has a pivotal role in the Lung Cancer nursing team and wider MDT.

The role should also support the Lung Cancer Specialist team in the delivery of nursing care in line with national standards[10] and NICE guidance for lung cancer.[11]

Page 15 is a description of qualifications, skills and competencies that we would expect a Band 4 Lung Cancer Navigator/Coordinator to possess or be working towards.

The role is patient focused; therefore the Lung Cancer Navigator/Coordinator should have excellent people skills and be able to communicate appropriately with both patients and healthcare professionals, be organised, proactive and be passionate about improving outcomes for lung cancer patients.

In the diagram presented on page 15, the skills and competencies are aligned with the Agenda for Change job matching profile.[12] These skills and competencies are expected of a Band 4 Lung Cancer Navigator/Coordinator to possess or be working towards under the four pillars of practice.

Whilst acknowledging the importance of the Lung Cancer Navigator/Coordinator role, LCNUK also acknowledges the limitations for progression once all Band 4 competencies have been achieved. As Lung Cancer Navigators/Coordinators become more experienced in the role, a framework for Band 5 competencies, focusing on the academic achievements of the individual and the underpinning of skills, has also been provided.

SKILLS AND QUALIFICATIONS – BAND 4: LUNG CANCER NAVIGATOR/COORDINATOR

SKILLS

Clinical Knowledge
- Understanding of lung cancer diagnostics staging and treatment modalities
- Understanding of lung cancer pathway and importance of timely diagnosis and treatment
- Familiar with lung cancer pathways, standards and targets (e.g. 2-week with 62-day pathway)

Communication
- Ability to communicate clearly and compassionately with patients and families
- Effective communication with MDT teams to ensure integrated care
- Willingness to undertake further study e.g., Sage and Thyme
- Confidence liaising with clinical and non-clinical teams

Patient Care
- Championing patients' needs to support informed decision making for patients and families
- Awareness of impact of a lung cancer diagnosis on patients and families
- Demonstrate empathetic support to patients and families

Organisational
- Ability to work in a highly developed environment independently and as part of a team
- Flexibility in adapting to changes in workplace dynamics
- Working closely with and supporting the LCNS team
- Identifying and escalating patient concerns when required
- Ability to recognise when clinical psychosocial concerns need escalating
- Proficiency in organising appointments for diagnostics and referrals to support a positive patient experience

Education
- Knowledge of resources and support materials suitable for different patient groups and ethnicities
- Competent in clinical documentation across multi systems written and electronic
- Consider additional develop opportunities to enhance role

QUALIFICATIONS

- Good general education (GCSE in Maths Grades A*-C (9-4) (or National 5 (N5) in Scotland Grades A-C))
- NVQ Level 2/3 or equivalent in a relevant health or social care
- Evidence of ongoing professional development

SKILLS AND QUALIFICATIONS – BAND 5: LUNG CANCER NAVIGATOR/COORDINATOR

This Professional Development Framework will standardise the role of the Lung Cancer Navigator/Coordinator, explaining the complexities and diversity of the role. Within the Framework and it's supporting documents, there are tools to help with recruiting Navigators/Coordinators. These include a job description, person specification and a business case template if you are trying to begin the recruitment process.

As the role is becoming more progressive, we felt it was important to recognise career progression for the more experienced Lung Cancer Navigators/Coordinators and provide future direction which will allow them to develop new skills and higher knowledge levels with more accountability and autonomy.

Banding of Lung Cancer Navigator/Coordinator posts is subject to variation and is determined in accordance with local and national NHS policies. The primary purpose of this Framework is to support professional development. Any references to banding are illustrative and not a formal determination of pay.

SKILLS AND QUALIFICATIONS – BAND 5: LUNG CANCER NAVIGATOR/COORDINATOR

SKILLS

Clinical Knowledge
- Awareness of quality issues and optimal lung cancer pathway
- Understanding of person-centred care
- Knowledge of relevant cancer diagnostics/treatments and interventions
- Working knowledge of health and social care environment
- Ability to risk assess using recognised tools

Communication
- Multi-disciplinary working and liaison with MDT members
- Sensitive nature and pleasant manner

Patient Care
- Promote effective service delivery and future changes in a positive way
- Evidence of working with cancer patients and their families

Organisational
- Willingness to accept additional responsibilities as delegated by senior staff
- Ability to assess situations, make decisions, coordinate and organise responses
- Ability to work flexibly
- Ability to seek assistance in difficult situations
- Proactive, solution focused
- Ability to organise and prioritise for self and others
- Ability to balance work, study and personal life
- Work on their own initiative
- Adaptable to change
- Recognise own limitations
- Work as an effective role model

Education
- Experience of developing services to provide compassionate evidence care
- Ability to demonstrate motivation and self-directed learning
- Excellent IT skills

QUALIFICATIONS

- Level 4 NVQ or 4 GCSEs (A*-C (9-4) grades) (or National 5 (N5) in Grades A-C in Scotland)
- Evidence of study at level 5 pre-degree or diploma or willingness to undertake further degree level study in health-related or relevant subject
- Evidence of continued role development
- Advanced communication skills or equivalent recognised communications course
- Coaching or teaching qualifications

Also see ACCEND Framework:
https://www.hee.nhs.uk/our-work/cancer-diagnostics/aspirant-cancer-career-education-development-programme

A CAREER AS A LUNG CANCER NAVIGATOR/COORDINATOR: CASE STUDIES

A career as a Lung Cancer Navigator/Coordinator can be hugely rewarding, professionally and personally. Some of our members have shared their stories, setting out why they chose to become a Lung Cancer Navigator/Coordinator and how they have developed their skills to progress in their role.

Case study 1

Alisha Gray, LUNG CANCER CARE COORDINATOR AND NAVIGATOR Band 4 at Harrogate and District NHS Foundation Trust

Prior to accepting a post as the Lung Cancer Care Coordinator, I spent 10 years working as the Lung MDT coordinator and cancer tracker. During this role I developed a specialist interest in lung cancer and was increasingly missing the patient contact. I was therefore delighted when the Macmillan Lung Cancer Coordinator role was advertised and I was appointed.

As one of the first Cancer Care Coordinators at the Trust, I was able to make the job my own and the role has certainly evolved into something quite different from when I started 7 years ago.

Some of my roles now include:

- Acting as a single point of contact for patients and carers: triaging enquiries, dealing with the ones that I know I can resolve within my capabilities and escalating to my CNS colleagues or to the consultants as required.
- Referring on to specialist services – for example, complementary therapy, dieticians, exercise programmes, welfare and benefits, clinical psychology, and also signposting to other resources and groups which could be of benefit.
- Chasing investigation reports in time for planned clinic appointments and requesting bloods prior to CTs.
- Maintaining a comprehensive spreadsheet, summarising where patients are on any given pathway. This helps with data collection for audits, which I have also been involved in.
- Running my own holistic needs assessment clinic.

However, my main role – and the one from which I get the most job satisfaction – is offering support and spending time with lung cancer patients and their families, providing support calls, ward visits and going to see patients whilst they have their chemotherapy treatments. I also support some patients in respiratory and oncology clinic appointments and have a weekly holistic needs assessment clinic. Over the coming year I will be the main point of contact for a defined cohort of patients as they undergo the investigative part of their lung cancer journey. This is something I've been working towards and am grateful to the nursing team for recognising my capabilities and helping me to continue to develop.

A unique part of my role over the last few years has been taking on some extra hours as lung cancer pathway navigator. This role has ensured earlier support for patients and faster cancer diagnosis by ensuring 2-week wait referrals are triaged promptly, relevant investigations are arranged, and patients informed efficiently.

I think anyone who works in this field does the job because they want to make a difference. People are going through probably the most difficult times of their lives, and anything I can do to make it more bearable, or that little bit easier for them and their families – whether that's practically or emotionally – makes it all worthwhile.

At times it can be really difficult. But I feel so lucky to work in such an incredible supportive team who value the role of the Coordinator and Navigator and can see the difference it makes, not only to the pathway but, most importantly, to the patient experience. I feel very passionate about advocating and supporting the development of this dynamic role nationally.

Case study 2

Alison Spray, LUNG CANCER CARE COORDINATOR Band 4 at York and Scarborough Teaching Hospitals NHS Foundation Trust

I finished a degree in Sports Studies in 2009 and started my NHS career in the patient access department processing cancer Fast Track referrals. From there my interest in the cancer pathway grew. I enjoyed being involved with the patients as they entered the unfamiliar world of tests and diagnostics, and I knew if I could help them navigate this difficult journey I would be making a real difference to their experience. I set my sights on the Lung Cancer Care Coordinator role and was appointed in 2012, and I've loved this job ever since (13 years and still going strong).

In 2013 I channeled my passion for the role into writing a poster on "The Role of the Lung Cancer Coordinator" which won first prize at the Lung Cancer Nurses Conference. With the incredible response and support from colleagues and peers, I then set about rewriting the job description to reflect the evolving role and complexities of supporting cancer patients in a difficult diagnostic pathway and this was successfully recognised as a Band 4 post.

Playing an important part in the LCNS team, the Coordinator is the "pivotal cog in the wheel", coordinating the pathway and appointments, triaging telephone calls, streamlining the pathway across all care settings, minimising patients' frustrations and barriers to care whilst overall reducing the admin for the CNS. This allows for effective utilisation of the nurses to work at their specialist level.

In more recent years the use of holistic needs assessments and personalised care planning have enabled us to put the patient at the forefront of everything we do as a LCNS team and ultimately improve patient experience.

I continue to champion the role of the Coordinator and hope in the future we will be able to work towards further career development for individuals, like myself, who have a real passion for cancer care and want to support the patients in the best way possible during the hardest times of their lives.

Case study 3

Amanda Abbott, LUNG CANCER PATIENT COORDINATOR Band 4 at Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

I started my healthcare journey in 1986 working in a care home, moving to the NHS in December 1997 where I completed my NVQs and Care Certificate.

I worked mainly on the respiratory ward before moving into main medical outpatients working in lots of different specialities (respiratory, gastro, rheumatology to name a few). This is where I developed my interest in lung cancer and did all the learning I could to enable me to progress in this field.

An opportunity arose to work on secondment with the LCNSs where I completed cancer packages on Advanced Communication, Chemotherapy & Radiotherapy and Patient care, e-learning from the Macmillan website.

I have now worked alongside the LCNSs since 2011 and have completed the Principles of Cancer Care and the ACCEND programme. During my time in this department my job role has continued to expand and develop along with my clinical skills, and this has enabled me to be an autonomous practitioner and take a lead in coordination of the patient pathway including arranging scans, appointments, biopsies, MDT, N/L appointments, triage patient phone calls and meet patients in target clinics.

I feel the role of the Lung Cancer Navigator/Coordinator is an integral part of the team and the smooth running of the pathway for all our patients.

Case study 4

Louise Blow, LUNG CANCER NAVIGATOR
Band 4 at Cwm Taf Morgannwg University Health Board

I began my role as a Lung Cancer Navigator in October 2021 after many years working in musculoskeletal physiotherapy, and although daunting to make such a change in employment, it has been a very rewarding experience.

I work closely with the LCNSs in a small team in one of our District General Hospitals and help support the respiratory consultants, LCNSs and our patients. A big part of my role includes completing the patients' holistic needs assessments, which provides an opportunity to discuss any queries or concerns they may have and working together to determine possible solutions and options of support. This may be through providing information leaflets, signposting or referral to NHS and external services such as benefit advisors, clinical psychologists, district nurses, social services and various charities to help with practical, physical and emotional issues. The holistic needs assessment tends to be done over the telephone due to capacity issues; however, we strive to accommodate face to face appointments as best able if a patient prefers this.

I support the LCNSs by dealing with telephone queries to the department, chasing investigation results, arranging appointments, attendances at the emergency department and day unit, and hospital transport as needed and assist with any requests within my scope of practice which allows the LCNSs to continue with their clinical duties and other calls that I may not have the qualifications or knowledge to resolve.

The majority of our patients are introduced to the LCNSs and myself through our Rapid Access Clinic at the point of suspicion and we help support throughout the pathway – through investigations, diagnosis, pre- and post-treatment and best supportive care. Some patients are diagnosed incidentally through an inpatient admittance, and we will keep in regular contact on the wards during this time which many patients have described finding beneficial.

Although a fairly new role, I believe the Lung Cancer Navigator/Coordinator post has proved to be an effective addition to the Lung Cancer Nursing Team for both staff and patients. I can be a point of contact for patients and family members, to offer a listening ear and support and to take on board some of the more time-consuming tasks the LCNSs would need to complete alongside their busy caseload and clinic commitments. The LCNSs are very supportive of my role, available for advice and direction, and fully encouraging of my role and any opportunities to develop my skills and understanding.

I am excited to be involved in the LCNUK Navigator framework programme and appreciate the opportunity to meet and work with such a team.

Case study 5

Karen Whiteside, MACMILLAN LUNG ASSISTANT PRACTITIONER Band 4 at Manchester University NHS Foundation Trust

I completed my Health and Social Care Foundation Degree Apprenticeship in 2019, which prepared me for a career as a qualified Assistant Practitioner. This apprenticeship built on my existing knowledge and skills within my role, combining work-based learning modules with specialist education. Upon completion, graduates are equipped to work autonomously and develop expertise specific to their clinical area.

Currently, I work as an Assistant Practitioner within the Lung Cancer Nursing team. In this role I provide timely assessments for patients prior to a lung cancer diagnosis, deliver appropriate interventions and collaboratively plan care using the lung cancer pathway effectively. I am passionate about progressing my career within this specialty and strive to build strong rapport with patients, their families, visitors and MDT members.

I chose the apprenticeship route because it suited my family commitments, allowing me to continue working while completing my training. The course also gave me valuable exposure to various specialties related to lung cancer services, broadening my clinical understanding.

Looking ahead, I aim to complete a top-up degree which will enhance my skills and knowledge, enabling me to advocate effectively for patients and promote patient-centred care, especially the significance of living with cancer.

As an Assistant Practitioner I have a crucial role in educating patients about their conditions, empowering them to manage their health effectively both before and after a cancer diagnosis and treatment. I collaborate closely with district nurses, palliative care teams, physiotherapists and occupational therapists to ensure seamless coordinated care. By providing consistent timely support, I help patients regain independence, improve quality of life and reduce hospital admissions.

Clinical Supervision in Cancer Care

Clinical supervision is a vital process in cancer care, providing professional support, reflection and learning opportunities that enhance individual development and improve patient outcomes. It allows healthcare professionals to discuss challenging cases, address emotional stresses and integrate new skills from formal training into practice. Supervision also supports referral pathways to more specialised practitioners, fostering a collaborative team approach to cancer care.

Cancer care is emotionally demanding, and supervision offers a safe space for healthcare professionals to process feelings of burnout, stress and vicarious trauma. This support is essential to building resilience and promoting self-care among those working in this field.

Case study 6

Larissa Griffiths, LUNG CANCER NAVIGATOR Band 4 at East Cheshire NHS Trust

My journey began within the NHS in 2008 as a healthcare assistant on a respiratory ward. After 8 years I was then appointed as the ward clerk on the same ward and was in this role for 2 years. Then in 2018 an opportunity arose for a secondment for a Lung Cancer Navigator role, working alongside the LCNS team. I was delighted to accept the role, being the first Navigator in the Trust. During my time as a Lung Cancer Navigator I have developed and expanded the role to make it as effective and efficient as possible whilst working alongside the LCNSs and other healthcare professionals.

A Lung Cancer Navigator is an integral part of the lung cancer nursing team. I am a point of contact to help support and navigate patients throughout their lung cancer pathway journey in doing this, also supporting the LCNSs by triaging calls, dealing and resolving calls that I know are within my remit but also able to recognise when to escalate more urgent calls to my LCNS colleagues or the respiratory consultants.

Part of my role is to chase investigation dates, reports and histology, preparing all of these results for our local and sector MDT each week, ensuring we have all the information required for the patients to be presented, then ensuring all the patients have the clinic appointments needed to receive their results and diagnosis. I support the nurses and doctors in the Rapid Access Lung Clinic, seeing both new and follow-up patients. Alongside that, I manage our post-radiation/surgical pathways, which are managed with spreadsheets to ensure that patients are not lost to follow-up and are on target on whichever pathway they are following. We have a nodule follow-up pathway for patients who have nodules that require further follow-up which I also manage with a spreadsheet to ensure they are not lost to follow-up.

Each month we invite patients to our lung cancer café, which has a different speaker each time. This is well attended and is an enjoyable time for both patients and the lung cancer team. It has been a great way to get to know patients and for them to get to know the team. I have found this especially beneficial to my role as patients have got to know me better, have put a face to the voice at the end of the phone, as I would not have met a lot of these patients face-to-face if not for the lung café. I help organise the speakers and manage the invitation list and the invitations to patients for the café.

Clinical supervision

As a team we are also given clinical supervision every 6 weeks. This is an essential support mechanism to maintain high standards of care and ensure emotional resilience and professional development. Supervision has been beneficial in helping me strategise for self-care and emotional boundaries, dealing with compassion fatigue and processing difficult outcomes. It is a great place to reflect on personal growth and well-being.

I am very passionate about my role as a Lung Cancer Navigator and feel extremely well supported by my lung cancer colleagues. I feel my role is beneficial to the lung cancer nurses as they are often juggling multiple tasks and patient concerns. By helping coordinate diagnostic tests, referrals and appointments, I reduce some of their logistical burden. This gives them more time to focus on delivering hands-on patient-centred care.

Case study 7: Navigator/Coordinator role progression case study (NMC registration)

Holly Marie Leech, MACMILLAN REGISTERED NURSE ASSOCIATE THORACIC ONCOLOLGY
Band 4 at Guy's and St Thomas' NHS Foundation Trust

I began my healthcare career as a Healthcare Assistant (HCA) in Oncology at Mount Vernon Hospital, where I spent five years supporting and caring for patients undergoing chemotherapy. This role required empathy, emotional resilience, and close attention to detail, as I worked with patients experiencing both the physical and emotional challenges of cancer treatment.

Seeking to expand my knowledge and clinical skills, I moved to Harefield Hospital to work as an HCA on a cardiothoracic ward. This opportunity allowed me to gain valuable experience in caring for post-operative patients following cardiac and thoracic surgeries. My background in oncology proved particularly useful, as I was able to provide both clinical and emotional support to our lung cancer patients, drawing on my previous experience.

Recognising my enthusiasm for learning and professional development, my manager encouraged me to apply for the Trainee Nursing Associate (TNA) programme. I was accepted into this NMC-approved two-year foundation degree, which combined academic study with practical, work-based experience. Through this programme, I gained exposure not only to adult nursing but also to paediatric and mental health care, which broadened my understanding of holistic patient care.

During my time as a TNA, a Senior Macmillan Nurse observed the compassionate way I supported our lung cancer patients and encouraged me to apply for the newly established Macmillan Cancer Support Worker role. I was successful in the interview and transitioned into this position, with full support from my manager to continue and complete my Nurse Associate training.

As this role was new to the Trust, I had the opportunity to help shape and develop it into something that truly benefited patients. With the backing of my manager, I led and contributed to several initiatives, including post-operative follow-ups, Enhanced Holistic Needs Assessments (eHNAs), support groups, bake sales, and audits. I also worked closely with inpatients and outpatients, created a contact list for patient signposting, and collaborated with other support workers and Clinical Nurse Specialists (CNS). In addition, I completed numerous training courses to enhance my skills and understanding, all of which have contributed to my personal and professional development.

After successfully completing my training and receiving my NMC PIN, my role transitioned to Macmillan Registered Nurse Associate. This qualification has enabled me to practise fully within my scope, take on greater responsibilities, and deliver a higher standard of care. It has also given me the confidence to offer meaningful emotional support to patients and their families during some of the most difficult moments of their lives.

Looking ahead, my long-term goal is to become a Registered Nurse. Once funding is available, I intend to undertake the 18-month top-up programme to achieve this. I am deeply committed to continuing my development and providing the best possible care to patients, and I look forward to the opportunities and challenges that lie ahead.

Case study 8: Navigator/Coordinator role progression case study (Band 5)

Katie Fryett, LUNG CANCER NAVIGATOR
Band 5 at South Tees NHS Foundation Trust

I was a Lung Cancer Care Co-ordinator for 4 years. A secondment opportunity arose for a Lung Cancer Navigator (at a Band 5 level), and I was successful at securing the role.

The role initially started under the performance Business Intelligence Unit (BIU) team. This has recently changed, and I am now managed in respiratory.

I initially meet the patient at the first faster diagnosis standard (FDS) appointment where the patient is made aware of a suspicious finding. From here, further investigations are booked and requested. A LCNS and I, support the patient through the diagnostics. I navigate the appointments with an aim to streamline this process, navigating barriers that would delay reaching a diagnosis.

I also oversee and provide guidance to a Cancer Care Co-ordinator, which is one of the reasons this role is graded to a band 5 level.

Another aspect of my role is I extract and analyse data on the performance of the pathway. From this, I identify delays and bottle necks, and I work with a wider team to implement new structure and changes to help support and improve targets in the pathway.

I am currently working on a standard operating procedure (SOP) to implement myself giving benign results to patients at the point of a non-suspicious CT, supporting the faster diagnosis targets.

I have supported the implementation of daily FDS clinics, shortening wait times and utilising clinic slots.

I triage and vet referrals for MDT submissions to ensure appropriate discussions. This helps to aid utilisation of slots and minimise delays for patient discussions. Streamlining the patient journey to improve outcomes and patient experience throughout.

"A comprehensive framework for lung cancer navigators must be rooted in timely diagnosis, individualised patient support, multidisciplinary co-ordination and equitable access to care – ensuring no patient is lost in the complexity of their cancer journey. Navigators compliment Lung Cancer Clinical nurse specialists in supporting lung cancer patients and their families. This framework is an excellent document for those working as navigators and those wanting to implement this role into their service.

The Navigator subgroup from LCNUK are to be applauded and thanked for all their hard work on a comprehensive and excellent document."

Karen Clayton
CHAIR, LUNG CANCER NURSING UK (2022 – 2025)

EVIDENCING CAPABILITIES AND PROFESSIONAL DEVELOPMENT

There are different ways that a Lung Cancer Navigator/Coordinator can evidence that they have the skills under each domain of the Framework. These include (but are not limited to):

- Constructive feedback from supervision or directly observed practice by line managers or colleagues
- Feedback from patients, carers and their families

- Records of accredited courses/work-based learning options attended and completed
- Certificates of academic achievements
- Certificates from study days/conferences attended

- Audits, quality improvement or research completed, submitted and published
- Examples of service development initiatives or innovation

- Performance reviews and appraisals
- Reflective accounts or diaries

- Requests for presentations – internal or external

- Participation in local, regional or national committees and steering groups

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