**Peninsula Cancer Alliance Site Specific Patient/**

**User Representative**

**Expression of Interest Form**

Thank you for your interest in one of the patient/carer representative roles we have told you about.

The Peninsula Cancer Alliance (PCA) is committed to ensuring that the patient and public voice is at the heart of all its cancer improvement work.

If you express an interest in a representative role and, after speaking to us, this interest continues and you are due to commence a role with us, we will need to collect and hold some basic data about you, which will help us find the best ways to work with you.

We will hold this data which may also later include financial data, if we need to pay you expenses securely. We will not disclose it to anyone outside of a small number of people in our Alliance team and Finance team nor use it in any other way apart from the sole purpose of engagement activities with the PCA.

Please complete the form below and indicate that you agree for us hold this information by ticking the square box at the end of the form.

If you have any queries, need a help completing the form and/or would like to find out more about an opportunity, please contact Beth Kingshott, PCA Support Manager, Peninsula Cancer Alliance by e-mail [rde-tr.peninsulacanceralliancessgs@nhs.net](mailto:rde-tr.peninsulacanceralliancessgs@nhs.net)

**This form can be completed and submitted electronically via e-mail or printed and completed with a black pen and then submitted by post to:**

FAO Beth Kingshott

Room: A214

RDE

Barrack Road, Exeter, Devon, EX2 5DW

1. **Personal details**

Title (e.g. Mrs):

Full name

Preferred name

Date of birth

1. **Contact details**

Email address

Address

Postcode:

Telephone number

1. **Experience of cancer**

**How have you been affected by cancer?** *(please tick)*

Patient Relative/Carer

1. **Which type of cancer and/or treatment do you have experience of or have an interest in?** *(please x one or more boxes that apply to you)*

|  |  |  |
| --- | --- | --- |
| **Tumour type** | **Experience** | **Interest** |
| Lung |  |  |
| Upper gastrointestinal |  |  |
| Lower gastrointestinal |  |  |
| Head and Neck |  |  |
| Gynaecological |  |  |
| Skin |  |  |
| Urological |  |  |
| Breast |  |  |
| Other (please specify) |  |  |

1. **How would you like to participate?** *(please x one or more boxes)*

|  |  |  |
| --- | --- | --- |
| **Engagement Activity** | **Yes** | **No** |
| To be invited to one off events relevant to my experience and interests on an adhoc basis |  |  |
| Participate in **specific project/group/forum** by attending relevant meeting/s |  |  |
| Review and feedback on written material, which could just be by providing e-mail feedback |  |  |
| Participate in surveys |  |  |
| Other (please explain in the box below) |  |  |
|  |  |  |

1. **Support needs**

**Please detail any support needs that you would like help with, to enable you to participate in these activities.**

This could be:

* Support with using online technology
* Provision of Easy Read information
* Provision of information in Large Print
* Interpreter/ translator needs
* Support worker presence
* Support with any transport costs (when/ if meetings take place face-to-face)

1. **Time commitment (if applicable to a specific role)**

The time commitment is outlined in the Brief/ Job Description. Can you commit this time?

Please tick  Yes  No  N/A

1. **Availability**

**When are you able to take part in meetings?**

1. During the day (usually this will be between 09:00 and 17:00)?

Please tick  Yes  No

If you are available in the day, which if any days are best for you? (please state)

1. In the evening (usually this will be between 17:00 and 19:00)?

Please tick  Yes  No

If you are available in the evening, which if any days are best for you?

(please state)

1. **Communications**

**Are you able to use phone, e-mail and MS Teams (like Zoom) to communicate with members of the team and take part in meetings?**

**Phone** (please tick)  Yes  No

**Email** (please tick)  Yes  No

**MS Teams (like Zoom)** (please tick)  Yes  No

If you have any training or support needs related to MS Teams (like Zoom) please

let us know below:

**How did you hear about the opportunity to be a patient/ carer representative with the Peninsula Cancer Alliance?**

1. **Your data**

The information about you that we will hold relates only to this role that you have registered for. It will allow us to contact you appropriately and will not be shared with any other party without your consent. **We can only hold this information with your consent.**

**Please tick x box to indicate that you agree to us holding your information** (You have the right to withdraw your consent for us to hold your information at any time. Should you wish to, please contact us by either email or phone using the contact details on this form).

The PCA may take photographs at events or use quotes and publish these on its website or social media channels to promote its activities.

**Please x this box if you consent to us using your image or quotes in this way:**

Signature: Date:

Your data will be held securely and in accordance with the Data Protection Act 2018. Please send your completed form to the address at the top of the form if by post or via e-mail to Beth Kingshott, PCA Support Manager to:

[rde-tr.peninsulacanceralliancessgs@nhs.net](mailto:rde-tr.peninsulacanceralliancessgs@nhs.net)

# **Equality Opportunity Monitoring Form**

## **Why we need this information and why we are asking for it**

The Peninsula Cancer Alliance is committed to promoting equality of opportunity, to ensure that everyone has the chance to participate fully in the activities and decisions of the organisation.

In completing this form, you will help us understand who we are reaching and how to better serve everyone in our community. The information will be used to provide an overall profile analysis of our patient and user representative member base, and to make sure that we are fulfilling our commitments. You do have a right not to disclose the information; however, by doing so you may impact our ability to ensure equality of opportunity.

## **Data protection**

The information you provide is anonymous and will not be stored with any identifying information about you. We may use anonymized statistics and data you have provided to have discussions about how to improve the diversity and spread of our membership, but no information will be published or used in any way which allows any individual to be identified. All details are held in accordance with the Data Protection Act 2018.

The information that we need, as outlined in the 2010 Equality Act, includes information about age, disability, gender reassignment, marital status, maternity, race, religious belief, sex, and sexual orientation.

## **Instructions**

## Please select the boxes below which are relevant to you.

**Ethnicity**

Please select what you consider your ethnic origin to be. Ethnicity is distinct from nationality.

|  |  |  |
| --- | --- | --- |
| **Asian/Asian British** | **Black/African/Caribbean/ Black British** | **Other ethnic group** |
| Indian  Pakistani  Bangladeshi  Chinese  Any other Asian background | Caribbean  African  Any other Black/African/Caribbean background | Arab  Any other ethnic group |

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Mixed/multiple ethnic groups** | | **White** | | | | **Rather not say** | | |
| White and Black Caribbean  White and Black African  White and Asian  Any other mixed/multiple ethnic background | | English  Northern Irish  Scottish  Welsh  British  Irish  Gypsy/Irish traveller  Any other White background | | | | Rather not say | | |
| **Age** | | |  |  | | |  |
| 10 - 14 | | |  |  | | |  |
| 15 - 19 | | |  |  | | |  |
| 20 - 24 | | |  |  | | |  |
| 25 - 34 | | |  |  | | |  |
| 35 - 44 | | |  |  | | |  |
| 45 - 54 | | |  |  | | |  |
| 55 - 64 | | |  |  | | |  |
| 65+ | | |  |  | | |  |
| Rather not say | | |  |  | | |  |
|  | | |  |  | | |  |
| **Sex** | **Sexual orientation** | | | |
| Male (M) | Heterosexual | | | |
| Female (F) | Gay man | | | |
|  | Lesbian | | | |
| Rather not say | Other | | | |
|  | Rather not say | | | |
|  |  | | | |
|  |  | | | |

**Gender reaffirmation**

Have you gone through any part of a process (including thoughts or actions) to change from the sex you were described as at birth to the gender you identify with, or do you intend to? (This could include changing your name, wearing different clothes taking hormones or having any gender reaffirmation surgery).

Yes No Rather not say

|  |
| --- |
| **Religion / belief** |
| No religion |
| Buddhist |
| Christian |
| Hindu |
| Jewish |
| Muslim |
| Sikh |
| Atheist |
| Any other religion |
| Rather not say |

|  |  |  |  |
| --- | --- | --- | --- |
| **Disability**  The Disability Discrimination Act 1995 (DDA) defines a person as disabled if they have a physical or mental impairment which has a substantial and long term (i.e. has lasted or is expected to last at least 12 months) adverse effect on one’s ability to carry out normal day-to-day activities. This definition includes conditions such as cancer, HIV, mental illness and learning disabilities.  Do you consider yourself to have a disability according to the above definition? | | | |
| Yes, limited a lot | Yes, limited a little | No | Rather not say |
| **If you selected yes**, please indicate your disability: | | | |
| Vision (e.g. blindness or partial sight) | | | |
| Hearing (e.g. deafness or partial hearing) | | | |
| Mobility (e.g. difficulty walking short distances, climbing stairs, lifting and carrying) | | | |
| Learning, concentrating or remembering | | | |
| Mental health | | | |
| Stamina or breathing difficulty | | | |
| Social or behavioural issues (e.g. neuro diverse conditions such as Autism, Attention Deficit Disorder or Asperger’s Syndrome) | | | |
| Other impairment | | | |
| Prefer not to say | | | |

|  |
| --- |
| **Carer responsibility**  Do you look after, or give any help or support to family members, friends, neighbours or others because of either:   * Long-term physical or mental ill-health/disability * Problems related to old age   Yes  No  Rather not say |
| **If you selected yes**, please indicate your caring responsibility (select all that apply): |
| Primary carer of a child/children (under 18) |
| Primary carer of disabled child/children |
| Primary carer of disabled adult (18 and over) |
| Primary carer of older person (65+) |
| Secondary carer |
| Rather not say |

**Please complete this form and the Expression of Interest Form and return both forms by email to:** [**rde-tr.peninsulacanceralliancessgs@nhs.net**](mailto:rde-tr.peninsulacanceralliancessgs@nhs.net)

**or by post to**:

FAO Beth Kingshott

Room: A214

RDE

Barrack Road

Exeter

Devon EX2 5DW

**Enquiries**

If you have any queries about the application process or would like an informal discussion about the opportunity, please contact Beth Kingshott, Peninsula Cancer Support Manager via [**rde-tr.peninsulacanceralliancessgs@nhs.net**](mailto:rde-tr.peninsulacanceralliancessgs@nhs.net)

Thank you.