National Cancer Action Team
Part of the National Cancer Programme

NHS

National Cancer Peer Review Programme
Manual for Cancer Services:
Psychological Support Measures
Version 1.0

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For Recipient's Use	

PSYCHOLOGICAL SUPPORT MEASURES

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Introduction

1.1 Aim of the Manual for Cancer Services

The Manual for Cancer Services is an integral part of Improving Outcomes: A Strategy for Cancer and aligns with the aims of the Coalition Government: to deliver health outcomes that are among the best in the world. The Manual will support the National Cancer Peer Review quality assurance programme for cancer services and enable quality improvement both in terms of clinical and patient outcomes.

The National Cancer Peer Review Programme, which is led by the National Cancer Action Team and includes expert clinical and patient/carer representation, provides important information about the quality of clinical teams and a national benchmark of cancer services across the country.

National quality standards/measures for cancer services were first published in 2001 and were updated in 2004 and 2008. The range of measures has subsequently been extended to cover virtually all cancer-sites and cross cutting cancer services (e.g. chemotherapy, radiotherapy). It is intended that the National Cancer Intelligence Network (NCIN) clinical reference groups will review the measures within the manual for cancer services annually to ensure they are clinically relevant and it is intended that the measures will underpin the NICE Quality Standards relating to cancer.

An independent evaluation of the National Cancer Peer Review Programme demonstrated strong support for the programme to continue, subject to reducing the burden of peer review and putting greater emphasis on outputs and outcomes as and when data becomes available.

In response to this the number of measures has been reduced by over one third in 2008 and more recently by a further 10%. In addition "Clinical Lines of Enquiry" (CLE) have been introduced, based on outputs/outcomes to support the Manual for Cancer Services. The revised process for peer review will be implemented in April 2011 but the measures contained within this manual will remain an integral part of the review process.

Compliance with the manual has not been centrally imposed. Although the NHS is not mandated to adhere to the measures in the Manual for Cancer Services, it is currently used by the National Cancer Peer Review Programme as part of their local assessment of cancer services and to provide a ready specification for commissioning of cancer services within a given locality.

1.2 Background and Context

Substantial progress has been made in cancer in the last decade, particularly since the publication of the NHS Cancer Plan in 2000. However, major challenges remain and in January 2011 Improving Outcomes: A Strategy for Cancer was published.

The strategy sets out how the future direction for cancer will be aligned with Equity and Excellence: Liberating the NHS in addition to meeting its stated aim to saving an additional 5,000 lives every year by 2014/15, aiming to narrow the inequalities gap at the same time.

The strategy acknowledges the importance of comprehensive information about cancer services for individual members of the public, cancer patients and their carers, healthcare professionals and commissioners.

1.3 Measures within the National Cancer Peer Review Manual

The peer review is changing its emphasis to focus on both clinical and patient outcomes. In order to achieve this, 'Clinical Lines of Enquiry' have been introduced and it is intended these outcome indicators will form part of the measures along with a reduced number of structure and process measures.

The development of cancer measures is an ongoing process in order to:

- reflect new NICE Quality Standards and clinical guidelines and revisions to existing NICE guidance;
- allow greater influence by users of cancer services and their carers;
- allow greater influence by clinicians;
- take account of possible modifications to measures following peer review visits;
- ensure the scope of measures encompasses the broader implementation of the Improving Outcomes: A Strategy for Cancer;
- reflect new initiatives such as lapco, information prescriptions.

The relationship between the NICE Improving Outcomes Guidance and Quality Standards and the Manual for Cancer Services is explained in more detail in appendix A.

1.4 Reviewing the Measures

The National Cancer Peer Review (NCPR) Programme aims to improve care for people with cancer and their families by:

- ensuring services are as safe as possible;
- improving the quality and effectiveness of care;
- improving the patient and carer experience;
- undertaking independent, fair reviews of services;
- providing development and learning for all involved;
- encouraging the dissemination of good practice.

The benefits of peer review have been found to include the following:

- provision of disease specific information across the country together with information about individual teams which has been externally validated;
- provision of a catalyst for change and service improvement;
- identification and resolution of immediate risks to patients and/or staff;
- engagement of a substantial number of front line clinicians in reviews;
- rapid sharing of learning between clinicians, as well as a better understanding of the key recommendations in the NICE guidance.

The NCPR programme has been keen to take the opportunity to reduce the burden on the NHS in line with the efficiency gains asked of all NHS organisations. The revised methodology will reduce the burden on the service without substantially impacting on the quality assurance process. It is envisaged that these changes will reduce the burden on the service by almost 50% from the previous process.

Appendix A

Interpretation of the National Manual for Cancer Services

1.1 Guidance Compared to Cancer Measures

The NICE Improving Outcomes Guidance is exactly what it says - guidance in general and indeed is excellent for this purpose. Guidance involves giving advice and recommendations on how things should be done now, in the future and sometimes on how things should have been done for sometime already. It may involve describing in effect the "perfect" service, using phrases like "the best possible", "to all patients at all times", etc. It may involve all-inclusive and far-ranging objectives and aspirations involving many agencies in long, interlinked chains of events and tasks which all have to be fulfilled before the desired outcome of the guidance is achieved. A particular person's accountability for each task is often not stated.

It may use influential and important ideas and models, which are however complex or not precisely definable, such as "network-wide patient care pathways" or "culturally-sensitive information". It always contains useful and necessary value judgements which use words like "sufficient", "appropriate", "robust" and "comprehensive", but it often has to leave unanswered the key question - what exactly is it which makes the issue under examination "sufficient", "appropriate", "robust" and "comprehensive" or not? It uses concepts which, although crucial, may not be measurable. It ranges widely from things which everybody gets right as a matter of course already through to principles which, if taken literally, nobody would comply with ever.

All these features, although they may sound unhelpful as described above, are present in all guidance documents and are part of the necessary and accepted style of guidance writing. Without this underlying type of mindset, guidance would not inspire, lead, motivate or guide and would probably be almost unreadable. The Manual for Cancer Services has to take a different approach. It is written for and only for the specific purpose of being used to assess a service against it, to aid self assessment and team development (a) by a peer review visit; (b) on a specific occasion; (c) a visit which has to be fair compared to visits to other services elsewhere and (d) to past and future visits to the same service. Therefore, the measures have to:

- be objective - with as little room as possible for arguments between assessors and assessed; and between different teams of assessors;
- be measurable - and at least capable of definitely being complied with or not;
- be specific - not addressing several issues at once or long, linked chains of tasks all being done by different agencies;
- be verifiable - by evidence produced for the visit; state who exactly is responsible for what - or nobody may take responsibility for anything;
- sometimes deal with the implications of the guidance - which may not have been explicitly stated but which are essential for anything to actually happen;
- be discriminating - it's no use spending time and money on assessing something which everybody gets right already;
- be achievable - it's no use committing everybody to permanent and automatic failure because of the way something is worded;
- be clear and unambiguous - the words will be taken to mean exactly what they appear to say, and therefore they have to say exactly what we mean and nothing else;
- pick out and address the most important issues - the peer review process is limited in its scope;
- be developmental - encourage continuous quality improvement and not produce destructive competition or a sense of failure;
- be sensibly and fairly related to previous standards - in order to be developmental -not just arbitrarily moving the goal posts.

All this results in the rather esoteric style of the manual. Please judge the measures on their merits in the light of the above and not in comparison to the guidance.

1.2 "The Responsibility for Assessment Purposes"

This refers to the fact that someone, or some group, is always held nominally responsible for compliance with each one of the quality measures. This has to be specified or, in terms of organising the peer review and collecting the results, it would be unclear who was being held as compliant or non-compliant or who the results could be attributed to. Where it is unclear who has responsibility there tends to be inertia. This attribution of responsibility does not necessarily commit a given person to actually carrying out a given task - this can be delegated according to local discretion, unless it is clear that a given task really is limited to ascertain group.

1.3 "Agreement"

Where agreement to guidelines, policies etc. is required, this should be stated clearly on the cover sheet of the three key documents including date and version. Similarly, evidence of guidelines, policies etc requires written evidence unless otherwise specified. The agreement by a person representing a group or team (chair or lead etc) implies that their agreement is not personal but that they are representing the consensus opinion of that group.

1.4 Confirmation of Compliance

Compliance against certain measures will be the subject of spot checks or further enquiries by peer reviewers when a peer review visit is under taken. When self assessing against these measures a statement of confirmation of compliance contained within the relevant key evidence document will be sufficient.

1.5 "Quality" Aspects of Cancer Service Delivery

Many of the measures expect that policies, procedures, job descriptions and other documents will be in place. In reviewing compliance with the measures (for instance measure met or not) during validation, verification and visits, reviewers will look only for the presence of such documents, unless aspects of the content are specified in the wording of the measure. Where some aspect of the content is specified then this will be taken into account in determining compliance. As part of the improvement of cancer services, reviewers may comment on the content of documents and agreements but this will not affect the determination of compliance.

Work is ongoing to enable us to subject more of the "quality" aspects of cancer service delivery to objective measures for future rounds of peer review.

Many reviewers have a legitimate and valuable contribution to make by way of comments on areas which are a matter of opinion rather than fact or authoritative and evidence based standards. This recognises the qualitative as well as quantitative approach to reviews. This contribution can be made by way of a textual report in addition to the objective recording of compliance against the measures. This report is separate from the review against the measures and is inevitably more subjective and open to debate. However, there are many ways in which it can add to the overall picture gained from the peer review.

1.6 Structure of the Measures

Each measure has a three part number, for example <u>11-1A- 201j</u>.

- The first part indicates the year the measure was first issued, for example <u>11</u> is 2011.
- The second part relates to a particular topic see below, for example <u>1A</u>.
- The third part is made up of a unique measure number in the topic and where relevant a suffix letter indicating a specific tumour and cross cutting services, for example <u>201j</u> (see below).

Index of Suffix Letters

a - Generic to all tumour sites

b - Breast specific

c - Lung specific

d - Colorectal specific

e - Gynaecology specific

f - UGI specific

g - Urology specific

h - Haematology specific

i - Head and Neck specific

j - Skin specific

r - Specialist Palliative Care specific

s - Chemotherapy specific

t - Radiotherapy specific

u - User Group specific

v - Rehabilitation specific

w - Complementary Therapy specific

x - Psychological Support specific

y - Acute Oncology

Each network will be made up of several localities/trusts and several NSSGs / cross cutting groups, each with multiple MDTs and services. These MDTs and services will each need to demonstrate compliance with the relevant quality measures. A network overview will be developed by bringing together the findings relating to individual MDTs and services as well as those concerning network organisation and structures.

Manual for Cancer Services On-line

An on-line version of the Manual for Cancer Services has been developed. The on-line version allows individuals to identify and extract measures by tumour site, organisation type and subject area in a variety of formats.

The on-line manual can be accessed from the CQuINS web site at <u>http://www.cquins.nhs.uk</u>.

MEASURES FOR PSYCHOLOGICAL SUPPORT SERVICES

Introduction

Psychological support for patients with cancer and their carers may be needed at any point in the patient care pathway and may be delivered by a variety of health professionals, depending on the nature of the intervention required. The measures in this section are based on the recommendations, regarding psychological support services, contained in the Improving Outcomes Guidance for Supportive and Palliative Care (the 'IOG'). Measures dealing with other aspects of the IOG, besides psychological support, appear elsewhere in the Manual for Cancer Services.

The measures do not attempt a definition of what constitutes psychological support, but for the purpose of peer review this has become, by default, the activities of the professional groups specified in the measures and of those staff specified by the types of training required in the measures.

In common with the rest of the supportive care measures, they usually refer to the needs of the patient 'and carers'. The latter group cannot be precisely defined, but for purposes of planning by commissioners it is acknowledged that there cannot be a definite increase in service provision based on any quantitative estimate of a number of formal referrals of individuals who are not themselves patients.

The measures approach psychological support as a service based in the hospital setting and delivered by trained health professionals. It is acknowledged that there are other valuable settings for, and means of delivery of psychological support but these are currently outside the remit of the measures of the Peer Review.

The Levels

The IOG uses a 4-level model of care for psychological support services. The term 'service levels' as used in the measures and peer review of psychological support services, does not indicate the level of service provision in the sense of amount or capacity of the service, but the type of service in the sense of severity or complexity of that particular range of clinical needs which is encompassed by a given level. This then gives rise to a similar measure of the difficulty involved and the intensity and skill needed in providing successful interventions at this level. Some of the parameters which define these levels are specified in this document. Other parameters are left to networks to agree, based on illustrative examples given as guidance, in this document. Details of this are found in appendix 1.

The concept of the levels, for peer review purposes, is intended as a currency for use primarily in service development and workforce planning. This is partly because it has only been possible to define the levels, clearly and objectively, in terms of the degree of training and experience of practitioners rather than by prescribing different types of intervention which a given practitioner should be restricted to. They should not, therefore be used in, say, detailed clinical guidelines to describe rigidly, who should carry out what, in a particular case. Specific types of intervention are only indirectly used in the definition of the levels, where they appear in the examples of the training programmes required.

An illustration of levels of intervention is shown in appendix 2.

The levels and the service are related as follows: The provision of a certain 'level' of service, say level 2, means that a practitioner of at least level 2 is needed to be able to provide that service on an independent basis. Conversely, a practitioner of a certain 'level', say level 2, is intended to be capable of providing a service up to but not beyond level 2, independently.

The Measures and the Peer Review

The measures and the peer review of psychological support services are in three parts.

i) The functions of the Network Board, in relation to psychological support services: Establishing a network lead for psychological support and a group which coordinates and advises on psychological support for the network. This is the responsibility for review purposes of the Chair of the Network Board and is reviewed under topic 11-1A-3x in the Manual for Cancer Services, compliance counting towards the

review of the Network Board.

ii) The functions of the Network Psychological Support Group: agreeing certain parameters regarding the levels; producing baseline mapping; service specification; service needs assessment; service development strategy; training and education strategy; referral guidelines; cancer directory information and provision of some specified staff training and professional support. This is the responsibility for review purposes of the Chair of the Network Psychological Support Group and is reviewed under topic 11-1E-1x of the Manual for Cancer Services, compliance counting towards the review of the Network Psychological Support Group.

iii) Measures for MDTs; specific staff on the team and support for those members.

Unless stated otherwise in a particular measure, the network will be reviewed as a single complete entity regarding psychological support. Thus, for example, there should be only one network lead for the service, for the whole network and the level 2 training should be applicable across the network.

Nomenclature

The names used locally for roles and groups are not themselves subject to review. They have to have standard titles throughout the manual for the purpose of the measures and peer review, but provided a person or group is put forward for review against the appropriate measures, their local title is irrelevant.

MEASURE DETAILS & DEMONSTRATION OF COMPLIANCE
Network Psychological Support Group

11-1A-301x

The Network Board should agree a single named lead for psychological support, for the network, who should be a consultant liaison psychiatrist, a counselling psychologist or a clinical psychologist. The lead should be the Chair of the Network Psychological Support Group.

The Network Board should agree a list of responsibilities and specified time in their timetable or job plan, for the role of network psychological support lead.

There should be a single group for the network having a membership which, as a minimum, is specified below:

- the network lead for psychological support who should be the chair of the group;
- a representative of each of the localities of the network, by a practitioner of at least Level 2 capability;
- two user representatives;
- named secretarial/administrative support.

There should be terms of reference for the Network Psychological Support Group which include:

- The group should be recognised as the network's primary source of opinion on issues relating to patients' and carers' psychological support and for co-ordination and consistency across the network on such issues.

Notes:

- *The group may choose additional members.*
- *It is strongly recommended that any members of the Network Palliative Care Group which represent patients' and carers' psychological support, are drawn from the members of the Network Psychological Support Group.*
- *If the local user group do not wish to, or are unable to nominate user representatives, but there is an agreed mechanism for obtaining user advice, then the measure will be deemed to have been complied with.*
- *These are terms of reference. Detailed measures for the functions of the group are to be found in topic 11-1E-1x.*
- *The network may agree additional terms of reference.*

Compliance: The named lead, agreed by the Chair of the Network Board.

Reviewers should enquire of the practitioner status of the named lead.

The list of responsibilities and specified time, agreed by the psychological support lead and the Chair of the Network Board.

The list of named members and what they represent, agreed by the Chair of the Network Board.

The terms of reference, agreed by the Chair of the Network Board and the network lead for psychological support.

TOPIC 11-1E-1x - FUNCTIONS OF THE NETWORK PSYCHOLOGICAL SUPPORT GROUP

Introduction

These measures cover:

- agreeing the training programme and the trainers and assessors for Level 2 practitioners;
- ensuring there are personnel available to give support to practitioners in MDTs;
- agreeing the induction programme for potential Level 3 and 4 practitioners and that such practitioners receive ongoing professional support;
- agreeing and distributing a policy on screening for patients' and carers' needs for psychological support;
- agreeing and distributing guidelines, with local contact points, for referral of patients and carers for psychological support;
- producing a baseline mapping of the networks current service provision;
- producing a current service specification;
- producing a current service needs assessment, from the baseline mapping and service specification;
- producing a service development strategy;
- producing a training and education strategy;
- providing information for the cancer services directory.

MEASURE DETAILS & DEMONSTRATION OF COMPLIANCE
The responsibility for review purposes for the measures in this section lies with the Chair of the Network Psychological Support Group (the network lead for psychological support).

The Level 2 Training Programme	
11-1E-101x	The Network Psychological Support Group should agree the content of a training programme for the network for health professionals from non-psychological disciplines, (in addition to attendance on the national advanced communications skills training) to enable them to provide level 2 psychological support for cancer patients and their carers. The training should cover: i) screening of patients and carers for their need for psychological support; ii) basic psychological support intervention techniques. See appendix 1 for definition of the service levels and illustrative guidance on training contents. *Compliance:* The content of the training programme agreed by the Chair of the Network Psychological Support Group. The reviewers should check whether they address (i) and (ii) above. *Notes:* • *Any further details of the training contents are not subject to review. Reviewers may wish to discuss this with the Network Psychological Support Group, but it is not an issue on which compliance depends.* • *Networks should **not** attempt to seek advice from cancer peer review employed personnel on the content of training programmes.*

Trainers and Assessors for Level 2	
11-1E-102x	There should be named personnel who act as trainers and assessors of level 2 competence for the network. They should themselves be level 3 or 4 practitioners. See appendix 1 for definition of the service levels. *Note:* *The personnel may include or entirely consist of practitioners from cancer networks other than the one under review.*

MEASURE DETAILS & DEMONSTRATION OF COMPLIANCE

Compliance: The named personnel agreed by the Chair of the Network Psychological Support Group

Support for Level 2 Practitioners

11-1E-103x There should be named practitioners for the network, who themselves are competent at least service level 3, who have undertaken to provide ongoing professional advice and support to the networks level 2 practitioners.

Note:

The actual number of support providers is not subject to review.

Compliance: The named personnel providing professional support. The reviewers should enquire of the service level status of the supporters and the working practice of the network regarding this role.

Level 3 Induction Programme

11-1E-104x The Network Psychological Support Group should agree the content of the network induction programme for potential level 3 practitioners who have no previous experience of working with cancer patients and their carers and/or palliative care.

Note:

The induction programme should meet the requirements of the British Psychosocial Oncology Society and Special Interest Group for Oncology and Palliative Care which is a faculty of the British Psychology Society.

Compliance: The content of the induction programme agreed by the Chair of the Network Psychological Support Group.

Screening

11-1E-105x The Network Psychological Support Group should agree a policy specifying their recommendations for the screening of cancer patients and/or their carers to assess their need for psychological support.

The policy should include screening by level 1 and level 2 practitioners.

The policy should be distributed to at least the lead clinicians of the MDTs in the network and the PCT cancer leads.

Note:

For the purpose of this measure, the term 'screening' is taken to mean an evaluation of the need for further psychological assessment of individuals in the population group in question; the evaluation being initiated by a health professional rather than the evaluation being initiated by self referral of individual members of the population, or by their referral by another health professional.

Compliance: The policy agreed by the Chair of the Network Psychological Support Group

The reviewers should enquire as to its distribution.

Note:

Minor shortcomings in the completeness of the distribution should not preclude compliance with this measure. Reviewers should exercise judgement in this matter.

Referral Guidelines

11-1E-106x The Network Psychological Support Group should agree referral guidelines for health professionals which include the following:

    i)   the indications for referral of cancer patients and/or their carers for psychological support;

    ii) the service level likely to be required for a given set of indications;

    iii) the local contact points for service access, in the different localities of the network.

The guidelines should be distributed to at least the lead clinicians of the MDTs in the network and the PCT cancer leads.

MEASURE DETAILS & DEMONSTRATION OF COMPLIANCE

Compliance: The guidelines, agreed by the Chair of the Network Psychological Support Group

The reviewers should enquire as to their distribution.

Notes:

- *The group may agree additional items in the guidelines besides those specified above.*
- *Minor shortcomings in the completeness of distribution, should not preclude compliance with this measure. Reviewers should exercise judgement in this matter.*

Introduction to measures 11-1E-107x to 11-1E-112x

The baseline mapping is the initial mapping of current service provision, prior to the initial peer review of the network's psychological support services.

At subsequent annual self assessments and/or peer review visits of psychological support service over the following 3 years, this measure should be applied as an annual update of the current service provision, recording the changes since the previous assessment. This acts as a monitor of progress, along the lines of the service development strategy and the training and education strategy, towards implementing the service agreed in the service specification.

At the end of 3 years, a new service specification should be provided and, with the mapping of the services current at that time, a new service needs assessment, a new development strategy and a new training and education strategy should follow, for the next 3 year cycle.

Thus, the measure on mapping of current service provision should be applied annually, and for those on service specification service needs assessment, development strategy and training and education strategy the evidence for compliance only needs to be updated once every three years.

Baseline Mapping (Mapping of Current Service Provision)

The Baseline Mapping should be completed each year.

The Baseline Mapping

11-1E-107x The Network Psychological Support Group should produce a baseline mapping of the current service provision for psychological support for cancer patients and/or their carers. It should include:

- i) the service in each locality of the network;
- ii) the amount of input in terms of WTEs or parts of WTEs at each of the service Levels (2 to 4) specified in the appendix.

Compliance: The baseline mapping, agreed by the Chair of the Network Psychological Support Group

The reviewers should verify that it fulfils (i) and (ii) above.

SERVICE SPECIFICATION

Introduction

The service specification is the quantifiable amount of service provision that is required to support cancer and palliative care psychological needs in the network.

The service specification should be revised every three years.

Service Specification

11-1E-108x The Network Psychological Support Group should produce a network service specification for psychological support services for cancer patients and/or their carers, which fulfils the following:

- i) it should be expressed in terms of WTEs or parts of WTEs of practitioner time, using the levels (2 to 4) in the appendix;
- ii) it should take into account the estimate of 10% of cancer patients needing access to level 4 psychological intervention in the year following diagnosis, 15% needing access to level 3 psychological intervention in the year following diagnosis and 10% needing support with advanced disease. (NICE Guidance on cancer services. Improving Supportive and Palliative Care for Adults with Cancer, D.1 Overall benefit 5.48 Page 83);

    iii) it should specify the settings (hospital, community) where the service is delivered and from which providers the service is proposed to be commissioned;

    iv) it should specify the access and waiting time standards;

    v) it should be expressed as the service required for each locality in the network;

    vi) it should allow 3 years as the planned time for its full implementation;

    vii) it should include service requirements for psycho sexual counselling for cancer patients.

Compliance: The service specification, agreed by the Chair of the Network Psychological Support Group.

The reviewers should verity that it fulfils (i) to (vi) above.

SERVICE NEEDS ASSESSMENT

Introduction

The service needs assessment is the difference between the service required (service specification measure 11-1E-108x) and the current service provision available as identified by the baseline mapping (measure 11-1E-107x).

This service needs assessment should be updated every three years.

Service Needs Assessment

11-1E-109x The Network Psychological Support Group should produce a network service needs assessment for psychological support for cancer patients and/or their carers which fulfils the following:

    i) it should be based on the difference between the service specification and the baseline mapping;

    ii) it should be expressed in terms of WTEs/part WTEs of practitioner time using the service levels (2 to 4) in appendix 1.

    iii) it should be expressed as the service need for each locality in the network, specifying the settings for service delivery, proposed providers and access and waiting times standards.

Compliance: The service needs assessment agreed by the Chair of the Network Psychological Support Group.

The reviewers should verify that it fulfils (i) to (iii) above.

SERVICE DEVELOPMENT STRATEGY

Introduction

The service development strategy is how the network will implement the required service identified in the service specification.

This service development strategy should be updated every three years.

Service Development Strategy

11-1E-110x The Network Psychological Support Group should produce a network service development strategy which fulfils the following:

    i) it should describe the proposed changes towards implementing the service specification over the 3 contracting years subsequent to the baseline mapping;

    ii) it should be expressed using the same parameters as the service specification measure.

Compliance: The service development strategy, agreed by the Chair of the Network Psychological Support Group.

The service development strategy should have been presented to the Network Board.

The reviewers should verify that it fulfils (i) and (ii) above.

MEASURE DETAILS & DEMONSTRATION OF COMPLIANCE

Training and Education Strategy

11-1E-111x The Network Psychological Support Group should produce a network training and education strategy which fulfils the following:

  i)   it should be based on the gap between the qualifications and competencies of personnel as required by the service specification and those of existing personnel;
  ii) it should deal with the service levels related training specified in appendix 1;
  iii) it should be set over the same three years as the service development strategy;
  iv) it should set a pragmatic target for a given number or percentage of personnel to be trained to stated levels of practice (2 to 4) as in appendix 1;
  v)   it should finally express the training and education needs in terms of numbers of places per year on named local, regional or national courses or programmes.

Note:

This training and education strategy should be updated every three years.

Compliance: The network training and education strategy agreed by the Chair of the Network Psychological Support Group.

The service development strategy should have been presented to the Network Board.

The reviewers should verify that it fulfils (i) and (v) above.

The Psychological Support Section of the Local Cancer Services Directory

11-1E-112x The Network Psychological Support Group should produce a psychological support section for the cancer services directory for each locality in the network.

It should list the contact points for psychological support services relevant to the locality.

Compliance: The psychological support sections for each locality in the network, each agreed by the Chair of the Network Psychological Support Group and the chair of the relevant locality group.

GENERIC MDT MEASURES

MEASURE DETAILS & DEMONSTRATION OF COMPLIANCE

Level 2 Practitioners for Psychological Support

1	At least one clinical core member of the team should have completed the training necessary to enable them to practice at level 2 for the psychological support of cancer patients and carers.

Notes:

- *This measure applies only to those disciplines which have direct clinical contact and which are named in the list in the MDT structure measure for core membership.*
- *The relevant disciplines include medical, surgical, nursing and allied health professionals.*
- *If the MDT has one or more clinical core members who are trained to level 3 or 4, the team is deemed to be automatically compliant with this measure.*
- *The definition of the levels may be found in appendix 1 of the Psychological Support measures.*

Compliance: The named member.

Written confirmation of completion of training agreed by the lead clinician of the MDT.

Support for Level 2 Practitioners

2	The level 2 practitioner(s) should receive a minimum of 1 hours clinical supervision by a level 3 or level 4 practitioner per month.

Compliance: Reviewers should enquire to ascertain that this is taking place.

APPENDIX 1- Service Levels

Introduction

This appendix gives the definitions, for the purpose of the measures and peer review, of the service levels.

The term 'Health Professional' as used in the definitions of levels 1 and 2, implies a professional in a discipline other than the psychiatry/psychology/counselling disciplines themselves, since it is assumed that basic qualification in these disciplines would exempt a practitioner from level 2 training.

Level 1

Is defined as a degree of psychological screening, intervention and support which is deliverable by any qualified health or social care professional, without any further psychological training other than that provided by the basic training in their own discipline.

Note:

Level 1 does not feature directly in the measures but it is specified here to set a baseline for comparison with the higher levels and to put them in perspective.

Level 2

Is defined as a degree of psychological screening, intervention and support which requires a practitioner who is a health or social care professional who has received further psychological training, as specified below, in addition to that provided by the basic training in their own discipline.

The additional training is as follows:

i. Attendance on the National Advanced Communications Skills Training course from one of the nationally approved programmes.

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ii. Participation in a network based training programme, relevant to cancer patients and their carers which covers basic psychological screening, psychological assessment and basic psychological intervention skills.

The detailed content of the training programme will be agreed by the network and is not subject to peer review, but for illustration purposes examples of the training in screening are: Jenkins, K. & North, N. (2008) 'Psychological Assessment Skills: A training course for all health and social care staff working in cancer services'. Salisbury NHS Foundation Trust; or, training in the use of a Holistic Needs Assessment tool such as the Distress Thermometer.

For illustration purposes, examples of the training in psychological intervention skills are: Training in Solution

Focussed Techniques, or Anxiety Management, or Problem Solving, or Cognitive Behavioural Therapy.

Level 3

Is defined as a degree of psychological screening, intervention and support which requires a practitioner who is one of the following:

- a counsellor, accredited by the British Association for Counselling and Psychotherapy;
- an NHS psychotherapist accredited by the United Kingdom Council for Psychotherapy;
- a registered mental health nurse with a diploma in counselling;
- a social worker with additional university accredited clinical diploma in counselling or psychotherapy.

Note:

Other health or Social Care professionals, who are accredited as in the last two bullet points above, are also considered able to practice at level 3.

Level 4

Is a degree of psychological screening, intervention and support which requires a practitioner who is one of the following:

- a consultant psychiatrist;
- a consultant liaison psychiatrist;
- a clinical or counselling psychologist.

Note:

All of the above should have completed an induction at level 3. That meets the British Psychosocial Oncology Society (BPOS) and SIGOPAC requirements.

APPENDIX 2 - Illustration of levels of intervention

Mr Brown is an inpatient who has been admitted for symptom relief and pain control. On admission he seemed pleased to have been admitted briefly and fairly optimistic that his symptoms could be controlled and that he would have a reasonable quality of life. His expectations were of a short stay in hospital. It proves more difficult than expected to manage his symptoms.

Level 1

The ward staff notice that over the last few days Mr Brown has become a little more withdrawn and use the distress thermometer to screen his concerns. It appears that he did not expect to be in for this long and is anxious to get home and worried about how much longer he will remain in hospital. On the basis of this new information staff provide information tailored to Mr Brown's needs on the management of his physical symptoms, agree to a discharge plan and in the meantime agree to return regularly to review his concerns with him.

Level 2

Level 1 staff realise that the delays in discharge are affecting Mr Brown and discuss his situation with Level 2 staff. The palliative care nurse assesses Mr Brown and together they establish that his symptoms may be linked to his anxiety. From further discussion they establish that when he feels more anxious and/or out of control his pain increase and his medication is less effective. Mr Brown and the palliative care nurse agree to try relaxation techniques and his symptoms improve.

Level 3

Mr Brown is discharged but remains anxious about his future. He seems unable to achieve the same quality of life as he had before and this is having an adverse impact on his relationship with his wife. He is screened by the palliative care nurse with a Holistic Needs Assessment at the local hospice and they decide together to refer him for counselling. This Level 3 work helps him explore the impact of his cancer journey so far and to consider the effect and meaning of his last hospital stay. Mr Brown discloses a previous episode of depression following work redundancy where he was admitted to briefly a local psychiatric service. As a result of this Level 3 intervention and relapse prevention work he manages to take up many of his former activities and his quality of life and relationship improve.

Level 4

Mr Brown's cancer progresses further and he loses use of his legs temporarily. He is admitted to hospital again for relief of symptoms. Staff notice that he has become very withdrawn and seems to have given up. Mrs Brown appears to be very distressed and says that she feels she has lost her husband already. At this stage Mr Brown's symptoms are still treatable and he could have a reasonable quality of life for some years. Level 1 and/or 2 staff discuss this with Mr Brown and agree to refer to clinical psychology. The psychologist assesses with the couple the impact of these physical and psychological changes on the couple, and their anxiety that he is clinically depressed again. Level 4 work offers couple therapy and an intervention for MrBrown's clinical depression. to communicate these effects to each other and to consider this in light of their expectations about themselves, their relationship and their family and friends. Both find this exploration helpful in understanding their usual ways of relating to each other and the outside world. Together they begin to focus on practising different coping strategies.

Level 1

Mrs X is a 65-year-old lady with screen-detected breast cancer. After undergoing surgery (mastectomy) Mrs X stared radiotherapy treatment. The radiographer noticed that Mrs X always came to her appointments by herself and although she seemed cheerful she often complained of tiredness. The radiographer asked Mrs X about how she was feeling at this stage in her treatment and about her support. Mrs X told the radiographer

that she was actually finding it quite difficult to get to the appointments by herself as she had to come a long way by bus, and that she didn't really have anyone to talk to about her experience of cancer as her husband had died and her family all lived quite far away and she didn't like to bother them. The radiographer asked Mrs X if she would be interested in finding out about support available for patients through the Macmillan information centre. After speaking to the information worker, Mrs X decided to accept the offer of a volunteer driver to bring her to appointments and also found out about a breast cancer support group in her local area that she could join.

Level 2

Mr X is a 45-year-old builder recently diagnosed with mesothelioma. He is married with two young children. At diagnosis Mr X was told that his cancer was most likely caused by exposure to asbestos at work. He was shocked to learn that he is likely to have less than a year to live. Mr X's key worker, the lung CNS, was present at his diagnosis and has since spoken to Mr X and his wife to provide information and to offer support. At his next appointment, his key worker explains to Mr X that she will be carrying out an assessment of his needs as a routine part of his care. During this assessment Mr X mentions that since his diagnosis, he has become very panicky when he experiences any chest pain or breathlessness. He has started to avoid any activity which may cause breathlessness. He is very angry about his diagnosis for which he blames his employers, and frightened of dying and of how his family will cope without him. He has had to give up work and the family are experiencing financial problems. Mr X's key worker is able to tell him that his feelings of anger and his anxiety are normal, but offers to help him to try to help cope with panicky feelings by learning cognitive behavioural skills. Mr X and his key worker agree that a referral to the team social worker would also be helpful to give Mr X and his wife some advice on benefits that the family may be entitled to as to discuss family support. Mr X's key worker gives Mr X some information to read and arranges to see him again in a few days time. Over the next few appointments Mr X's key worker helps Mr X to recognise when he is experiencing anxious thoughts and to control his breathing. Mr X reports that although he still experiences episodes of anxiety, he is less "panicky" than before and feels more able to manage these feelings. He has started enjoying playing with his children again, which he had been avoiding due to worry about becoming breathless.

Level 3

Mr Y is a 36-year-old man, who has been treated for colorectal cancer with surgery,radiotherapy and chemotherapy. Mr Y is gay. He is single although has recently started a new relationship. At follow up appointment with his consultant Mr Y mentions that although he is grateful that his cancer has been successfully treated, he is very worried about recurrence and concerned that any signs of stomach aches or tiredness could mean that the cancer is coming back. He is worried about how his new partner will cope with the fact that he been told that he may need a permanent stoma bag. As a result he is avoiding physical intimacy with his new partner. He says that his new partner is understanding, but worries that this issue will potentially cause problems in their relationship. Mr Y agrees to his consultant referring him to the psychological support team at the cancer centre for specialist psychosexual assessment and counselling. He attended 10 sessions of counselling, which he reported that he found helpful. Mr Y found it useful to include his new partner in some of these sessions to explore his partner's understanding of the cancer and the effects of treatment and to discuss ways in which they could adapt their sexual relationship.

Level 4

Mrs Y is a 48 year old lady who recently diagnosed with cervical cancer. The gynaecology team CNS contacts the psychological support team for advice, as Mrs Y is clearly extremely distressed by having to undergo physical investigations and has said that she does not want any surgery. Mrs Y will not give any reason and will not allow the consultant to discuss this with her husband present. Mrs Y has not agreed to the referral to the psychology team and says it his "her decision". Following discussion with the team, the psychologist offers to see Mrs Y jointly with the gynaecology CNS. During this appointment, the psychologist asks Mrs Y if she has experienced any trauma that may be linked to her current distress. Mrs Y discloses that she experienced sexual abuse in childhood and was then raped in her teens. She has never told anyone about this previously, including her husband, whom she does not want to find out. She is terrified of cancer but is upset about the

possibility of having to be examined or treated by a male doctor. The CNS assures Mrs Y that she can be seen by a female doctor, and explains that it would be helpful for her doctor to understand the reasons for her difficulties. Mrs Y agrees to her consultant being told this information but does not want this in her notes. The psychologist suggests that Mrs Y may benefit from specialist psychological intervention to help her to cope with her experience of sexual abuse. Mrs Y states that she does not wish to be referred to mental health services, which she perceives as 'stigmatising'. She does, however, agree to see the psychologist from the cancer centre regularly during her treatment. Mrs Y finds this support helpful and, although she finds her cancer treatment difficult, is able to cope with this better and to receive the treatment that she needs.