Improving Outcomes
Guidance (IOG) for
Supportive and Palliative Care:
Psychological Support Chapter 5

Education and Training
Strategy for Psychological Support

January 2011 – March 2014

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1 Background and Context

This paper describes the approach to be taken across Pan Birmingham Cancer network PBCN to the delivery of education, training and support within the field of psychological support and intervention, to staff working with adult cancer patients.

PBCN includes the population of approximately 1.8 million and comprises 7 Primary Care Trusts (NHS Birmingham East and North, Sandwell, Walsall, Solihull, Heart of Birmingham, South Birmingham, and part of South Staffs). Services are commissioned from 7 Hospital Trusts:

- Birmingham Women’s Foundation Trust
- Birmingham Children’s Foundation Trust
- Heart of England Foundation Trust
- Royal Orthopaedic Foundation Trust
- Sandwell and West Birmingham Trust
- University Hospital Foundation Trust
- Walsall Hospitals Trust

Within the network there are 79 adult multidisciplinary teams (MDTs) split as follows:

- 61 adult site specific teams
- 6 chemotherapy teams
- 5 hospital specialist palliative care teams
- 4 hospice specialist palliative care teams
- 3 community specialist palliative care teams

The importance of providing psychological support to cancer patients has become increasingly recognised in the past decade. Prior to the publication of the Calman-Hine report¹ in 1995 there were few Clinical Nurse Specialist posts outside of specialist cancer hospitals. This report made it clear that cancer patients need access to someone with clinical expertise, specialist knowledge and good communication skills. This was further emphasised in 2000 in The Cancer Plan² which recommended communication skills training for senior cancer clinicians and emphasised the importance for patients to have access to counsellors, psychologists and psychiatrists when required. The 2004 Improving Outcome Guidance on Supportive and Palliative Care devoted Chapter 5 to the provision of psychological support to all cancer patients that require and would like to access it.

The need for professionals to be effective in patient communication is also clear from feedback from the 2009 Pan Birmingham Network patient survey. Comments highlight the importance it can have, and the ongoing impact into the rehabilitation phase of care, for example:

“I feel emotionally in limbo and feel I need to talk to some-one. Because I have put a brave face on, people presume I am OK, especially now my hair is growing back. Work expects me to return soon but I am nowhere near being able to do so”.

“I found it impossible to talk to my specialist nurses as I found them to be ‘oh you’ll be alright’……… I found this attitude made me angry”.

“I feel if I had had contact with people to talk it through with and that my husband was spoken to understand how I might be feeling and reacting to treatment, I would not have been mentally stressed and not have had the pressures from my husband if he understood more of how I am. A very hard and lonely time”.

Expectations of the ability of staff to demonstrate effective communication skills has increased amongst commissioners, patients and the staff themselves; training and support must therefore be provided to help them meet these needs and expectations.
The 2004 document: *Supportive and Palliative Care Improving Outcomes Guidance*\(^3\) (SPC IOG) recommended four tiers of psychological support and expertise that should be available to patients, depending on their needs (see Figure 1 below). Clinical case examples illustrating the four levels are described in Appendix 1.

<table>
<thead>
<tr>
<th>Level</th>
<th>Group</th>
<th>Assessment</th>
<th>intervention</th>
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</thead>
<tbody>
<tr>
<td>1</td>
<td>All Health and Social Care Professionals</td>
<td>Recognition of Psychological Needs</td>
<td>Effective information giving, compassionate Communication and General Psychological Support</td>
</tr>
<tr>
<td>2</td>
<td>Health and Social Care Professionals with additional experience</td>
<td>Screening of Psychological Distress</td>
<td>Psychological techniques such as Problem Solving</td>
</tr>
<tr>
<td>3</td>
<td>Trained and accredited Professionals</td>
<td>Assessment of Psychological Distress and Diagnosis of some Psychopathology</td>
<td>Counselling and specific psychological interventions such as anxiety management and solution-focused therapy, delivered according to an explicit theoretical framework</td>
</tr>
<tr>
<td>4</td>
<td>Mental Health Specialists</td>
<td>Diagnosis of Psychopathology</td>
<td>Specialist psychological and psychiatric interventions such as psychotherapy, including cognitive behavioural therapy (CBT)</td>
</tr>
</tbody>
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*Figure 1: the NICE four-tier model of psychological support in cancer care.*

**Level 1:** All staff, including clinical, ancillary, volunteers, etc., by definition of their working in health care are required to meet this level. Employing Trusts have the responsibility to train and equip staff to recognise psychological needs and their importance, and to provide effective information, compassionate communication and support.

**Level 2:** In order to meet the level 2 criteria staff are additionally required to attend an *Advanced Communication Skills Training* three-day workshop (ACST/Connected); and to
have additional training in screening of psychological distress and basic psychological assessment and intervention. In order for these skills to be retained and developed they must have monthly psychological supervision.

**Levels 3 and 4**: These levels are met by qualified registered mental health nurses (RMNs), psychiatrists, and accredited psychologists, psychotherapists and counsellors.

Around time of publication of the SPC IOG a National programme for advanced communication skills was already being developed. From 2005 until late 2010 about 500 senior cancer staff per year have attended these workshops in PBCN. The peer review psychology measures (2010) clarify the requirement at levels 2-4 of the ‘basic training on screening and intervention’ for level 2 and of regular supervision and support. Strategies for training and for service development should reflect this four tier model. **This paper outlines the plan of the member organisations of the PBCN to meet these requirements.**

### 2 Summary of Training Programme for Cancer Care Staff

Pan Birmingham Cancer Network has developed a training programme to meet the requirements of its staff and of the peer review measures (see fig. 2), consisting of a stepped model:

**Level 2 Criteria as per Improving Outcomes Guidance (IOG)/Peer Review:**

For one senior cancer clinician from each MDT:

*Required:*

- Advanced Communication Skills Training (must be completed first);
- Training in Level 2 screening, basic psychological assessment and intervention;
- Monthly clinical supervision following training to facilitate application and development of acquired skills in clinical practice.

**PBCN Recommendation:**

For all senior cancer clinicians:

- Training in Level 2 screening, basic psychological assessment and intervention and monthly clinical supervision following training to facilitate application and development of acquired skills in clinical practice (to avoid the lottery of support only from the one MDT member trained to Level 2).
- Sexuality and intimacy in cancer.
- Basic principles of hospital cancer rehabilitation.

*Advanced level training:*

- Cognitive Behavioural Approach Skills in Clinical Practice (subject to extra funding).
For all health care professionals working in cancer care:

- Spiritual care screening, assessment and intervention
- Bereavement support: a one day course aimed at improving knowledge and confidence so that practitioners can work at level 3 of bereavement support - Spiritual Care, Screening, Assessment and Intervention - as defined by Marie Curie spiritual care competencies –see Appendix 5.

**Fig. 2: PBCN Training Programme for Psychological Support in Cancer Care**
3 IOG/Peer Review Required Training Programme for Cancer Care Staff

3.1 Level 1 Psychological Support

The IOG and Peer Review measures state that under Level 1, as Hospital staff we are all required to communicate effectively with our patients and their families, and to provide psychological support. They also state that hospitals currently provide needed training to their staff and that there is no measure to meet in this area.

3.2 Level 2 Psychological Support

The IOG and Peer Review measures state that at least one core member of the MDT should be trained to Level 2. Therefore, as a minimum one core member of each of the 61 adult site specific MDTs in PBCN should receive this training. The Psychological Support NSSG (at the request of the Supportive and palliative Care NSSG) have agreed that this training should be offered to the other 18 teams (palliative care, etc), as standard. Therefore a total of 79 staff require training as a minimum. There are 3 elements to this training which will be discussed separately:

• ACST/Connected
• Level 2 one-day course in screening, basic psychological assessment and intervention
• Regular (monthly) Clinical Supervision for staff providing Psychological Support

3.2.1 Advanced Communication Skills Training Programme (ACST/Connected©)

The ACST programme is rolled out nationally through the Connected© - Advanced Communications Skills Training scheme. All core members of MDTs should have undergone training provided by this national programme. Currently this training is funded by the Department of Health. From April 2011 provision of these courses will alter, with the responsibility for ensuring that staff are trained returning to the services commissioned by the PCTs (largely the Trusts but also hospices and PCT provider arm).

Network Commitment:

2009/10:
170 places have been made available to core MDT senior cancer staff within the Network.

2010/11/12/12:
A further 380 places are available.

Identified gaps in provision:
An estimate of the number of places needed from 2011 follows: with 79 MDTs across the region, and with about 8 members each (if we include AHPs and senior nurses), there are about 632 staff who need training. When all are trained, new posts, turnover and refreshers (still undefined by Connected-NCAT) will require the continuous provision of about 100 to 150 places per year.
3.2.2 Level 2 Psychology: Basic Screening, Assessment and Intervention

Training on basic screening, assessment and intervention for senior cancer staff is a requirement of the Supportive and Palliative Care IOG\(^1\) and the Peer Review Measures (09-1E-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 and assessment of patients and carers for their need for psychological support.

II. Basic psychological support intervention techniques.

Network Commitment:

2009/10:
PBCN Psychological Support NSSG developed a programme based on the Jenkins & North model as suggested in the peer review measures, which was piloted in autumn 2009. The NSSG approved a final version of the programme in May 2010 which can run 30-60 places per year, as required by the clinical teams. So far 54 staff have attended this training and are Level 2 accredited (numbers correct as of November 2010).

3.2.3 Level 2 Psychological Support: Regular Clinical Supervision requirements

The IOG and Peer Review measures require ongoing monthly clinical supervision of Level 2 trained staff, and that this should be provided by Levels 3 and 4 staff. **This is required before individuals can take part in the L2 training.** Commissioners/Trusts are required to ensure sufficient monthly clinical supervision places are available for at least one core MDT member. The PBCN clinical psychologists are able to provide 4 clinical supervision groups per whole time equivalent per month: total internal supervision capacity 48.

The most financially and clinically viable option for the delivery of clinical supervision is for monthly groups of ninety minutes for four staff. External supervisors will be required to fulfil Peer Review Measures, including own supervision with a Level 3 or 4 Psychological Support staff and induction to work in cancer/ill health/ end of life (see point 3.5 below). The Psychological Support NSSG will support the recruitment of these by providing advice to the Trusts in the form of:

- a directory of possible externally sourced supervisors;
- experience the supervisors need to have had (they will also be asked to show proof of experience in providing supervision, to non psychology staff);
- governance procedures;
- procedures to ensure consistency of quality and review of supervision;
- regular monitoring of the quality of the clinical supervision using tools like the Session Rating Scale (by Scott Miller and Barry Duncan, 2000) adapted for Supervision, to be used in most supervision sessions for immediate feedback, and the Manchester Clinical Supervision Scale (on a twice-yearly basis) (By Julie Winstanley, 2000).
- Information to staff re: what to expect when attending supervision
Network Commitment:

2010/11:
Individual Trusts and Hospices are looking at funding supervision groups using a variety of funding sources, including Macmillan Cancer Support.

Identified gaps in service provision:
In accordance with the requirements outlined by the IOG and Peer Review measures, minimally 80 core MDT staff currently require supervision. To meet the Network recommendation of all senior cancer clinicians being able to offer full Level 2 support a gap analysis of how many CNSs (over 120), senior ward staff (about 20), senior AHPs (about 30), senior chemo and radio staff (about 20) require regular supervision adds up to 180. This would need 45 monthly supervision groups, whereas 12 are currently being offered by the Cancer Psychology Network group.

There are other models to support staff at Level 1 that can carry additional psychological care responsibilities, including training some Level 2 staff in CBT 1st Aid (Cognitive Behavioural Therapy) and then support them in cascading such skills to capable and identified staff at Level 1.

4 Network recommended Training Programme for Cancer Care Staff

4.1 Level 1 Psychological Support

Senior staff that regularly work with cancer patients but do not reach full Level 2 (mainly those who are not core MDT members) should be offered at least:

- Advanced Communication Skills Training and/or
- Extended training in Level 1 screening and patient self-management. This can be extended to training along the lines of the four sessions (two days) of the Jenkins & North training programme, the Sage & Thyme training, or the Advanced Development Programme that Macmillan is piloting for senior clinical staff working with cancer survivors.

Staff are likely to be:
- Senior chemotherapy nurses
- Consultants
- Senior therapeutic radiographers
- Senior Allied Health Professionals working in cancer care (S&LT, Dieticians, OTs & Physiotherapists)
- Senior staff at cancer support and information centres

The Network Cancer Psychology Service can negotiate with local Trusts to offer Level 1 training (PBCN approved Level 1 Training) if this is paralleled with a proportionate reduction in clinical duties.

4.2 Level 2 Psychological Support

The Network recommends that all CNSs should be able to train to Level 2 if they wish to. This means that training and supervision must be made available for senior cancer care staff, including consultants, clinical nurse specialists and other senior cancer nurses, allied
health professionals working predominantly with cancer patients, senior therapeutic radiographers and district nurses. Strategies must therefore be developed to ensure that this becomes possible. The Network Cancer Psychology Service can negotiate with local Trusts to offer Level 2 training beyond the expected one core senior member per MDT (PBCN approved Level 2 Training).

4.3 Level 2+ Advanced Psychological Support

In order to provide support to all staff who should work at Level 2 (rather than to just one core member per MDT) sources of funding are being explored to train between 20 and 30 Level 2 staff in Cognitive Behavioural Approach skills (aka CBT 1st Aid) and in supervision of psychological support skills. These CBT 1st Aiders can then cascade support to 80 to 120 of their Level 1 colleagues by offering one supervision group a month (or up to 160-240 staff with two supervision groups a month).

Network Commitment:

2010/11:
In 2008 the PBCN funded a pilot of training in advanced psychological support for experienced palliative care staff, following the Sage et al CBT workbook (CBT for Chronic Illness and Palliative Care: A Workbook and Toolkit). Due to the success of this and other national pilots Marie Curie has informed the Network that it will fund 28 further training places starting in February 2011. These places will be open to staff across the country so 10 places have been allocated to regional staff. The PCBN Psychological Support NSSG has delivered two brief introduction to Cognitive Behavioural Approaches workshops in August and September 2010 so that local staff could make an informed choice whether to apply for this Marie Curie advanced psychological support training and to make them eligible for such training (some prior experience is required). PCBN psychologists will also provide some of the extra clinical supervision required by this advanced training (six months on a monthly basis, funded by the Marie Curie/DOH grant).

4.4 Level 3 Staff Induction Programme

The Peer Review Measures state that all Level 3 or 4 staff new to cancer care need an induction programme to maximise their clinical effectiveness and safety.

Each new Level 3 member of the team will meet their manager (with support from another Level 3 or 4 staff) and discuss their developmental needs: gaps in their experience and knowledge will be identified and a plan for development mutually agreed.

Will they get a mentor for the first 6-12 months to assist them in working through their plan?

Within PBCN this will include:
- seminal reading,
- attending MDTs
- shadowing and co-working with other cancer professionals,
- attending Continuous Professional Development events such as those organised by local agencies, and/or national events such as those run by the British Psycho-Oncology Society (BPOS) and/or the Faculty of Psychologists in Cancer and Palliative Care (SIGOPAC), the Palliative Care associations, etc.
4.5 **Level 3 and 4 Supervision**

The IOG and Peer Review Measures set the expectation for Level 3 and 4 to be regularly supervised. Since this is a statutory obligation for BACP registered counsellors, HPC registered psychologists and BABCP or UKCP registered psychotherapists, only RMNs and ASWs with University Diplomas in Counselling or Psychotherapy need to provide proof of their regular supervision.

4.6 **Level 3 Accreditation**

There are over ten staff across the Network in possession of relevant Diplomas in Counselling (i.e. University accredited, with accredited, logged supervision hours), and very experienced in cancer and palliative care, but who are not fully BACP accredited. Currently the government is encouraging the registration of counsellors and psychotherapists, most likely via the Health Professions Council (HPC, maybe in 2011-12), just like it has with practitioner psychologists (from July 2009). No staff in or out of the NHS will be permitted to practice as counsellors or psychotherapists without it once registration is required. Trusts, Hospices and Community Teams have the opportunity to support these staff in achieving full BACP (or otherwise) compliance, which will automatically lead to HPC compliance.

The Psychological Support NSSG will liaise with local hospices to discuss their priorities in this area.

4.7 **Level 3 Staffing Levels**

Currently only two staff are known to meet the Level 3 criteria: Dr Ann Bond, registered psychotherapist, three sessions at the Clinical Haematology Service at the QE, and Mr Desmond McGuire, RMN and holding a Counselling Diploma, employed full time as ENT counsellor by UHB.

A strategy to develop staff identified in point 4.6 above is needed, to be developed in conjunction with local hospices, as these employ most of these staff.

5 **References**

References:


4. PBCN Psychology Mapping document (ATTACHED)

Mrs Smith, 42, is married and the mother of two children (a boy, 12 and a girl, 15). She has been diagnosed with breast cancer which is being treated with a lumpectomy, chemotherapy and radiotherapy.

**Appendix One: the Four tier model**  
Example of the 4 levels in practice

<table>
<thead>
<tr>
<th>Level</th>
<th>Presentation of Distress</th>
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<tr>
<td>1</td>
<td>Her prognosis is hopeful but still uncertain. She is approaching the end of her chemotherapy and has been off work for six months. She is fatigued, describes herself as a bit flat and listless. She finds herself thinking about her cancer a lot and feels unusually irritable with her husband and children.</td>
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<tr>
<td>2</td>
<td>In addition to the above, Mrs Smith feels she often does not want to see people. She frequently expresses worry about the future and about bodily symptoms, which is aggravated by uncomfortable side-effects from chemo- and radiotherapy. There are times when she can enjoy herself but often she feels a bit anxious and low in mood. On the whole, however, she feels that she is coping.</td>
</tr>
<tr>
<td>3</td>
<td>Mrs Smith has been feeling low for several months. She feels tired and achy, overwhelmed with household tasks and worries that she is not able to be a good mother and that she has become a burden on her family. She is convinced that the cancer will return. She feels that she has lost the person she used to be, feels disfigured and unattractive and that she is drifting apart from her husband. He appears unable to talk about her fears and has stopped touching her. She has begun dreading a return to work and has lost confidence; she had her first panic attack going out last week.</td>
</tr>
<tr>
<td>4</td>
<td>Mrs Smith feels hopeless and depressed and has thoughts of ‘just ending it all’. This frightens her as it reminds her of the nervous breakdown she had five years ago when her mother died of breast cancer. She is convinced that her daughter will ‘inherit’ breast cancer too and feels devastatingly guilty about this. Meanwhile biopsy showed tumour spread and eventually she had to have a mastectomy; now she feels ‘an ugly freak’, and this evokes feelings about when she had anorexia nervosa as a teenager. Her husband is frustrated with her withdrawal and, feeling angry and helpless, has started spending a lot of time at the pub. His work is suffering and that increases her fears about finances. Their daughter seems more withdrawn and their son has been getting into trouble at school a lot.</td>
</tr>
</tbody>
</table>

This table is not meant to show the development of a single case over time, but to illustrate four separate hypothetical cases of increasing complexity. The same personal details and diagnosis have only been used for clarity of comparison. Similarly, referrals do not have to ‘work up’ through the levels; i.e. a professional working at L1 or L2 can directly refer to an L4 professional if the complexity of the case warrants it.
Appendix 2  Practice at Level 2 as outlined in the Supportive and Palliative Care IOG.

Assessment
5.26 Professionals operating at this level should be able to assess for psychological distress at key points in the patient pathway, including:
- around the time of diagnosis
- during treatment episodes
- as treatment ends
- at the time of recurrence.

5.27 These assessments should be undertaken by designated professionals (such as nurse specialists, social workers and GPs), appropriately trained in assessing for psychological distress. They should include the impact of cancer on people’s daily lives, mood, family relationships (including sexual relationships) and work. Those undertaking an assessment should elicit worries and other feelings by establishing trust and listening in a permissive and non-judgemental manner. The assessment process itself may lead to the resolution of concerns; if not, it should result in an offer of appropriate psychological support. Patients experiencing significant psychological distress should be offered referral for specialist psychological support/intervention.

Intervention
5.28 Level 2 involves psychological techniques such as problem solving delivered by trained and supervised health and social care professionals to manage acute situational crises at key points in the patient pathway. Clinical nurse specialists, among others, might be trained and supported to undertake assessments and to deliver relevant interventions.
Appendix 3  The peer review measures supporting this section of the IOG

PSYCHOLOGICAL SUPPORT MEASURES GATEWAY No. 14674 - AUGUST 2010 17

The Level 2 Training Programme
10.1 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.

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
10-1E-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.

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

Measure details & demonstration of compliance
Support for Level 2 Practitioners
10-1E-103x There should be named practitioners for the network, who themselves are competent at, 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
10-1E-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.
Training and Education Strategy

10-1E-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 the appendix;

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 % 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.

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 discipline 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 4  Level 2 Programme Content and Learning Goals

Assessment
5.26 Professionals operating at this level should be able to screen for psychological distress at key points in the patient pathway, including:
- around the time of diagnosis
- during treatment episodes
- as treatment ends
- at the time of recurrence.

5.27 These assessments should be undertaken by designated professionals (such as nurse specialists, social workers and GPs), appropriately trained in screening for psychological distress. They should include the impact of cancer on people’s daily lives, mood, family relationships (including sexual relationships) and work. Those undertaking an assessment should elicit worries and other feelings by establishing trust and listening in a permissive and non-judgemental manner. The assessment process itself may lead to the resolution of concerns; if not, it should result in an offer of appropriate psychological support. Patients experiencing significant psychological distress should be offered referral for specialist psychological support/intervention.

Intervention
5.28 Level 2 involves psychological techniques such as problem solving delivered by trained and supervised health and social care professionals to manage acute situational crises at key points in the patient pathway. Clinical nurse specialists, among others, might be trained and supported to undertake assessments and to deliver relevant interventions.

Level 2 psychological skills study day
A one day workshop this workshop aims to increase confidence, knowledge and skills in screening, assessment and basic psychological intervention of patients with cancer

Course aims
- To continue to use their current knowledge and skills or psychological support
- Take some new skills and approaches into their job
- Learn about other skills they are not keen/feeling capable to implement yet, but that they can learn about.
Appendix 5  List of Trainers and Clinical Supervisors

Level 2 Training in Psychological Support is delivered by two experienced trainers, with one of them meeting Level 3 or Level 4 of the IOG. Here is the List of Trainers and assessors of Level 2 Training within the Pan Birmingham Cancer Network [as per Peer Review Measure 10-1E-102x]:

Trainers and Clinical Supervisors
- Dr Darja Brandenburg, Good Hope Hospital,
- Ms Liz Coombes, Queen Elizabeth Hospital,
- Dr Meera Shah, Queen Elizabeth Hospital,
- Mr Robin Pajmans, Heart of England Hospital and Sandwell Hospital,
- Dr Iñigo Tolosa, Queen Elizabeth Hospital.

External Clinical Supervisors
- Dr Ruth Williams
- Dr Ruth Howard

Contracted in but meet the Network Clinical Governance Criteria

Other Level 3 or 4 trainers can be developed, possibly by running a Level 2 workshop with a current one, etc. It is recommended that the second trainer is a local senior clinician, trained and experienced in psychological support, and who further understands local needs and protocols (lead cancer nurse, experienced CNS, palliative care physician, AHP, etc with further training in Psychological Support, i.e. Level 2 Psych Support Training, Jenkins & North Psychological Assessment training, CBT 1st Aid training).