National Cancer Peer Review Programme

Manual for Cancer Services:
Rehabilitation Measures
Version 2.0
Following a three month consultation period, this is the final version of the Rehabilitation measures for inclusion in the Manual for Cancer Services. The measures can also be found on the CQUINS website at www.cquins.nhs.uk.
# REHABILITATION SPECIFIC 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 11-1A-201j.

• The first part indicates the year the measure was first issued, for example 11 is 2011.
• The second part relates to a particular topic see below, for example 1A.
• 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 201j (see below).

Index of Suffix Letters

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<td>Generic to all tumour sites</td>
<td>Specialist Palliative Care specific</td>
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<td>b</td>
<td>s</td>
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<tr>
<td>Breast specific</td>
<td>Chemotherapy specific</td>
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<td>Lung specific</td>
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<td>Haematology specific</td>
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<tr>
<td>Head and Neck specific</td>
<td>Skin specific</td>
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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 http://www.cquins.nhs.uk.
INTRODUCTION

Rehabilitation in relation to cancer can be preventative, restorative, supportive and palliative. It is recognised that patients may have rehabilitation needs throughout their care pathway, and that their needs should be assessed at key points on the pathway.

The measures are based on the recommendations in the Improving Supportive and Palliative Care for Adults with Cancer (the IOG). The IOG uses the '4-level' model of care as an aid to service and workforce planning. The Network AHP Leads group have defined national levels of care for rehabilitation see appendix 2. Measures dealing with other aspects of the IOG appear elsewhere in the Manual.

For practical purposes, in order to define a limit to the peer review for this area of service, the measures consider rehabilitation to apply only to the services offered by the four Allied Health Professions (AHPs): Physiotherapy, Occupational Therapy (OT), Speech and Language Therapy (SLT) and Dietetics; but in addition, if a lymphoedema service is offered by personnel outside the above AHPs (usually by specially trained nurses) this separate service would also be included. Otherwise, a lymphoedema service will be considered for the purposes of the peer review, as being included in the activities of the 4 AHPs and is not systematically and separately identified in the measures. In either case, the lymphoedema service should be included in what the measures require (service specification, guidelines etc).

The measures and the peer review for cancer rehabilitation are in two parts.

(i) Establishing a network cancer rehabilitation lead and a network cancer rehabilitation group with specific membership, terms of reference and administrative support. This is the responsibility for review purposes of the chair of the network board and is reviewed under topic 1A in the Manual for Cancer Services. Compliance counts towards the review of the network board.

(ii) The functions of the network cancer rehabilitation group: agreeing criteria for the 4-level model, a survey of current service provision, agreeing cancer rehabilitation guidelines, developing a service specification, needs assessment and training and education strategy and providing a rehabilitation section for each locality’s cancer services directory. These functions are the responsibility for review purposes of the network cancer rehabilitation lead (who should also chair the network cancer rehabilitation group) and are reviewed under topic 1E in the Manual for Cancer Services. Compliance counts towards the review of the network cancer rehabilitation group.

Further notes on implementing the 4-level model and on producing the rehabilitation guidelines, the service specification, needs assessment and training and education strategy can be found in the introduction to topic 1E and in the relevant measures themselves.
### THE NETWORK CANCER REHABILITATION GROUP

**Network Cancer Rehabilitation Group**

**11-1A-301v** The Network Board should agree a single named lead for cancer rehabilitation for the network, who should be a qualified member of one of the Allied Health Professions and a member of the network palliative care group. The Network Board should agree a list of responsibilities, and specified time in their timetable or job plan, for the role of network cancer rehabilitation lead.

*Notes:*

The cancer rehabilitation lead should also be the chair of the network cancer rehabilitation group. See [appendix](#) 1 for an example list of responsibilities (for illustration only).

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

- the network cancer rehabilitation lead, who should be the chair of the group;
- in addition a representative of each of the four AHPs;
- two user representatives;
- named secretarial/administrative support.

*Notes:*

- The group may choose additional members. For instance, it is strongly recommended that if there is a lymphoedema service in the network which is lead by and/or delivered by nurses, one of them should be a nurse member of the group.
- It is strongly recommended that the members of the network palliative care group which represent AHPs and/or rehabilitation are drawn from members of the network cancer rehabilitation 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.

There should be terms of reference for the Network Cancer Rehabilitation Group which include:

- The group should be recognised as the network primary source of opinion on issues relating to cancer rehabilitation and for co-ordination and consistency across the network on such issues.

*Notes:*

- These are terms of reference. Detailed measures for the functions of the group are to be found in [topic](#) 1E.
- The Network Board may agree additional terms of reference.

**Compliance:** The named lead agreed by the Chair of the Network Board.
The list of responsibilities and specified time agreed by the cancer rehabilitation lead and Chair of the Network Board.
The list of named members and what they represent, agreed by the Chair of the Network Board.
The list of members of the network palliative care group.
The terms of reference agreed by the Chair of the Network Board and the network cancer rehabilitation lead.
Introduction

These measures cover:

• Agreeing network criteria for implementing the 4 level model of care for cancer rehabilitation.
• A baseline mapping of the current provision of cancer rehabilitation in the network.
• The development of cancer site specific rehabilitation pathways.
• The development of a service specification.
• From the service specification and the current service provision, the development of a service needs assessment.
• The development of a training and education strategy resulting from the service needs assessment.
• A rehabilitation section for each locality’s cancer services directory.

National guidelines for Cancer and Palliative Care Rehabilitation provide an evidence base for the subsequent measures and a framework for rehabilitation services.

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<tr>
<th>MEASURE DETAILS &amp; DEMONSTRATION OF COMPLIANCE</th>
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<tr>
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<tr>
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<td>Baseline Mapping of the Current Service Provision</td>
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<td>11-1E-101v</td>
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<tr>
<td>The Network Cancer Rehabilitation Group should produce a baseline mapping of the current service provision for cancer rehabilitation in the network, which fulfils the following every three years:</td>
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<tr>
<td>i) according to the national rehabilitation baseline mapping tool - AHP mapping tool kit available from the National Cancer Action Team.</td>
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<tr>
<td>Compliance: The baseline mapping agreed by the Network Cancer Rehabilitation Lead. The reviewers should verify that it fulfils (i) above.</td>
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<tr>
<td>The Network Cancer Rehabilitation Group should agree rehabilitation pathways with each network site specific group for the cancer site(s) which it deals with. The pathways should specify:</td>
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<tr>
<td>• the particular clinical indications for referral to rehabilitation services;</td>
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<td>• the relevant intervention or procedure or therapy required;</td>
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<tr>
<td>• the contact points for referrals.</td>
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<td>Notes:</td>
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<tr>
<td>A single integrated rehabilitation pathway should be agreed with each NSSG, which covers any or all of the four AHPs as relevant.</td>
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<td>Where there is no NSSG in the network for a given cancer site, guidelines should be agreed with the NSSG for the network to which patients with that cancer are referred.</td>
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<tr>
<td>The Network Cancer Rehabilitation Group should agree the rehabilitation pathway for patients with breast cancer.</td>
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<td>Compliance: The guidelines agreed by the Network Cancer Rehabilitation Lead and the Chair of the Breast Cancer NSSG.</td>
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<td>The Rehabilitation Pathway for Patients with Lung Cancer</td>
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<td>The Rehabilitation Pathway for Patients with Upper GI Cancer</td>
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<td>The Rehabilitation Pathway for Patients with Urological Cancer</td>
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<td>Compliance:</td>
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<td>The Rehabilitation Pathway for Patients with Skin Cancer</td>
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<td><strong>11-1E-110v</strong></td>
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<td>Compliance:</td>
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## MEASURE DETAILS & DEMONSTRATION OF COMPLIANCE

### The Rehabilitation Pathway for Patients with Brain and CNS Malignancy

**11-1E-111v**

The Network Cancer Rehabilitation Group should agree the rehabilitation pathway for patients with brain and CNS malignancy.

**Compliance:**

The guidelines agreed by the network cancer rehabilitation lead and the Chair of the Neuro Oncology Disease Site Group.

### The Rehabilitation Pathway for Patients with Sarcoma

**11-1E-112v**

The Network Cancer Rehabilitation Group should agree the rehabilitation pathway for patients with sarcoma.

**Compliance:**

The guidelines agreed by the network cancer rehabilitation lead and the Chair of the Sarcoma Advisory Group.

### SERVICE SPECIFICATION

#### Introduction

The service specification is the quantifiable level of services that are required to support cancer and palliative care rehabilitation needs in the network.

### Network Service Specification for Cancer Rehabilitation

**11-1E-113v**

The Network Cancer Rehabilitation Group should produce a network service specification for cancer rehabilitation, which fulfils the following:

1. It should be expressed in terms of WTEs of practitioner time, using the levels illustrated in the *appendix 2* and each of the four AHPs, plus a separate lymphoedema service, if relevant.
2. It should be estimated from the required interventions described in the cancer site specific rehabilitation pathways.
3. It should take into account the MDT workload.
4. It should specify the settings (Hospital, community) where the service is delivered and from which providers the service is proposed to be commissioned.
5. It should specify the access and waiting time standards.
6. It should be expressed as the service required for each locality in the network.

**Compliance:**

The service needs specification, agreed by the network cancer rehabilitation lead. The reviewers should enquire as to the methods used to produce the service specification and verify that it fulfils (i) to (vi) above.

### SERVICE NEEDS ASSESSMENT

#### Introduction

The service needs assessment is the difference between the services required (service specification measure **11-1E-113v**) and the current service provision available as identified by the baseline mapping (measure **11-1E-101v**).

### Network Service Needs Assessment for Cancer Rehabilitation

**11-1E-114v**

The Network Cancer Rehabilitation Group should produce a network service needs assessment for cancer rehabilitation which fulfils the following:

1. It should be based on the difference between the service specification (measure **11-1E-113v**) and the baseline mapping (measure **11-1E-101v**).
2. It should be expressed in terms of WTEs of practitioner time, using the levels illustrated in the *appendix 2* and each of the four AHPs, plus a separate lymphoedema service, if relevant.
3. It should specify the settings (Hospital, community) where the service is delivered, specifying the settings for the service delivery and proposed providers, access and waiting times standards.

**Note:**
**MEASURE DETAILS & DEMONSTRATION OF COMPLIANCE**

All care levels and all AHPs may not be relevant to each cancer site, and there may be more than one option for service provision.

**Compliance:** The service needs assessment agreed by the network cancer rehabilitation lead. 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.

**Network Service Development Strategy for Cancer Rehabilitation**

**11-1E-115v** The Network Cancer Rehabilitation Group should produce a network service development strategy which fulfils the following:

i) It should describe the proposed changes required to implement the service specification.

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

*Note:* The service development strategy should be a three year strategy which is reviewed annually.

**Compliance:** The service development strategy, agreed by the network cancer rehabilitation group. The reviewers should verify that it fulfils (i) and (ii) above.

**Network Cancer Rehabilitation Training and Education Strategy**

**11-1E-116v** The Network Cancer Rehabilitation Group should produce a network cancer rehabilitation training and education strategy which fulfils the following:

(i) It should be based on the gap between practitioners' qualifications, experience and competencies identified as required by the service needs assessment, and those of the existing practitioners, and should take into account the changes in training and education needs consequent to the service development strategy.

(ii) It should deal with post basic training specific to cancer practice, for basically trained AHPs.

(iii) It should also provide for 'specialist' training to create 'advanced' practitioners.

(iv) It should be set over a defined, three years, with a start and end date.

(v) It should set a pragmatic target for a given number or percentage of practitioners to be trained to stated levels of practice on the four level model.

(vi) 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.

**Compliance:** The cancer rehabilitation training and education strategy, agreed by the network cancer rehabilitation lead. The reviewers should enquire as to how it was produced and verify that it fulfils (i) to (vi) above.

**Network Service Directory for Cancer Rehabilitation**

**11-1E-117v** The Network Cancer Rehabilitation Group should produce a rehabilitation section for each locality directory in the network.

It should list the contact points for cancer rehabilitation services relevant to the locality.

**Compliance:** The rehabilitation section agreed by the network cancer rehabilitation lead, for each locality directory in the network and each agreed by the chair of the relevant locality group.
APPENDIX 1 - Outline of Role

Network Lead Allied Health Professional (AHP)

Introduction

This section describes the appropriate scope for this role and revises the key responsibilities of the network lead AHP.

Scope of the Post

To be responsible for developing the contribution of allied health professionals to cancer rehabilitation and survivorship, with effective multi-professional collaboration, and service user participation. This role will provide professional leadership for assessing need, planning provision and informing the commissioning process to improve cancer rehabilitation services across the network.

Key Responsibilities

Professional engagement with provider organisations

- Promote effective communication across professional and organisational boundaries.
- Ensure there are named lead AHPs for Trusts and establish working links with any specialist AHPs from the network site-specific groups. To include links with cancer leads for PCTs.
- Ensure succession planning and leadership development is encouraged with opportunities for Trust cancer AHPs to develop key skills required for progression to network lead AHP posts as required.
- Ensure that network strategy relating to rehabilitation is inclusive of Trust clinical expertise.

Professional leadership within network team and network structures

- Provide professional advice to the management team, the cancer network groups and network board.
- Advise and support the service improvement lead to ensure the effective implementation of the Modernisation Agenda, and the redesign of local cancer rehabilitation services as required.
- Lead or support in the adoption and implementation of nationally determined priorities including the NICE Improving Outcomes Guidance and the CRS.
- Lead and provide direction to the relevant supportive and palliative care network groups to support the implementation of the supportive and palliative care guidance.
- Provide advice and support to the network site specific groups raising the profile of cancer rehabilitation issues relevant to those specific sites.
- Advise on the necessary actions required to prepare for peer review and ensure that resulting action plans are agreed and progress regularly monitored.

Workforce planning

- Assess the needs of the AHP workforce and develop a common education strategy with local stakeholders (including SHA and HEI’s).
- Develop and promote implementation of a strategy for recruitment, retention and succession planning across the network for allied health professionals.
- Ensure that the workforce component of the network strategy for rehabilitation is robust and agreed by the network board.
Research

- Promote a comprehensive programme of research/audit in cancer and palliative care rehabilitation is established across the network.
- Encourage evidence based practice through research, audit and training.

Commissioning

- Provide advice and support in the development and implementation of the network service delivery plan and enabling strategies as it relates to AHPs and cancer rehabilitation.
- Provide AHP leadership for the implementation of cancer rehabilitation service reconfiguration arising from the Implementing Outcome Guidance and other NICE guidance.
- Ensure active Rehabilitation input into commissioning arrangements for LDPs and service reconfiguration.

Other

- As part of the national lead AHP forum, provide advice and actively contribute to any new national initiatives relating to the cancer rehabilitation agenda.
- The network lead AHP will work closely with the Modernisation Agency, Cancer Action Team, Cancer Policy Team, Department of Health and the Healthcare Commission to advise, contribute and shape national initiatives including the cancer rehabilitation agenda.
APPENDIX 2 - Levels of Care

Recommended model of rehabilitation assessment and support

Those involved at each level and their functions are as follows:

Level 4

Involves advanced practice and expert AHPs who work mostly or exclusively with patients who have cancer (more than 75% of their time).

They will provide expert advice and input for clearly defined rehabilitation needs.

Practitioners with the skills to provide expert care will have received higher level training (possibly accredited) and as part of their role may provide post graduate training within the specialty.

They will be highly experienced senior or consultant practitioners with a defined amount of experience.

Level 3

Involves experienced, senior AHPs, with higher than basic levels of training in rehabilitation techniques and approaches to managing patients with cancer and/or palliative care needs.

They will deliver interventions which require knowledge of the impact of the disease and its treatment.

They may have a varied caseload of which 25-75% of their time is focused on cancer and palliative care.

Level 2

AHPs who provide treatment at level 2 deliver routine assessments of rehabilitation needs. They will be a graduate in one of the Allied Health Professions. Patients with cancer and palliative care needs form a small percentage of what is often a mixed caseload. Patients may be referred to a more experienced colleague according to need.

AHPs working at this level will have a basic understanding of cancer and the impact of the disease and its treatment.

Level 1

This involves all people who provide day to day care including the patient and the carer. Patient's needs are assessed using an agreed assessment tool with basic interventions initiated by a healthcare professional.

Health care assistants and assistant practitioners working under the guidance of a healthcare professional can also provide care at this level.

Referrals may be made to the next appropriate level of care. Because rehabilitation is about the ability to function and perform everyday activities, it is hard to calculate rehabilitation input at this level.