Cancer Prehabilitation and Rehabilitation: Service Improvement Tool

Background

This Wessex Cancer Alliance (WCA) prehabilitation and rehabilitation service improvement audit tool for people both *using* services and *providing* services compliments what good looks like in prehabilitation and rehabilitation for people with cancer' toolkit to enable standardised self and peer assessment.

Wessex Cancer Alliance's (WCA) prehabilitation and rehabilitation service improvement tool is for:

- people *using* services, and
- *teams providing* prehabilitation and/or rehabilitation for people with cancer.

The tool compliments our 'what good looks like in prehabilitation and rehabilitation for people with cancer' toolkit to enable standardised self and peer assessment.

About this service improvement tool and its scope

This service improvement tool will support health and care staff who are designing, developing and delivering prehabilitation and rehabilitation for people with cancer.

This includes Cancer Alliances, Integrated Care Boards, cancer care teams, primary care teams, healthcare provider organisations, generic community rehabilitation services, commissioners, third sector organisations and education and research institutions.

The following five values are included in the service improvement tool – the '**PACED'** approach:

Value 1: **P**erson-focused (in planning, prioritisation and goal setting, decision making and delivery of care)

Value 2: **A**ccessible and timely

Value 3: **C**o-ordinated (by a care MDT) in partnership with the person

Value 4: **E**xperience of care is optimal

Value 5: **D**elivered with skill and competence

How to use this tool

1: Help your team before using by circulating the tool and toolkit. Ask the team to review the documents in advance to allow them to prepare for a team discussion.

2: Schedule a team meeting/time to complete the tool - we estimate this will take 20-30 mins

3: Plan service user feedback, identify when this will be carried out and when the results are reviewed/discussed

4: Schedule a follow up meeting to discuss SU results

5: Agree actions and plan to implement

6: Schedule annual review

<u>This tool is divided into two parts.</u>

Section 1 – is an overview of the service for completion.

Section 2-6 – Five values have been identified which cover all elements of the service design, development and delivery. Each of the five values has several statements relating to your service.

- You are asked to rate each statement from **never** (0 points) to **always** (3 points).
- At the end of each section, you will be asked to add up your scores, take time to identify areas where you are performing well and areas where you may like to consider service improvement opportunities.
- The evidence section enables you to include evidence where possible for example: audits, patient feedback, patient satisfaction and questionnaires.

The total score will indicate whether you are at bronze, silver or gold level as per the score ranges below:

Gold: score of 81-93

Silver: score of 60-80

Bronze: score <59

When you submit your completed tool the Wessex Cancer Alliance will award your service with a certificate based on the level achieved.

This tool has been designed with the aim of regularly taking the time to check in on your service. It is recommended that this tool is utilised at least every 12 months and that progress is measured, recorded and celebrated and recorded.

Section 1 – Overview of the service

Please complete the details set out below.

	Service overview	
Name of your service		
Lead contact person		
Service contact details		
Location of service		
Type of service provider	NHS	
	Voluntary/ third sector	
	Local authority	
	Other (please add details)	
Where and type of service provided	**Please select all that apply and list others that may be relevant in the 'other' space**	
	Community	
	Primary care	
	Home	

	Secondary care inpatient	
	Secondary care outpatient	
	Tertiary/specialist inpatient	
	Tertiary/specialist care outpatient	
	Hospice	
	Cancer specific service	
	Other (add details)	
Stage in pathway when patients are seen by the service	**Please tick all that apply**	
	Pre-diagnosis	
	Diagnosis and before treatment	
	During treatment	
	After treatment	
	Palliative care	
	End of life care	
Interventions and support delivered to patients	**Please tick all that apply**	
	Universal	
	Personalised prehabilitation care plans are developed for each person with cancer	
	Making referrals to other healthcare professionals	
	Advising on self-management	
	Health coaching	
	Universal interventions including the promotion of healthy lifestyle in people living with cancer which may include exercise and/or nutrition and/or emotional support/smoking and alcohol advice	
	Supporting those with commonly presenting side effects and rehabilitation needs	

	Targeted	
	Exercise	
	Nutrition	
	Psychosocial support	
	Specialist	
	Delivering specialist interventions to people with severe functional and cognitive impairment	
	Complex emotional, financial or practical needs to support patients with activities of daily living	
	Delivering specialist interventions to people having radical surgery or combinations of treatments	
	Delivering specialist interventions to people with advanced diseases, complex palliative and end of life care issues	

Section 2: Values

Value 1: : **P**erson-focused (in planning, prioritisation and goal setting, decision making and delivery of care)

- Individualised service which involves the person as an equal partner in both decision making, planning, prioritising needs and goal setting.
- Is outcome/goal focused and considers the person holistically not just in the context of their cancer diagnosis.
- Incorporates practical and emotional support.
- Ensures the person is aware of what is going to happen including what prehabilitation and rehabilitation services are available to them
- Includes input from both carers and family members e.g. understanding needs/concerns of the person, the persons prehabilitation/care plans, if-then planning, or if a service is provided for a person ensuring family members understand and are supported as well e.g. family behaviour change) – recognising that cancer does not just affect the person with the diagnosis

		Never (0)	Sometimes (1)	Often (2)	Always (3)	We can evidence this by…..
1.	Puts people and their families/carers at the heart of everything we do.					
2.	We take time to ask people what matters to them. This is documented in their records and used to inform goals and plans for support.					
3.	We provide individualised personalised care tailored to each person and their needs and current situation. These plans are based on appropriate screening (link to toolkit section) and assessment tools (link to toolkit section) being used alongside personalised conversational skills to understand needs and provide a guided/focused approach.					
4.	We consider the person holistically considering all aspects of their life – including practical, psychological and physical support.					
5.	We provide care that is pro-active, helping people to recognise and work towards goals that are self-identified and that are meaningful to them. Based on screening and assessment (link to toolkit section) tailored prehabilitation and/or rehabilitation interventions (link to toolkit section) are provided.					
6.	We ensure patients and their families/carers understand and agree to what their prehabilitation and rehabilitation will involve. including co-creating goals they are working toward/intended outcomes of their care.					
7.	We make time to regularly review prehab/rehab plans and progress toward goals to ensure they are still relevant and meaningful and adjust accordingly.					
8.	We involve the patients families, carers and support network in both planning and decision making (as appropriate) recognising that care affects the whole family.					

9.	We advise about relevant services that are available to them in their area relevant to their needs and identified goals.					
	TOTALS					
	Examples of what we do well					
	Examples of challenges and how we plan to address these					
	Identified opportunities for improvement					

Total score for value 1	/27

Value 2: Accessible and timely

- Is easily accessible to all (and consistent)
- available at the time in the pathway when needed (regardless of trajectory of disease)
- enough time is allocated in appointments
- looks at the whole pathway of care
- allows access to long-term rehabilitation if needed
- Is accessible to all that require it (has made consideration around equitable care: access to interpreters, wheelchair access etc.)

		Never (0)	Sometimes (1)	Often (2)	Always (3)	We can evidence this by…..
1.	There is awareness in the area that the service is available (what/who/when it is for) and it is clearly signposted to for people that need it The service has the ability to enable people to self-refer.					
2.	The service is accessible at the following points along the patient pathway or signposts to an appropriate service for the persons needs e.g. referring back to community and primary care after completion of treatment					
	• Pre-diagnosis					
	• Diagnosis and before treatment					
	• During treatment					
	• After treatment					
	• Palliative care					
	• End of life care					
3.	There is equitable access to the service for all who need it. Consideration is given to how the service is accessed including access to interpreters, different forms of information are available, there is access for wheelchairs and provision of transport to service.					
4.	The services offers treatment at a time and place including virtual support, that suits individuals without undue delay [1]. People are offered choice and supported to access times that work for them.					
5.	The service allocates sufficient times for appointments. This is tailored according to individual need/circumstances.					

[1] Refer to your local criteria

6.	The service ensures outpatients are seen within 10 minutes of their appointment time and inpatients within one working day from being referred.					
	TOTALS					
	Examples of what we do well					
	Examples of challenges and how we plan to address these					
	Identified opportunities for improvement					

Total score for value 2	/18

Value 3: Co-ordinated (by a care MDT) in partnership with the person

- Consistent coordinated care with good communication between the whole MDT (including the person with cancer) – including use of an end of treatment summary and care plan.
- Good signposting (including knowledge of available services)
- Makes sure the person is aware of what is happening and will happen including need for cancer rehabilitation and what services are available
- Regular updates provided to the person's primary care team
- Good communication in and out within a service

		Never (0)	Sometimes (1)	Often (2)	Always (3)	We can evidence this by…..
1.	The service discusses all patients regularly within a local MDT or equivalent meeting. The service has agreed routes for escalation (link to monitoring escalation and evaluation at a universal, targeted and specialist levels) and when to involve other healthcare professionals.					
2.	Everyone who uses our service is provided with a lead point of contact including contact numbers and/or an out of hours number for emergencies as appropriate.					
3.	The service develops (in partnership with the person) a coordinated personalised care and support plan which includes input from all key relevant professionals and as informed by the needs/priorities of the individual.					
4.	Where a person is receiving treatment from more than one service, we make sure that the other services (s) is/are aware of what we are doing, and vice versa.					
5.	We provide regular updates to the patients GP and wider clinical team as appropriate and correspondence includes the person with cancer (unless they choose not to receive it)					
	TOTALS					
	Examples of what we do well					

	Examples of challenges and how we plan to address these
	Is there anything you would add to your service?
	Identified opportunities for improvement

Total score for value 3	/15

Value 4: Experience of care is optimal

- Care given is compassionate, supportive and understanding
- Services actively seek insight to learn about experience of care

		Never (0)	Sometimes (1)	Often (2)	Always (3)	We can evidence this by…..
1.	Patients say that the service is supportive and understanding					
2.	Patients say that the service is enabling and empowering. We ask people about their experience of care through a clear process/methodology for gaining feedback about the service from people that use it. We ensure feedback is accessible.					

3.	We work with service users to learn about and improve the experience of care.					
4.	The service provides opportunities to meet others who have experienced similar issues (where appropriate).					
	TOTALS					
	Examples of what we do well					
	Examples of challenges and how we plan to address these					
	Is there anything you would add to your service?					
	Identified opportunities for improvement					

Total score for value 4	/12

Value 5: Delivered with skill and competence

The service is provided by trained professionals who are able to provide expert care where the ACCEND framework [2] is used to underpin the development staff core capabilities in practice, education opportunities and career pathways.

		Never (0)	Sometimes (1)	Often (2)	Always (3)	We can evidence this by…..
1.	The service is provided by healthcare professionals who have been deemed competent in their knowledge, skills and capabilities in cancer and its treatments and options clearly including: • Types of cancer treatments (Foundations of cancer care Catalogue (learninghub.nhs.uk) • Tests and results commonly used (Foundations of cancer care Catalogue (learninghub.nhs.uk) • Symptom management including long term and late effects and complications (Link to Rehabilitation interventions in toolkit)					
2.	The service is provided by healthcare professionals who have been deemed competent in their knowledge, skills and capabilities in their understanding of the issues patients may experience when completing treatment and transitioning from acute care					
3.	Ensure staff have access to further training, education, development and support.					
4.	Staff providing prehabilitation, rehabilitation at a universal level should have the ability to escalate concerns/issues.					

[2] Aspirant Cancer Career and Education Development programme | Health Education England (hee.nhs.uk)

	Staff providing prehabilitation and/or rehabilitation at a targeted and specialist level should have clinical supervision in place. (section 3.8 and 3.9) Staff providing psychological support should have access to appropriate psychological clinical supervision(link to 3.11)					
5.	The service actively seeks to promote behaviour change through Making Every Contact Count (MECC), Very Brief Advice (VBA) Motivational Interviewing, health coaching and other behaviour change approaches.					
6.	Ensures all care given makes optimal use of available evidence by basing it on evidence based practice.					
7.	Identifies areas that require further research and seeks to add to the evidence base.					
	TOTALS					
	Examples of what we do well					
	Examples of challenges and how we plan to address these					
	Is there anything you would add to your service?					
	Identified opportunities for improvement					

Total score for value 5	/21

Total scores	Your scores
Value 1	/27
Value 2	/18
Value 3	/15
Value 4	/12
Value 5	/21
Total of all scores	**/93**
Percentage score	

Gold: score of 81-93

Silver: score of 60-80

Bronze: score <59

Summary
Action areas for next 12 months
Next steps