<table>
<tr><th colspan="5">Report to the Wessex Cancer Alliance Board</th></tr>
<tr><td>**Title:**</td><td colspan="4">**Psychological Support across Cancer Services in Wessex: A Plan for Improvement**</td></tr>
<tr><td>**Sponsor**</td><td colspan="4">Wessex Cancer Alliance</td></tr>
<tr><td>**Author**</td><td colspan="4">Dr Andrew Merwood,
Dr Teresa Corbett
Abigail-Sara Desouza
Stephanie Heath</td></tr>
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<tr><td>**Purpose**</td><td>**Assurance or reassurance**</td><td>**Approval**</td><td>**Ratification**
X</td><td>**Information**</td></tr>
<tr><td>**Summary of paper:**</td><td colspan="4">In this report, we set out to understand what psychological support is required by people affected by cancer throughout Wessex, calculating the level of psychological need among those newly diagnosed with cancer and mapping the available psychological support services in acute hospitals across the region in the year 2022-23. We also sought to understand the provision of training and supervision to support the wider cancer workforce and took a horizon-scanning approach to understand the potential roles of NHS Talking Therapies and the third sector in contributing to cancer psychological care via a hub-and-spoke model.
While the gap in services we have found is significant, so too is the impact of unmet psychological need among on people with cancer, their families, cancer clinicians and the wider health economy. We therefore believe that this gap must now be addressed, and we have outlined five key recommendations to ensure immediate action, which are:
1. A consensus plan for the commissioning and delivery of specialist (Level 3-4) psychological support, with equity across the region.
2. To embed psychosocial care through the provision of psychological training and supervision for the universal (Level 1) and enhanced (Level 2) workforce.
3. To implement a hub-and-spoke model of comprehensive personalised cancer psychosocial support, with different levels of intervention across community and acute settings.
4. To take a standardised approach to measuring the impact of services.
5. To develop services that are inclusive, improving access to cancer psychological care across the communities we serve.</td></tr>
<tr><td>**Implications:**</td><td colspan="4">Clinical, Organisational</td></tr>
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(Clinical, Organisational, Governance, Legal?)	
Key risks and mitigations:	**Secondary care focus**
Summary: Conclusion and/or recommendation	We have set ambitious goals to support the implementation of these recommendations and to achieve these, we will need to work in partnership with a variety of stakeholders including NHS provider organisations, Integrated Care Boards, Clinical Health Psychology departments and Psychological Professionals, Specialist Palliative Care services, NHS Talking Therapies, the third sector, and of course experts by experience. We hope that we can now begin to improve the psychological support for people affected by cancer across Wessex, and we look forward to working with our partners and stakeholders as we begin to enact our implementation plan.

Psychological Support across Cancer Services in Wessex: A Plan for Improvement

Results of scoping exercise 22/23

October 2024

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We would like to thank the members of the Wessex Cancer Alliance (WCA) Psychosocial Support Special Interest Group (SIG), chaired by Jane Winter, WCA Lead for cancer Nursing and Allied Health professionals (AHPs), for their expert guidance throughout the planning and implementation of this scoping exercise. We thank Maria Noblet, who undertook this work in her former role as Consultant Nurse at Portsmouth Hospital University NHS Trust, and Kate Lippiet, who undertook this work in her former role as WCA Treatment Programme Manager, for beginning this work. We are grateful to all those who contributed to the production of this report via questionnaires, focus groups, semi-structured interviews or case studies, and who offered feedback at various stages of writing. This includes our Counsellors and Psychologists who deliver services for patients and families across Wessex. Finally, we would like to extend our sincere thanks to our experts by experience and the people with lived experience of cancer who have contributed to this report and with whom we work on a day-to-day basis – we hope that this work will lead to meaningful improvements in cancer psychological care in future.

Authors:
Dr Andrew Merwood, Psychology Clinical Lead, Wessex Cancer Alliance
Dr Teresa Corbett, Acting Programme Manager (Personalised Care), Wessex Cancer Alliance
Abigail-Sara Desouza, Programme Manager (Targeted Lung Health Checks & Treatment Variation), Wessex Cancer Alliance
Stephanie Heath, Former Programme Manager (Personalised Care), Wessex Cancer Alliance

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Foreword

Sally Rickard to write a foreword here…

Person with lived experience to write a foreword here… (possibly JC?)

"For my physical health I received outstanding care, with many parts of my care personalised, what mattered to me was respected…However, what was not recognised was my emotional health… I was not supported by the team who looked after my physical health so well to prepare for living beyond cancer, the emotional impact. Three years on, since I finished treatment, I struggle with the side effects of treatment such fatigue, neuropathy, and arthritis. It had an impact on my heart. I had so many bone marrow biopsies that I'm left with nerve damage which means I'm in pain every day. The mental and emotional impact this has on me is huge and, feels worse than when I was going through treatment. I never imagined I'd still be in this position this far down the line, while obviously I'm grateful to be alive and have achieved a lot in the last 3 years; it's never easy. The guilt that comes along with struggling is very conflicting too. There doesn't seem to be much awareness out there of what life is like after cancer, the emotional impact. During treatment you are constantly being monitored by doctors and nurses, so when you finish treatment and you only get checked on every few months, it feels scary, daunting, lonely at times. I thought I would simply bounce back to who I was before, and how wrong I was. I'm trying so hard to put everything that happened behind me, I never want my diagnosis to define who I am. I've felt embarrassed about living with side effects & wish nothing more to be as I was before cancer. I rarely talk to friends about any of it because I worry it'll change how they perceive me. I feel as though the world almost expects you to "just get on with it" as if nothing happened. When I had cancer, people said I was "strong" & "inspirational", this made me feel uncomfortable, I simply had no choice. Now, I don't have cancer anymore but am living with both physical and mental side effects, I often feel like a burden to people around me. Life after cancer can be just as lonely and isolating as life during cancer. If my emotional health had been acknowledged as being in some way as important as treating me physically, would I have been able to cope differently living beyond cancer? I think so."

– Expert by Experience

" The Cancer Nurse Specialists helped me pick up the pieces in the moments after I was told I had cancer. They remained calm, gave me the facts, pointed me in the right direction when I needed to know more and were always there for me, no matter how small the issue. They helped me to feel I was not alone, not a hospital number, but a person; when you feel all about you is disintegrating, it can be helpful to remember you are a person and not a diagnosis or a statistic. The psychological benefit of that is very important. It helps to feel like you still have some control".

– Expert by Experience

Executive summary

People affected by cancer – patients, their families, and carers – are at increased risk of poor psychological outcomes. NICE (2004a) guidance has long been clear that to support adults affected by cancer, different levels of psychological care are required, which must be embedded in our acute hospitals, our hospices, and even primary care. This is only possible with a specialist cancer psychological workforce.

The specialist cancer psychological workforce (often referred to as the Level 3-4 psychological workforce) plays a unique role in providing direct psychological care to people affected by cancer and in addition, provides specialist consultation, training, and supervision to embed different levels of cancer psychosocial support across healthcare systems. There is convincing evidence to show that these services improve the lives of patients and families by reducing psychological distress and improving quality of life, and that these services are essential in supporting people with pre-existing mental health difficulties to access and navigate cancer care. There is also compelling evidence to show that these services improve the overall care provided by the wider cancer workforce and can even help the wider workforce to stay well in work. Additionally, there is strong evidence that these services can reduce the overall cost of healthcare, leading to economic savings across our health and care systems.

In this report, we set out to understand what psychological support is required by people affected by cancer throughout Wessex, calculating the level of psychological need among those newly diagnosed with cancer and mapping the available psychological support services in acute hospitals across the region in the year 2022-23. We also sought to understand the provision of training and supervision to support the wider cancer workforce and took a horizon-scanning approach to understand the potential roles of NHS Talking Therapies and the third sector in contributing to cancer psychological care via a hub-and-spoke model.

Through scoping and mapping, we estimated that almost 5,000 adults with cancer and almost 1,000 family members would require access to specialist psychological support each year in Wessex. These numbers reflect the level of need in the first year following diagnosis only, and do not reflect ongoing needs experienced by people in the survivorship period or who are living with a life-limiting cancer diagnosis.

At the time of mapping, there were 20 counsellors or psychologists working in specialist cancer services across our six acute providers, or 14.83 whole-time equivalent (WTE) members of staff. To fully meet the needs of patients and families affected by cancer, 35.14 WTE clinicians are required, while to additionally provide training and supervision to the wider workforce and allow for increased incidence of cancer, up to 51.13 WTE clinicians are required. This indicates a workforce gap of up to 78% across Wessex. Cost utility analysis suggests that the monetised health gain that could be realised through addressing this gap is up to £9,893,565 across Wessex.

While the gap in services we have found is significant, so too is the impact of unmet psychological need among on people with cancer, their families, cancer clinicians and the wider health economy. We therefore believe that this gap must now be addressed and we have outlined five key recommendations to ensure immediate action, which are:

6. A consensus plan for the commissioning and delivery of specialist (Level 3-4) psychological support, with equity across the region.
7. To embed psychosocial care through the provision of psychological training and supervision for the universal (Level 1) and enhanced (Level 2) workforce.
8. To implement a hub-and-spoke model of comprehensive personalised cancer psychosocial support, with different levels of intervention across community and acute settings.
9. To take a standardised approach to measuring the impact of services.
10. To develop services that are inclusive, improving access to cancer psychological care across the communities we serve.

We have set ambitious goals to support the implementation of these recommendations and to achieve these, we will need to work in partnership with a variety of stakeholders including NHS provider organisations, Integrated Care Boards, clinical health psychology departments and psychological professionals, specialist palliative care services, NHS Talking Therapies, the third sector, and of course experts by experience.

We hope that we can now begin to improve the psychological support for people affected by cancer across Wessex, and we look forward to working with our partners and stakeholders as we begin to enact our implementation plan.

Glossary

In this report, we have used the following terms in the context listed, however we recognise there may be local interpretation and understanding of the terminology used.

Term	***Definition***
Psychosocial	Within this document the term ‘psychosocial’ is often used alongside ‘psychological’ support. Psychosocial support captures the broad range of determinants effecting emotional wellbeing, the importance of which is recognised in this work. This also acknowledged the scope of variety in interventions to support emotional wellbeing that may be delivered by a range of professionals, in a range of care settings.
Screening	A process by which to recognise and identify if a person has any psychological needs or concerns.
Assessment	Formal evaluation of signs and symptoms of psychological distress and the severity, to inform decision making e.g., a treatment pathway, intervention, and/or care planning. Assessment should be conducted by a registered healthcare professional.
Level 1 practitioner	All health and social care professionals coming into contact with people affected by cancer, who should have the ability to recognise signs and symptoms of psychological distress.
Level 2 practitioner	Health and social care professionals with additional expertise (trained and competent to screen and assess for psychological distress and provide interventions to de-escalate concerns, and with access to psychological supervision to support them in their roles).
Level 3 practitioner	Accredited professionals with specific training that enables them to assess psychological distress and the diagnosis of some psychopathology. Interventions provided by level three practitioners may include counselling and specific psychological interventions such as anxiety management and solution-focused therapy, delivered according to an explicit theoretical framework. Level 3 roles typically include: Counsellors, Psychotherapists, and Mental Health Practitioners (e.g., Registered Mental Health Nurses or Social Workers), and some practitioners working within NHS Talking Therapies services.

Level 4 practitioner	Mental health specialists - e.g., Practitioner Psychologists, Psychiatrists, providing highly specialist interventions including different forms of psychotherapy.
Psycho-oncology	A highly specialist area of psychological support which addresses the psychological and social needs of people affected by cancer. In general, these services are linked to acute hospital trusts, based in secondary care, and key roles within this group may form membership of the multidisciplinary team (MDT).
Psychological Supervision	In the context of supporting the cancer workforce, who are working as Level 2 practitioners, this is a structured, formal process of supporting psychological competencies in a safe and confidential environment, learning and reflection for health and social care professionals, working with people with cancer. Supervision sessions are led by level 3 or 4 practitioners.
NHS Talking Therapies, for anxiety and depression (TTad; formerly known as Improving Access to Psychological Therapies, IAPT)	The NHS Talking Therapies, for anxiety and depression (TTad) programme was developed in 2008 to improve the delivery of, and access to, evidence-based, NICE recommended, psychological therapies for anxiety disorders and depression within the NHS. The TTad programme and associated services provide support for long-term physical health conditions however TTad services are not cancer specific.

Background

Psychological support for people affected by cancer: A national health priority.

People affected by cancer - including patients, their family members, their carers, and even cancer professionals - can face a range of psychological and emotional difficulties as a result of the disease. Despite advances in treatment and improved patient outcomes, for some, cancer is still perceived as being synonymous with death, giving rise to a range of existential concerns for people diagnosed with cancer and their loved ones. This is especially the case for those with a life-limiting or life-shortening disease. Cancer and its treatment can lead to a range of physical health changes, leading in turn to changes in roles and abilities and to associated feelings of loss, grief, anxiety, anger, sadness, and despair. Relationships may be impacted, not least by changes in role, sexual functioning, or intimacy. Valued living may be impaired.

Psychological distress may be experienced by people affected by cancer regardless of whether they have pre-existing difficulties with their mental health. A diagnosis of cancer may lead some people to access psychological support services for the first time as they attempt to adjust to the impact of a diagnosis, treatment, or even end of life care. For some, access and adherence to medical care will not be possible without this psychological support. For others, a diagnosis of cancer may happen in the context of pre-existing psychological distress, trauma, or mental health difficulties, or may be one of several adverse life events. For these individuals, cancer can exacerbate pre-existing difficulties, compounding psychological distress.

Nationally, there is recognition of significant under-resourcing of mental health services in general (British Medical Association, 2024) and additionally, of significant unmet need relating to psychological support services for people affected by cancer. These issues are often compounded by one another: For example, health inequalities continue to be experienced by people with severe mental illness (SMI) who access cancer care (Kerrison et al., 2023). The importance of psychological services for people affected by cancer therefore continues to be prioritised by the National Cancer Programme while concurrently, the development and delivery of mental health care has been prioritised in the NHS long-term plan (NHS England, 2019).

The NHS Long-Term Plan (2019) also highlights the importance of personalised cancer care, emphasising a need to address both physical health and psychological wellbeing. Macmillan have similarly highlighted the need to address unmet psychological and emotional difficulties as part of cancer care (Macmillan Impact Brief, 2015). Therefore, while cancer is a physical health condition, holistic cancer treatment, including a level of psychological support, is recognised as a national health priority to support the whole person to recover from the disease.

Our priorities in Wessex

Wessex Cancer Alliance made a commitment within its five-year strategy to undertake a review of psychological support services, to develop a plan to address gaps in provision, and to promote examples of good practice (Wessex Cancer Alliance, 2020). This commitment compliments the work of the National Cancer Programme and the ambitions of the 'Living With and Beyond Cancer' National Team to scope the provision of psychological services across different levels of support based on recognised best practice (NICE, 2004a; see Section 1.2).

Wessex Cancer Alliance (WCA) is prioritising a focus on psychological support in its goal to improve the holistic care and personalised support for people experiencing cancer within Wessex. Our aim is that this report will be the first step towards co-creating a meaningful and sustainable model of psychological support in Wessex. Developing this model will necessarily bring together NHS commissioners, providers and clinicians, representatives from charities and the third sector, and of course people with lived experience of cancer and psychological distress.

Our vision is that all people affected by cancer in the Wessex region - patients and their families - will have access to equitable and high-quality psychological support. We aspire to provide this:

- ***when*** and ***where*** people require it, delivered by ***culturally-inclusive*** services which can understand and address health inequalities.
- at the ***appropriate level*** to meet individual need (based on NICE guidance outlining level of support), following the evidence base, *and* based on appropriate assessment of need using clinical judgement and validated psychometric tools.
- delivered by an ***appropriately resourced, well led, and well-trained workforce*** with the knowledge, skills, and confidence to deliver this support.
- with a ***sustainable and effective*** framework of supervision for practice to support practitioners to thrive in competence and confidence, to deliver safe and effective patient care.

Examples of good practice and the ways in which we are working towards these objectives are highlighted throughout this report.

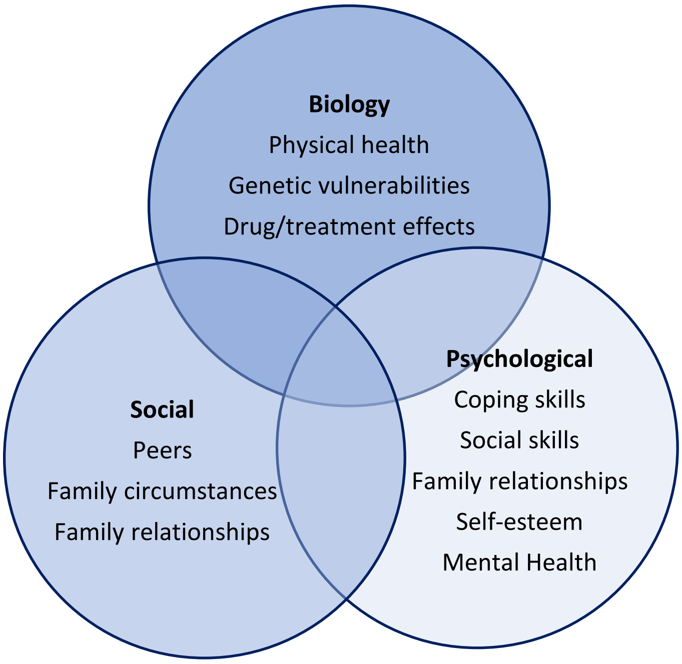
Levels of psychological support and the model of personalised cancer psychosocial care

The focus of this scoping report supports the wider NHS England Personalisation agenda and the associated Comprehensive Model of Personalised Care (NHS, 2018), by advocating for a biopsychosocial model of care and ‘whole person’ approach with integration of physical, social and mental health and wellbeing needs (Figure 1). In turn, this approach can facilitate delivery of supportive care based around what matters to individuals and tailored to meet their needs.

However, a biopsychosocial perspective represents only one step towards holistic, individualised cancer care. We must also consider the spiritual and existential impact of cancer (e.g., the bio-psycho-social-spiritual model, Sulmasy, 2002). Additionally, culturally inclusive cancer care must pay attention to a broad range of social identity characteristics (so-called ‘Social GRACES,’ Burnham, 2012; see Table 1) and to the intersectionality of these characteristics and identities. Failure to consider these personal and cultural attributes may lead to individuals being marginalised or minoritised during and after cancer care (Kelly-Brown et al., 2022).

An example of good practice in meeting the individual needs of people affected by cancer is considered in relation to the Right By You project, in Box 6.

Figure 1. The biopsychosocial model of care



Note: Adapted from Engel, 1977.

Table 1. The Social GGRRAAACCEEESSS

G	Gender Geography
R	Race Religion
A	Age Ability Appearance
C	Class/ Caste Culture
E	Ethnicity Education Employment
S	Sexuality Sexual orientation Spirituality

Note: From Burnham, 2012.

The NHS Personalisation agenda, including the need to deliver universal, enhanced and specialist support, complements NICE (2004a) guidance on improving supportive and palliative care for adults affected by cancer, outlined in Table 2.

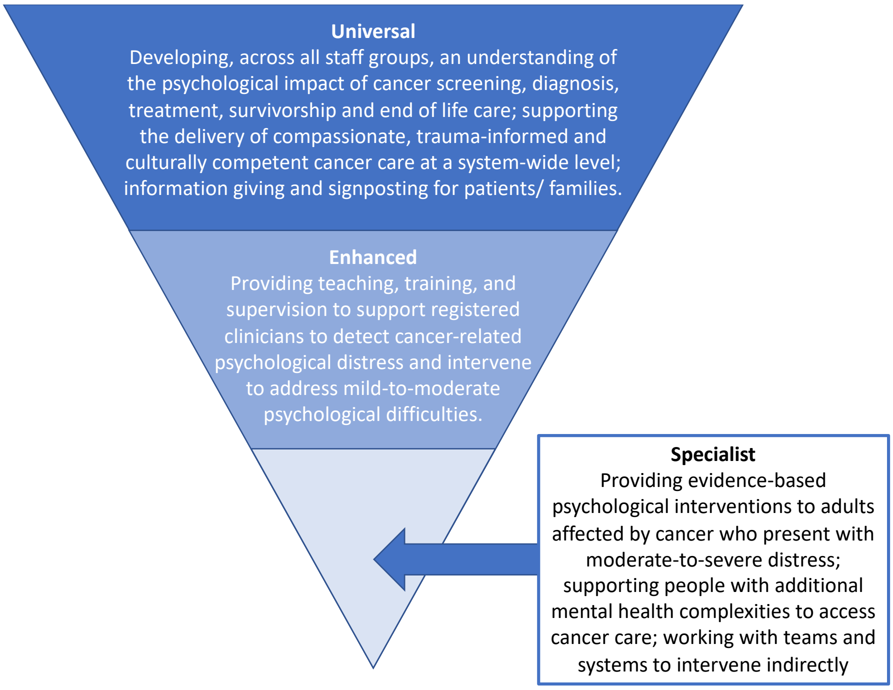
Table 2: NICE (2004a) recommended Levels of Professional Psychological Support in cancer care.

Level	Group	Responsibilities
1	**All health and social care professionals:** • Supportive and assistive roles – cancer support workers, healthcare assistants • Administrative and clerical workers • Clinicians – medics, nursing workforce • Volunteers • Friends, family, and carers	Recognition of psychological distress, focussing on compassionate communication and universal psychological support.
2	**Health and social care professionals with additional expertise:** • Clinical Nurse Specialists (CNSs) • Allied Health Professionals (AHPs) • Physicians and Surgeons	Screening and assessment for psychological distress, providing input to deescalate psychological concerns.
3	**Trained and accredited health and social care professionals:** • Mental Health Practitioners • Social workers with accredited mental health training • Counsellors • Family therapists	Assessment of psychological distress and the diagnosis of some psychopathology. Provide counselling and specific interventions delivered according to an explicit theoretical framework. Provide psychological supervision to clinical workforce, by facilitating support sessions.
4	**Mental health specialists:** • Clinical Psychologists and other HCPC-registered Practitioner Psychologists (e.g., Counselling or Health Psychologists) • Psychiatrists	Assessment of psychological distress and diagnosis of psychopathology. Provide specialist psychological and psychiatric interventions. Provide psychological supervision to clinical workforce, by facilitating support sessions.

The NICE guidance specifies the need for four different levels of psychological care. These range from universal recognition of the psychological and emotional needs of people affected by cancer by all health and social care professionals (Level 1), through to enhanced psychological support provided by those with additional expertise (Level 2), specialist support from trained and accredited professionals (Level 3) and finally, highly specialist support provided by trained mental health professionals (Level

4). These levels of care can be mapped to the Comprehensive Model of Personalised Care (NHS, 2019) such that Level 1 psychological support is considered Universal, Level 2 psychological support is Targeted, and Level 3-4 psychological support is Specialist, as depicted in Figure 2.

Figure 2. The role of psychological services: An adapted model of personalised care



Universal
Developing, across all staff groups, an understanding of the psychological impact of cancer screening, diagnosis, treatment, survivorship and end of life care; supporting the delivery of compassionate, trauma-informed and culturally competent cancer care at a system-wide level; information giving and signposting for patients/ families.

Enhanced
Providing teaching, training, and supervision to support registered clinicians to detect cancer-related psychological distress and intervene to address mild-to-moderate psychological difficulties.

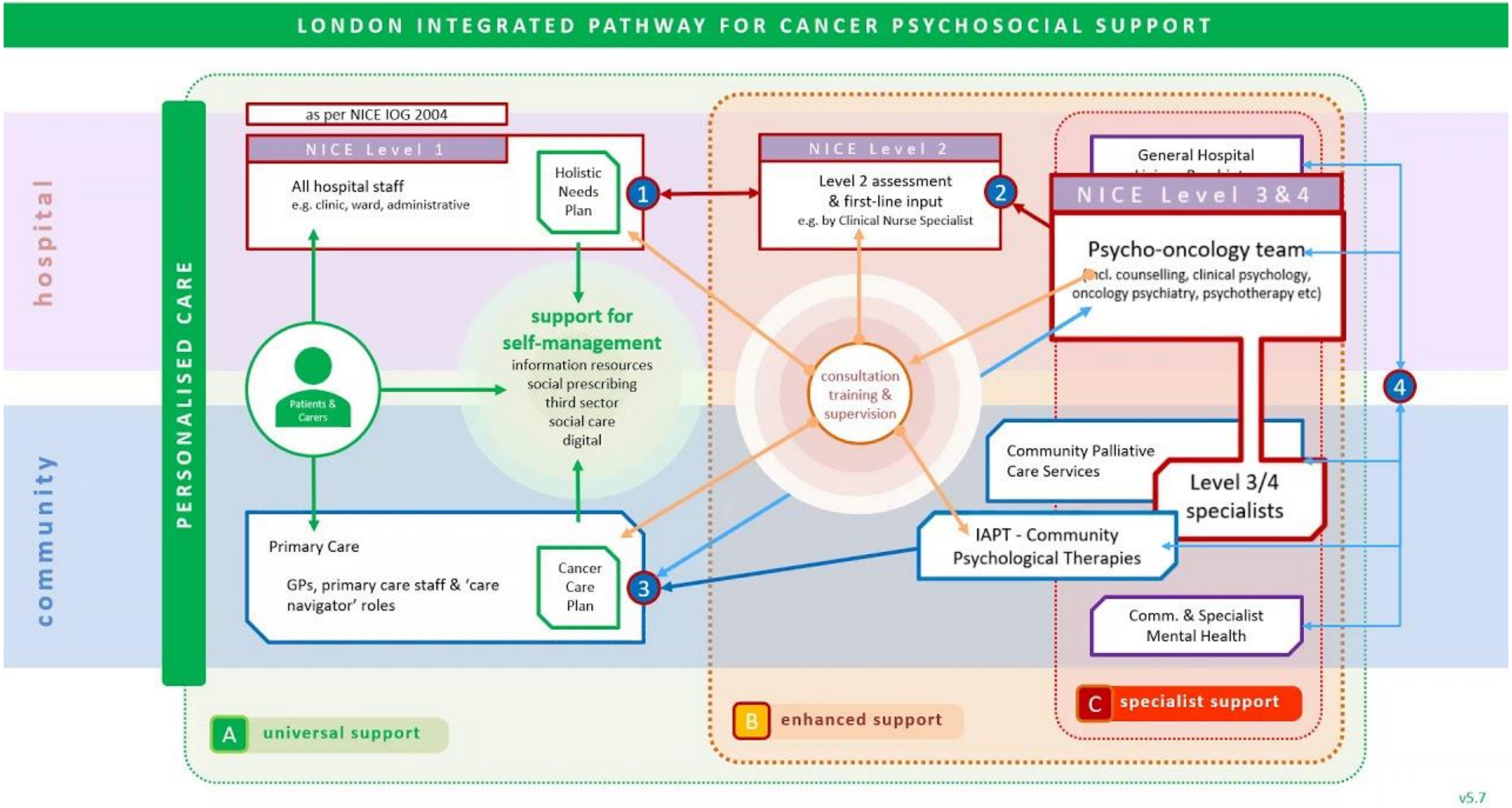
Specialist
Providing evidence-based psychological interventions to adults affected by cancer who present with moderate-to-severe distress; supporting people with additional mental health complexities to access cancer care; working with teams and systems to intervene indirectly

The targeted (Level 2) role was once undertaken almost exclusively by cancer Clinical Nurse Specialists (CNSs). However, the Aspirant Cancer Career and Education Development (ACCEND) programme (Health Education England, 2023) makes clear that an awareness of psychological distress and incorporation of psychological strategies into personalised care plans are core capabilities in cancer practice across the pre-registered and registered cancer workforce. Consequently, registered nurses and allied health professionals (AHPs) should be able to assess and respond to the psychological needs of cancer patients at a level commensurate with their roles up to and including consultant level.

Figure 2 additionally makes clear the need for specialist (Levels 3-4) practitioners to support the development and delivery of safe and effective psychological support at the universal and enhanced levels. This is achieved through the provision of psychological skills training, psychological supervision, and consultation with non-psychologists. Therefore, while only a proportion of individuals will require direct, specialist intervention, the provision of specialist services underpins all other levels of care.

The comprehensive model of personalised care (NHS, 2018) and NICE (2004a) guidance have been further integrated via the Model of Personalised Psychosocial Care (Figure 3; London Transforming Cancer Services Team, 2020), which highlights the role of specialist services in supporting safe, effective, integrated cancer psychological care across the wider healthcare system.

Figure 3. Pan-London Model of Cancer Personalised Psychosocial Care (London Transforming Cancer Services Team, 2020)



It is clear from Figure 3 that specialist (Level 3-4) psychological services are important not only for the delivery of bio-psycho-social-spiritual cancer care within acute hospital and hospice settings, but also as a hub offering consultation, training, and supervision to support non-cancer specialists working with people affected by cancer in primary and secondary care. An integrated hub model such as this is essential if we are to address health inequalities and support people with mental health difficulties to access the right services at the right time and in accordance with a *'No Wrong Door'* approach.

Detecting and responding to psychological distress

The personalised care agenda relies on stratified psychological support delivered in a timely manner. Stratified care involves matching people with the best available intervention based on level of need (Delgadillo et al., 2022). To achieve personalised cancer psychological care, early identification of, and response to, psychological distress is essential across the cancer pathway; in the lead up to, and from the point of, diagnosis of cancer; during and after treatment; and across the varying trajectories of cancer up to and including end of life care.

Levels of psychological distress

Psychological distress (i.e., intense, painful feelings and emotions) is shaped by a person's current and historical context including their mental and physical health. It can also be affected by perceived and actual social support, relationships and attachments, experiences of cancer and loss, health and illness-related beliefs and behaviours. A range of other sociocultural factors may also contribute to the meaning of cancer to an individual, their family and community.

Psychological distress should be recognised as an understandable reaction to a cancer diagnosis. Up to 50% of people diagnosed with cancer are likely to experience clinical levels of distress in relation to their disease, with 25% of people requiring access to specialist (Level 3-4) support (NICE, 2004a).

In the year following cancer diagnosis, it is estimated that:

- **15% of people with cancer will experience mild-to-moderate distress** at a level that requires specialist psychological support from trained health professionals or specific psychological interventions such as counselling (Level 3 intervention; NICE, 2004a).
- **An additional 10% of people with cancer will experience severe psychological difficulties** which warrant highly specialist psychological support from mental health professionals such as Clinical Psychologists (Level 4 Intervention; NICE, 2004a).

After initial diagnosis and treatment, it is estimated that:

- At least **15% of those living with advanced disease will require specialist psychological support** (Macmillan, 2006).
- Survivors of the 20 most common types of cancer are at i**ncreased risk of anxiety and depression**, which increases in the medium-to-long-term survival period, and with **worse mental health outcomes** for those with the poorest prognosis (Forbes et al., 2024).
- Among those who experience disease recurrence, **the prevalence of psychological distress is 50%** (NICE, 2004a).

Throughout the course of cancer care, it is recognised that:

- There is a **55% higher risk of suicide** among patients diagnosed with cancer as compared to people without cancer (Calati et al., 2017), and evidence of **increased risk of self-harm** among cancer survivors (Forbes et al., 2024).
- Psychological difficulties such as depression or low self-efficacy are associated adverse outcomes for people with cancer including **reduced quality of life and higher rates of mortality** (e.g., Foster et al., 2016; Jansen et al., 2018).
- Complex psychological difficulties such as **post-traumatic stress disorder** (PTSD) may be developed in response to a cancer diagnosis or cancer treatment (Smith et al., 1999).
- Cancer and treatment can lead to **chronic physical health complications**, such as chronic pain (Syrjala et al., 2014) and fatigue (Jacobsen et al., 2007), which will benefit from psychological management (e.g., NICE, 2021).

Among family members, it is estimated that:

- Up to **70% of carers experience difficulties with their mental health**; 51% of carers experience stress; 45% experience anxiety; and 26% experience depression (Macmillan, 2006).
- In at least 20% of cancer cases, f**amily members will require access to specialist psychological care** (Macmillan, 2006; London Transforming Cancer Services Team, 2020).
- Over **75% of family members do not receive <u>any</u> form of psychological support**.

Detecting psychological distress

- The detection of psychological distress must begin at **Level 1**, with a universal awareness of the psychological impact of cancer. **All professionals** working with people affected by cancer should demonstrate a compassionate understanding of psychological distress in the context of cancer. The detection of psychological distress is key component of Holistic Needs Assessments (HNAs), which should be routinely completed at key stages during a patient's cancer care. HNAs provide a useful tool for beginning to identify psychological and emotional concerns.

- The initial detection of distress using HNAs may be augmented with validated psychometric tools – i.e., questionnaires used to measure different psychological difficulties and signs of distress. There is no universally agreed upon psychometric tool for use in cancer settings (BPS, 2015): In UK practice a number of tools are used including those that screen for anxiety, depression and other mental health difficulties (e.g., the CORE-OM, GAD-7, HADS, PHQ-9); others assess general wellbeing (e.g., the WEMWBS), as well as functional outcomes and quality of life (e.g., the FACT-G, EORTC-QLQ). It is sometimes helpful to think of these psychometric tools as an overall index of psychological distress, as opposed to diagnostic measures of clinical depression or anxiety disorders per-se, meaning that clinical judgement and careful interpretation of scores is required. **HNA's and validated psychometric measures**

may be used by registered professionals working at Level 2 as part of a psychological assessment.

- Psychometric tools can be useful for prioritising referral to **specialist Level 3-4 services**. These tools can facilitate detection of psychological risk and any pre-existing mental health difficulties. Within specialist services, these tools may also be used to measure outcomes during the course of a psychological intervention.

- As multimodal prehabilitation becomes a standard component of cancer care (Macmillan, 2020), there is a need to screen for psychological distress early in the cancer pathway so that it is recognised and responded to as part of the psychological component of prehabilitation (see Box 5 for more information).

- Similarly, as cancer screening is increasingly offered through the NHS for breast, bowel, and lung cancers, and as the use of early detection tests is adopted, there is a need for awareness of the psychological impact of cancer screening among professionals working at universal, targeted and specialist levels.

Responding to psychological distress

When psychological distress is detected, **all professionals** working with people affected by cancer should be able to signpost patients and their family members to the relevant healthcare professionals who can offer support. This includes **signposting to targeted (Level 2) support** delivered by cancer CNSs, AHPs and others trained to deliver low intensity psychosocial interventions as part of holistic cancer care, and **signposting to specialist (Level 3-4) services** when additional support is required.

To respond to cancer-related psychological distress, there is a need to deliver cancer psychosocial support at all levels and to implement a Wessex-wide Model of Cancer Personalised Psychosocial Care. Key considerations in the implementation of this model include:

- Appropriate training at the universal level (Level 1) to support all staff in acute and primary care to recognise cancer-related psychological distress, whether this is in relation to a cancer diagnosis or prior to diagnosis in relation to early detection programmes.
- Appropriate training and supervision at the targeted level (Level 2) to support cancer CNSs and AHPs and others to detect and respond to psychological distress. An example of work already underway across Wessex is highlighted in Box 1.
- Care pathways, training, and supervision to support NHS Talking Therapies (primary mental health services for people experiencing difficulties such as anxiety and depression) to work with people affected by cancer as part of their Long-Term Conditions pathways (NHS England, cited 2024). These services are essential to address common mental health difficulties experienced by people living life with or after cancer and who are accessing care outside of the acute setting. Ongoing work within Wessex suggests that NHS Talking Therapies clinicians want access to training and supervision to improve their confidence to work with cancer, and that people affected by cancer want assurances that their experiences of cancer will be recognised and understood in community mental health settings (see Box 2).

- Care pathways linking acute psycho-oncology services in secondary care with NHS palliative care and bereavement psychology services, so that patients and their families can be referred on when appropriate. These services deliver specialist (Level 3-4) interventions to support people affected by a life-limiting cancer diagnosis or in relation to end of life care. Such services sometimes overlap with acute psycho-oncology services but are more often based in the community where they may be linked to hospice care.
- Care pathways promoting awareness and joined up working between commissioned NHS psychological therapies services and counselling provided via the third sector.
- Provision of specialist services in the acute hospital setting. These services should be responsive to psychological difficulties experienced during or immediately after a patient's multidisciplinary care and work closely with specialist palliative care and bereavement services. Such services can also act as a hub for linking in with NHS primary care and Talking Therapies, with the third sector, and offer training and support for enhanced practitioners.
- The precise model of care and activity levels adopted by specialist (Level 3-4) practitioners will vary depending on the remit of a service including the job roles and bandings of individual clinicians: UK psycho-oncology data from 2015 suggested that patients were seen, on average, for 4-8 appointments but with some patients receiving 16 or more appointments as part of their psychological care; additionally, while the average number of patients per whole-time clinician per year was 120, there was recognition that more senior practitioners, including those with leadership responsibilities, would be able to offer fewer clinical contacts per year (BPS, 2015).

The scoping and mapping work undertaken for this report pays particular attention to service provision in acute settings, focussing on the needs of patients and families affected by cancer in their first year following a cancer diagnosis. This report similarly makes recommendations to support the development of sustainable services in acute settings that are well resourced and well led. While this approach enables a clear focus for this report, it is recognised that psychological therapies provided by the third sector, NHS Talking Therapies, and hospice and palliative care services are all essential to meet the needs of people affected by cancer, particularly *after* the initial year following diagnosis or for those with a life-limiting illness.

The impact of Level 3-4 psychological support in cancer care

The impact of embedding specialist (Level 3-4) cancer psychological support services in acute care can be understood at multiple levels. This includes the direct impact on patients and family members, the impact on cancer clinician and support staff, and the wider impact which is felt at organisational and integrated care systems levels.

Impact on patients and family members

It is beyond the scope of this report to provide detailed information about the effectiveness of different psychological therapies across all cancer types. However, across cancers psychological interventions are associated with reductions in distress and improvements in quality of life for patients with cancer (Faller et al., 2013). Specific psychological interventions (e.g., mindfulness-based interventions) are associated with reduced distress among people living with cancer, including those with advanced disease (Paley et al., 2023).

Cancer psychological interventions may be associated with improved physical health outcomes. This includes evidence of increased short-term survival rates among patients (Fu et al., 2016). Psychosocial factors targeted during psychological interventions, including anxiety, depression, stress coping strategies, social support, and locus of control, may also be associated with improved adherence to cancer treatments (Theofilou & Panagiotaki, 2012; Gruszczyńska, Sosnowska & Szemik, 2020).

Among the family members and carers of patients with cancer, there is evidence that psychological interventions are associated with reduced distress and improved quality of life (Fu et al., 2017; Gabriel, Creedy & Coyne, 2020).

The timing of interventions is important, with evidence that patients may be more receptive to psychological support if it is offered nearer to the time of cancer diagnosis (Brebach et al., 2016). This highlights the importance of delivering timely psychological care, and the need to work flexibly and responsively to support patients is recognised by practitioners working in specialist services and the people affected by cancer who use these services (Box 3).

A number of interventions may be best delivered by a specialist (Level 3-4) practitioner embedded in a cancer multidisciplinary team - for example, the work undertaken to support patients may include multimodal prehabilitation that incorporates a psychological component as well as nutrition and exercise interventions (Levett & Grimmett, 2019; Macmillan, 2020). Integrated psychological support may also relate to treatment decision-making, such as the psychological assessment of people considering risk-reducing or elective mastectomy (BPS, 2018; NICE, 2013), or to acute inpatient care (Singer, Das-Munshi & Brähler, 2010). Embedded psychological practitioners may also be part of a team supporting patients to make decisions about ending treatment as part of enhanced supportive care (Berman, 2016).

Taken together, the findings from research suggest that embedded cancer psychological support leads to a range of improved outcomes for patients and family members accessing acute services. The personal impact of such support is described in more detail the patient stories.

Since the COVID-19 pandemic, it is increasingly common for specialist (Level 3-4) psychological care to be offered online as well as in person, which takes account of patient preferences and may help to reduce inequalities around access to care (COVID-19 Recovery Psychosocial Support Task and Finish Group, 2021). Online approaches also enable the delivery of support synchronously (i.e. live or real-time) or asynchronously, which supports access to materials in a convenient location, at the appropriate time for the individual. Remote approaches may help to address barriers that may prevent those with cancer from attending in-person intervention sessions such as illness or treatment side effects, geographic distance, and access to transportation, as well as work- and family-related responsibilities (e.g., need for childcare) (Benedict et al 2022). Approaches such as videoconferencing provide an efficient means of reaching those who may otherwise be physically and/or socially isolated or lack the self-efficacy to report problems and seek support. There is evidence that these interventions can be effective for reducing distress among people affected by cancer (e.g. Lleras de Frutos et al 2020).

Impact on cancer workforce

Specialist (Level 3-4) cancer psychological support services can support the wider cancer workforce in two main ways:

1. Training of non-psychologist cancer workforce

Specialist (Level 3-4 practitioners) can support non-psychologists to develop an understanding of the psychological impact of cancer. They can also support clinicians to develop associated skills in detecting and responding to cancer-related psychological distress. The function of training and supervision is to ensure that those working at an enhanced level are able to support patients holistically by providing good psychological care. Training in psychological assessment skills and enhanced communication skills delivered by specialist (Level 3-4) practitioners leads to improved psychological knowledge and practice among clinicians working at an enhanced level (Jenkins & North, 2008; Hulbert-Williams et al., 2021).

Training cancer clinicians, such as CNSs and AHPs, to develop psychological skills is essential to create capacity across the system. Some patients may be more likely to engage in psychological support when it is delivered by nurses they already know. (Brebach et al., 2016). The training component of specialist (Level 3-4) roles has been most clearly described in relation to the development and delivery of formal psychological assessment skills training for cancer CNSs and the provision of associated, monthly clinical supervision (NICE, 2004a; National Cancer Peer Review Measures, 2011; BPS, 2015).

2. Supervision and support for Level 2 practitioners

Specialist (Level 3-4) practitioners can provide a *restorative* space for Level 2 practitioners – i.e., a space in which practitioners can reflect on, experience, and process the emotional impact of their work (Proctor, 2008). Attendance of psychological supervision is associated with reduced burnout and compassion fatigue among cancer nurses (MacMillan et al., 2016; Hession & Habenicht, 2020). In turn, psychological supervision can help cancer nurses to stay well and in work, and additionally ensure that nurses are supported to deliver compassionate care to patients. While traditionally, psychological supervision has been offered to the cancer nursing workforce, there is evidence that other cancer professions are also at risk of burnout (Baker et al., in prep). This suggests that restorative forms of psychological supervision could be offered to other members of the cancer workforce.

Psychological supervision is additionally associated with increased confidence in delivering psycho-social cancer care (Hession & Habenicht, 2020). In this way, psychological supervision also serves *normative* (i.e., upholding service quality, norms, and standards in relation to psychological care) and *formative* (i.e., the development and maintenance of psychological skills) functions (Proctor, 2008) by ensuring that enhanced practitioners continue to deliver good care commensurate with their roles.

Impact on provider organisations and the health and care system

The impact on provider, place and system can be understood by looking at healthcare utilisation and cost utility, making a case for the economic benefit of delivering cancer psychological services at Levels 3-4.

The cost of unmet psychological need

Long-term conditions including cancer are associated with higher rates of mental health problems (McManus et al., 2016). Research by the King’s Fund and Centre for Mental Health estimates that £1 in every £8 spent on long-term conditions, including cancer, is linked to poor mental health and wellbeing (Naylor et al, 2012). This is supported by international research that indicates that the cooccurrence of a physical health concern alongside a mental health problem leads to a 45-75% increase in associated healthcare costs (The Mental Health Task Force, 2016).

Cancer patients experiencing difficulties with their mental health demonstrate increased intensity of service use. For example, compared to those without depression, cancer patients with depression were twice as likely to have an emergency or urgent care visit, twice as likely to experience a 30-day hospital admission and 81% more likely to be hospitalised. Such patients are also likely to have incurred 14% higher inpatient expenditure, had 25% more non- mental health visits to primary care, and incurred 76% more healthcare visits overall (Mausbach & Irwin, 2017; Lo et al., 2013; Pan & Sambamoorthi, 2015).

A recent meta-analysis (van Beek et al., 2021) looked at the association of psychological difficulties with healthcare and societal resource use and costs among cancer patients. Key findings include evidence that:

- Depression is associated with increased mental healthcare use by people affected by cancer.
- Fear of cancer recurrence is associated with increased use of primary care including GP appointments.
- Depression and anxiety are associated with increased hospital inpatient healthcare use.
- Depression and anxiety are associated with increased hospital outpatient healthcare use including emergency department visits, ambulatory visits, and general outpatient care.
- Depression and anxiety among people affected by cancer delay or prevent a return to work.
- Among people affected by cancer, depression increases inpatient, outpatient and total healthcare costs and that anxiety also increases total healthcare costs.

The results of this comprehensive review indicate that untreated psychological difficulties among people affected by cancer can and do lead to increased use of acute and primary healthcare. In turn, this can and does increase the cost of healthcare. This has implications for the wider healthcare system, which is already financially constrained, and which faces significant pressures in terms of inpatient occupancy and outpatient wait lists across acute and primary care.

Cost savings associated with providing psychological care to patients affected by cancer.

Investment in specialist psychological services for people affected by cancer has the potential to save money for provider organisations and health and care systems.

A meta-analysis of 91 studies found that psychological interventions across a range of medical settings have been shown to lead to cost-savings estimated at 20%; crucially, the available evidence indicated a financial benefit even after controlling for the cost of providing psychological interventions (Chiles et al., 1999). Similar findings were demonstrated in an evaluation of a UK psychology service for patients accessing the emergency department of an acute hospital trust in Liverpool, where a brief psychological intervention helped to reduce intensity of service use and rates of readmission, with an average cost saving of £7 per £1 spent (Dr Foster, 2019). Specialist psycho-oncology services have also been found to result in financial savings that offset medical costs (Carlson & Bultz, 2004).

Further evidence of the financial impact of delivering good psychosocial care is available in the results of psycho-oncology service mapping undertaken elsewhere. The London Transforming Cancer Services Team (2020) estimates that specialist psycho-oncology services can generate financial savings by increasing the number of Quality Adjusted Life Years (QALYs) among cancer survivors. A QALY is a score that ranges from 0-1, on which 1 represents perfect health; increases in this metric can be monetised and have been given a threshold range by NICE of £20,000-30,000 per 1 QALY. Working on the basis that 50% of cancer patients who receive psychosocial support will experience a modest gain of 0.07 QALYs (a figure based on changes in anxiety and depression symptoms seen in primary mental health), the London Transforming Cancer Services Team (2020) estimated that in North London alone, the monetised health gain from delivering psychological interventions to people affected by cancer could be as much as £723,800 per annum.

Together, these findings strongly suggest that savings made through the provision of psychological care outstrip the costs of providing services.

Cost savings associated with psychological support for the cancer workforce.

Additional benefits to provider organisations and the wider system may be experienced when specialist (Level 3-4) practitioners support other cancer clinicians to stay well in work.

Analysis of published data on NHS staff sickness found that across 2022, the staff sickness absence rate for NHS England was 5.6%, equivalent to 74,500 additional full-time staff including 2,900 doctors and 20,400 nurses (Palmer & Rolewicz, 2023). Almost a quarter of sick days (23%) were due to psychological difficulties including anxiety, depression, stress, and other mental health problems (Palmer & Rolewicz, 2023). Cancer healthcare professionals may be at increased risk of psychological difficulties because their roles expose them to psychological stressors including end-of-life care, delivering bad news, ethical dilemmas related to cancer care, and interactions with overwhelmed patients and families (Challinor et al 2020). Indeed, a large body of international evidence indicates that oncology professionals may be subject to greater occupational stress than healthcare workers in other specialities (Gribben, & Semple, 2021).

The cascading effects of burnout are extensive. Higher levels of sickness absence result in increased costs and disruptions in service provision. Concurrently, pressures are pushed to the remaining staff, creating a vicious cycle of stress and burnout (Kowalczuk, Krajewska-Kułak, & Sobolewski, 2020). Staff shortages due to burnout result in high patient-to-nurse ratios, an increase in nurse workloads. Burnout in cancer care has also been associated with an increased risk of medication errors and compassion fatigue (Challinor et al 2020), as well as increased readmission rates, urinary tract infections, and surgical site infections (Wilkes, 2022). These factors collectively cost the health service millions of pounds (Gribben, & Semple, 2021). The mental health of the oncology workforce is therefore central to providing safe and cost-effective patient-centred care (Wilkes, 2022).

In contrast, good staff health, wellbeing and engagement can lead to significant benefits for both staff and patients (Royal College of Physicians, 2015). Benefits include improved patient experience of care, including higher levels of patient satisfaction. Further benefits comprise reduced costs, including lower rates of sickness absence, reduced use of agency staff, as well as improved productivity and higher rates of staff retention. Additional professional and personal benefits for NHS staff include improved morale, job satisfaction and wellbeing. These findings highlight the instrumental protective value of fostering wellbeing within the oncology workforce, which can be achieved through resilience and wellbeing initiatives (HaGani, Yagil, & Cohen, 2022) and through the development of a positive workplace culture that incorporates good peer support, clinical supervision, and debriefing after challenging situations (Gribben, & Semple, 2021).

Restorative psychological supervision delivered by specialist (Level 3-4) practitioners, as described on page 21, in addition to training and other initiatives to improve wellbeing and embed a compassionate culture of cancer care, therefore has the potential to offset the cost of poor staff health in cancer services, leading to economic savings. Addressing the root cause of psychological difficulties through culture change in cancer services is also consistent with pledges made in the NHS People Plan (2020).

Summary of background literature

The literature summarised in this section of the report has outlined the key functions of specialist (Level 3-4) psychological support services for people affected by cancer. The model of care and its links to the personalised care agenda have been described, the need to provide services has been considered, and evidence of the impact of these services for patients, clinicians, provider organisations and integrated care systems has been provided.

The remainder of this report describes the methodology and results of mapping of specialist (Level 3-4) psychological support services across Wessex, before going on to make recommendations regarding the necessary next steps to meet our overarching aim of co-creating a meaningful and sustainable model of cancer psychological support.

We have focussed this report primarily on the provision of specialist (Level 3-4) services in acute settings as this was the main objective for service mapping as specified by NHS England Cancer Programme. However, as a secondary aim, we have sought to take account of psychological support that exists elsewhere in the system, and of universal and enhanced (Level 1-2) psychological support.

Project methodology

Psychological support mapping was undertaken from April 2022 until January 2023.

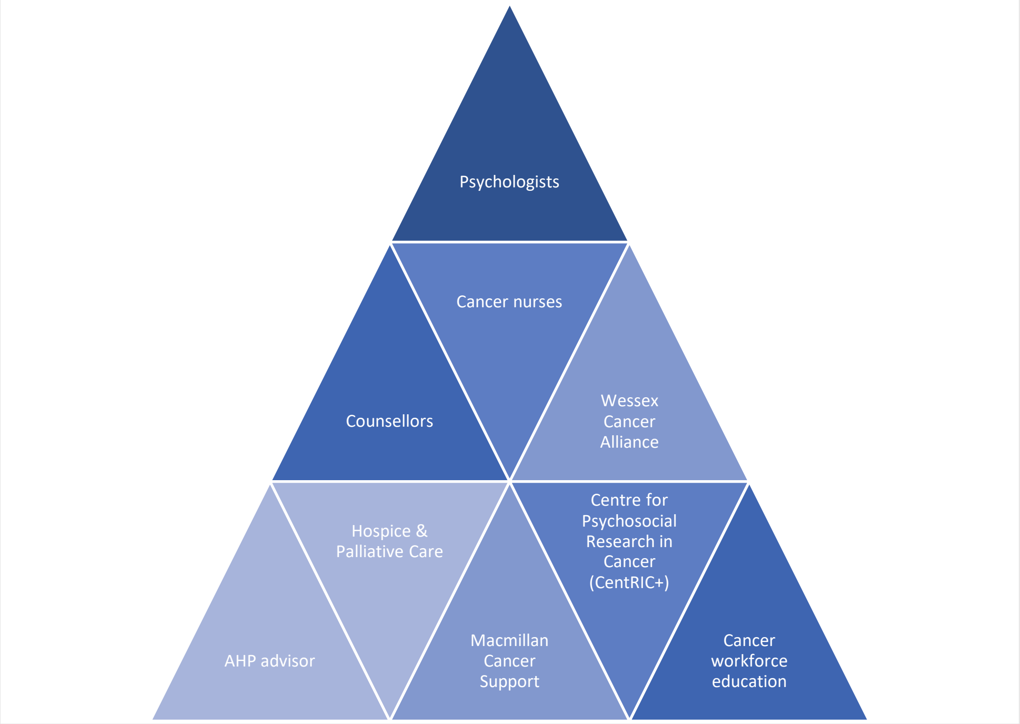
Participants

The mapping exercise was undertaken by the WCA Personalised Care Work Programme, adopting work previously undertaken by the WCA Treatment and Care Programme. An overview of those who participated in the mapping project is provided below, with a full list of contributing individuals and organisations provided in Appendix A.

Special interest Group

A special interest group (SIG) was established by the WCA, within the personalised care work programme, to enable engagement with key stakeholders to progress local scoping. The SIG comprised representatives of different the levels of psychological support (NICE 2004a) including Clinical Nurse Specialists (Level 2 practitioners), Counsellors (Level 3 practitioners) and Practitioner Psychologists (Level 4 practitioners). Members from community, secondary care and third sector organisations spanning the WCA footprint were also invited to join. A full list of SIG members is included in Appendix B and the SIG make-up summarised in Figure 4.

Figure 4. Matrix of members forming the psychosocial support specialist interest group (SIG).



Service providers and commissioners.

To map the provision of psycho-oncology services in acute hospitals, we approached organisational representatives across the Alliance footprint who were identified as providing or facilitating psychological support. This included representative of the following acute hospital trusts:

- Dorset County Hospital NHS Foundation Trust
- University Hospitals Dorset NHS Foundation Trust
- Hampshire Hospitals NHS Foundation Trust
- Isle of Wight NHS Trust
- Portsmouth Hospitals University NHS Trust
- University Hospital Southampton NHS Foundation Trust

Additionally, to understand the availability of other cancer psychological support services in Wessex, representatives from services in following areas of practice were contacted:

- Specialist community palliative care psychological therapies services
- Third sector organisations providing psychological therapies for people affected by cancer.
- NHS Talking Therapies (formerly IAPT) services.

Commissioners were also contacted to understand what services (if any) were formally commissioned for people affected by cancer across Wessex.

Professional representatives

Representatives across a range of professional groups were invited to participate in informal interviews to understand more about the role of psychological support services in Wessex:

- Commissioning Manager
- Cancer Service Manager
- Practice Nurse
- Cancer Care Coordinator
- Primary Care Network (PCN) GP lead
- NHS Talking Therapies Service Leads
- Oncology Dietician
- Nurse Education Lead

Data Collection methods

Online surveys

Four questionnaires were codesigned with input of the SIG. These questionnaires were administered online and were used to map provision of cancer psychological support services in acute hospitals, hospice, and palliative care services, third sector organisations, and NHS Talking Therapy providers. All questionnaires included the following components:

- Staffing provision for Level 3-4 psychological support services.
- Types of interventions delivered by Level 3-4 services.
- Estimated provision of Level 2 psychological support.
- Provision and update of psychological skills training.
- Provision and update of psychological supervision.
- Staffing provision for levels 2-4 practitioners.
- Interventions delivered at level 3 and 4.
- Screening and assessment tools used in practice.
- Escalation pathways.
- Links and access to other specialities e.g., mental health providers, neuropsychology, art therapy
- Referral pathways to/from NHS Talking Therapies.
- Data collection on unmet psychosocial need delaying treatment.
- Feedback to Wessex Cancer Alliance.

A sample survey for specialist (Level 3-4) practitioners was conducted to further understand the proportion of time within a post allocated to delivering support to people with cancer, as well as additional responsibilities including providing psychological supervision to the level 2 workforce.

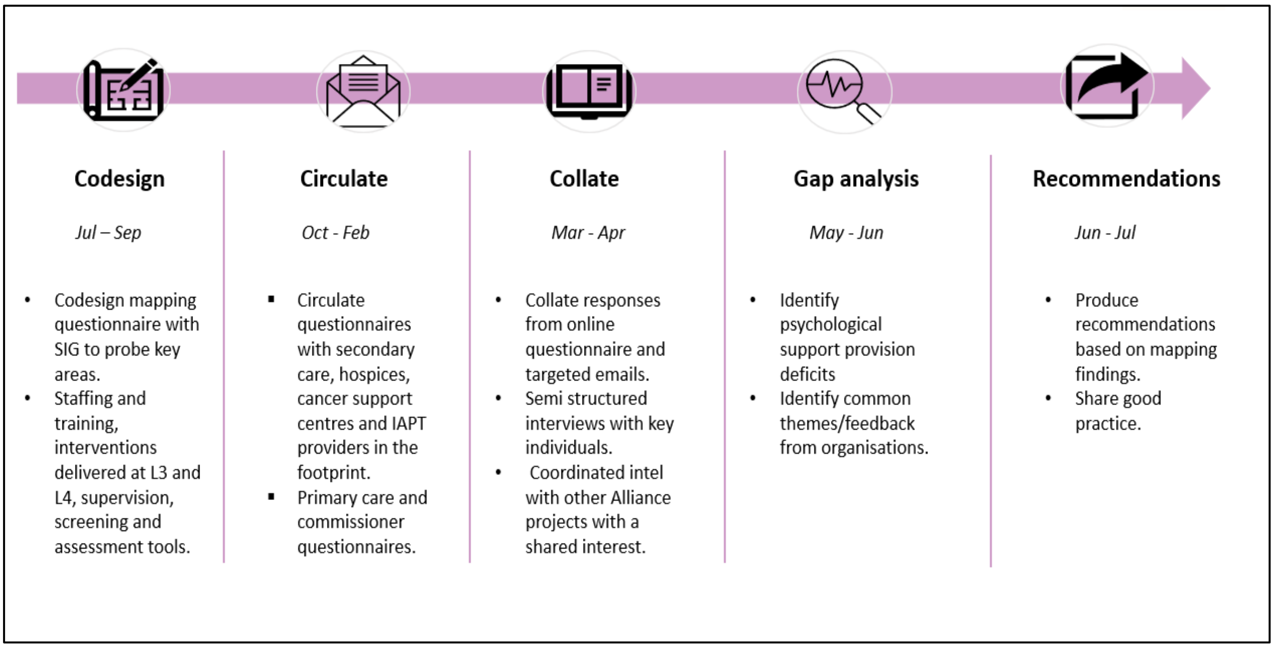
Informal interviews

Informal interviews were conducted to gain further insight on key elements probed by the mapping. Interviews were predominantly conducted online, however four commissioning representatives provided feedback to key questions via email exchange in place of being interviewed.

Procedure

Key milestones in the project are summarised in Figure 5 and distinct phases of the project methodology are described in detail below.

Figure 5. Project approach to mapping cancer psychological support provision across Wessex



Codesign

Jul – Sep

- Codesign mapping questionnaire with SIG to probe key areas.
- Staffing and training, interventions delivered at L3 and L4, supervision, screening and assessment tools.

Circulate

Oct - Feb

- Circulate questionnaires with secondary care, hospices, cancer support centres and IAPT providers in the footprint.
- Primary care and commissioner questionnaires.

Collate

Mar - Apr

- Collate responses from online questionnaire and targeted emails.
- Semi structured interviews with key individuals.
- Coordinated intel with other Alliance projects with a shared interest.

Gap analysis

May - Jun

- Identify psychological support provision deficits
- Identify common themes/feedback from organisations.

Recommendations

Jun - Jul

- Produce recommendations based on mapping findings.
- Share good practice.

Gap analysis

To understand gaps in services, we applied the gap analysis method described by the London Transforming Cancer services Team (2020):

- We estimated the level of psychological need across Wessex by using figures from NICE (2004a) guidance, estimating that during the first year following a diagnosis, 15% of those diagnosed will need level 3 support and a further 10% will require level 4 support.
- We estimated that 20% of family members would require level 3 or 4 support in the same period.
- We estimated that an additional 20% capacity would be required by services to ensure delivery of Level 2 supervision and training.
- We estimate a further 10% capacity will be required to account for an increase in cancer diagnoses based on current trends.
- To estimate the staffing level required to provide services, we used data from King (2015) which suggests that the average psycho-oncology clinician sees 120 new patients per annum. Based on feedback from the SIG, we acknowledge this is likely an overestimate of current service activity, however this provided a consistent approach to mapping.

Cost utility analysis

We followed the methodology described by the London Transforming Cancer Services Team (2020) to analyse cost utility. This involved estimating the number of Quality Adjusted Life Years (QALYs) associated with a reduction in anxiety and depression symptoms among people affected by cancer as a result of a psychological intervention and estimating monetised health gain (MHG) per QALY in accordance with a threshold range defined by NICE (2013).

Consistent with the London model, a QALY score is defined on an interval level as 0 or 1, where 0 represents death and 1 represents perfect health; a QALY gain has been estimated based on recovery data from NHS Talking Therapies as in the range of 0.071 (lower threshold) and 0.152 (upper threshold); MHG is estimated to range from £20,000 (lower threshold) to £30,000 (upper threshold) per QALY gained.

Using this definition, and assuming that 50% of patients seen by a psychological professional will show an improvement in psychological distress (in accordance with NHS Talking Therapies data), the London model recommends using the following equations to estimate lower and upper threshold QALY gains and monetised health gains:

Lower threshold:

$$\text{QALY} = (N_{L3} + N_{L4}) \times 0.07$$

$$\text{MHG} = (N_{L3} + N_{L4}) \times 0.07 \times £20{,}000$$

Upper threshold:

$$\text{QALY} = (N_{L3} + N_{L4}) \times 0.11$$

$$\text{MHG} = (N_{L3} + N_{L4}) \times 0. \times £30{,}000$$

> *In these equations,* $\mathbf{N_{L3}}$ *refers to the number of patients who require support at level 3 and* $\mathbf{N_{L4}}$ *refers to the number of patients who require support at Level 4. Note that the upper QALY threshold gain of 0.11 is calculated as the average of lower and upper threshold estimates i.e., 0.071+0.152/2) and should therefore be considered a conservative figure.*

We generated lower and upper estimates of QALYs and MHG for each area across each locality in Wessex based on the estimated gains if a full service was provided at Level 3 and Level 4. We extended this to also estimate the gains associated with providing services for families.

Findings

Respondent characteristics

The Wessex region, depicted in Figure 6, consists of six providers of acute cancer care across two integrated care systems (see Table 3). We found that the region additionally incorporated 13 hospice and palliative care services, five NHS Talking Therapies Services, and five cancer support and information centres for people affected by cancer. This report focusses predominantly on the specialist (Level 3-4) psychological services provided at acute hospitals. Details of the services provided across these hospitals is provided in Table 3.

Figure 6. Map of Wessex Region

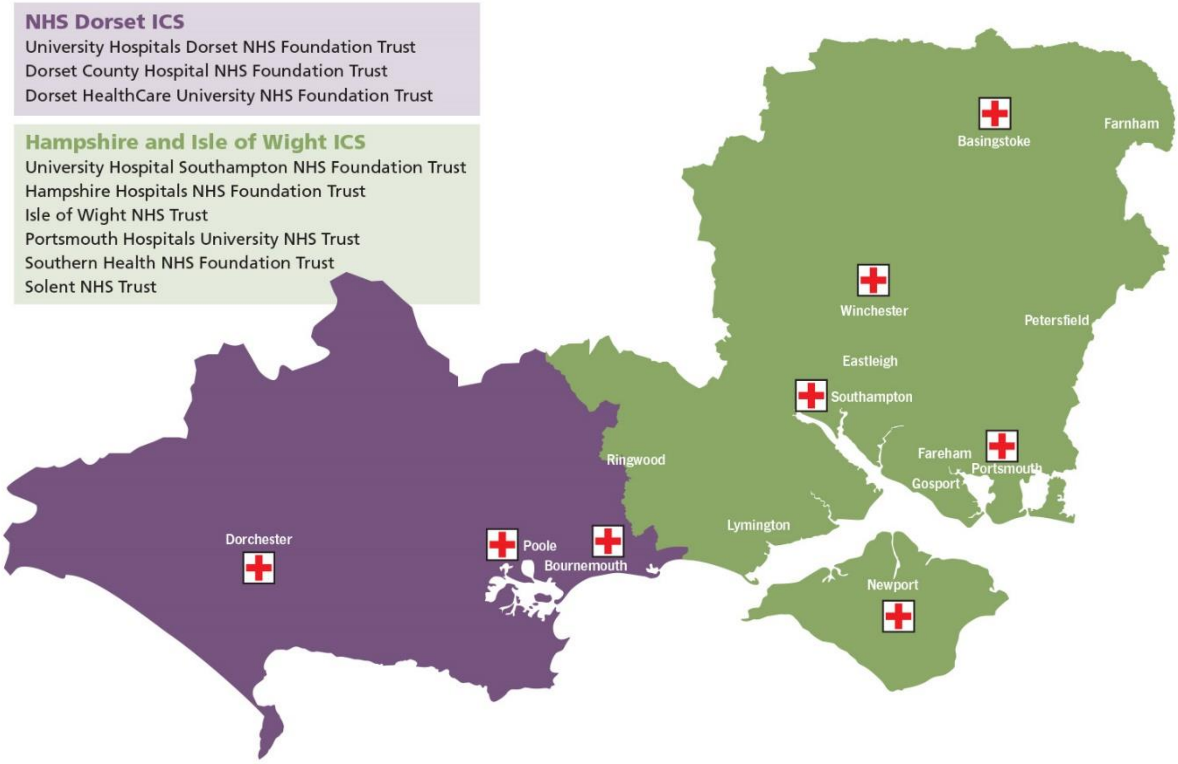


Table 3. Information on Wessex services

System	Provider	Area covered	Cancer services provided
Dorset	Dorset County Hospital NHS Foundation Trust (DCH)	West Dorset	• Colorectal • Cancer of Unknown Primary • Dermatology • Gynaecology • Haematology (Myeloma, lymphoma, leukaemia, and non malignancies) • Head and Neck cancers (incl. Thyroid cancers) • Lung • Upper Gastro-Intestinal and Hepatobiliary cancers • Urology
	University Hospitals Dorset NHS Foundation Trust (UHD)	East Dorset	• Breast • Metastatic Breast • Brain • Cancers of Unknown Primary • Colorectal • Dermatology (incl. melanoma, basal cell carcinoma, sqaumous cell carcinoma, and metastatic disease) • Gynaecology • Haematology (Malignancies, stem cell transplantation) • Head and Neck cancers (incl. Thyroid cancers) ￼ • Sarcoma • Lung • PanNET • Upper Gastro-Intestinal and Hepatobiliary cancers • Urology (incl. prostate bladder, testicular, kidney, ureteric, penile)
Hampshire and Isle of Wight	Hampshire Hospitals NHS Foundation Trust (HHFT)	North Hampshire	• Acute Oncology • Brain • Breast • Metastatic Breast • Colorectal • Cancers of Unknown Primary • Dermatology • Gynaecology • Haematology • Head and Neck cancers (incl. Thyroid cancers) • Lung • Upper Gastro-Intestinal and Hepatobiliary cancers • Urology • Peritoneal Malignancy (National referrals) • Peritoneal Mesothelioma (National referrals)
	Isle of Wight NHS Trust (IOW)	Isle of Wight	• Breast • Colorectal • Cancers of Unknown Primary, Brain tumours and rarer cancers • Dermatology • Gynaecology

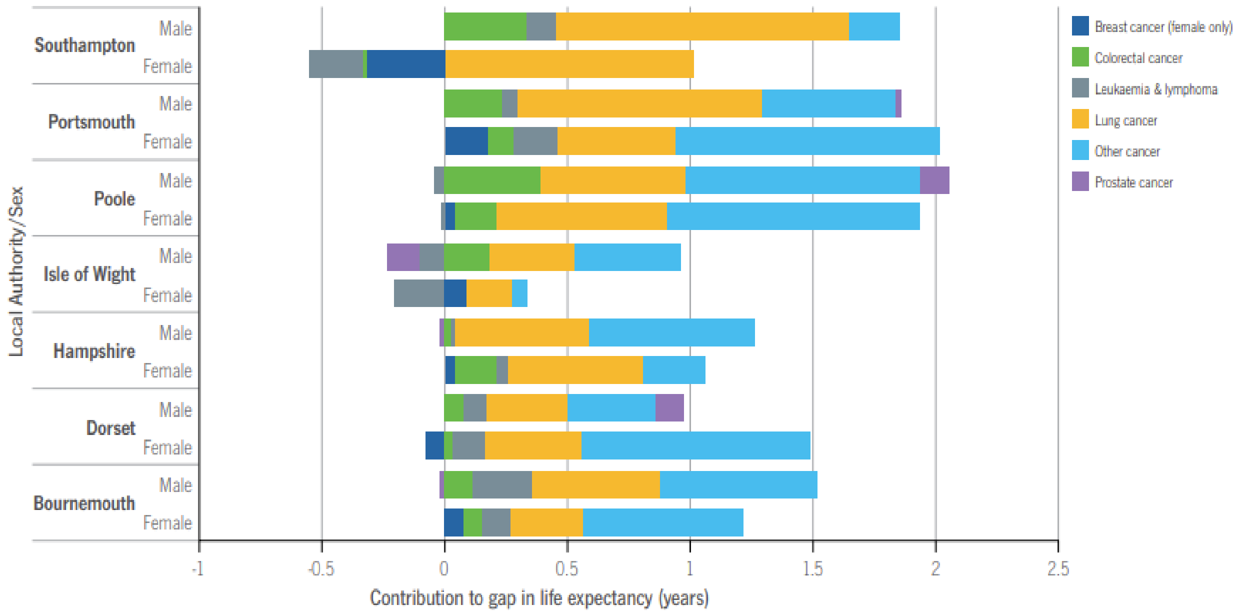
			• Haematology • Head and Neck cancers. ￼ • Lung • Upper Gastro-Intestinal and Hepatobiliary cancers • Urology (Bladder, prostate, testicular, kidney, penile)
	Portsmouth Hospitals University NHS Trust (PHU)	City of Portsmouth and Southeast Hampshire	• Breast and metastatic breast cancers • Brain • Cancers of Unknown Primary • Colorectal • Dermatology • Gynaecology • Haematology • Head and Neck cancers (incl. thyroid cancers) ￼ • Lung (including mesothelioma) • Lymphoma • Upper Gastro-Intestinal and Hepatobiliary cancers Urology
	University Hospital Southampton NHS Foundation Trust (UHS)	City of Southampton, New Forest, and South-West Hampshire	• Breast • Brain • Cancers of Unknown Primary • Colorectal • Dermatology • Gynaecology • Haematology (Bone Marrow Transplant & cell therapy) • Haematology (Myeloid) • Head and neck cancers. ￼ • HPB (Liver, Pancreatic, Biliary, Duodenal) • Lung (including mesothelioma) ￼ • Lymphoma • Sarcoma • Upper Gastro-Intestinal and Hepatobiliary cancers Urology (Bladder, Kidney, Prostate, penile, ureter, Germ cell)

Demographic characteristics across the Wessex region

The area of Wessex is quite diverse in terms of age. The Dorset and Isle of Wight areas have an older than average population; 27% and 26% (respectively) are over 65 years old. This compares to 17% for England. The Wessex population is projected to grow over next 5 years (and beyond) with the most significant growth in the over 65s. Wessex also has areas with large numbers of younger people; likely associated with universities. Southampton City and Portsmouth, for example, have a substantial proportion of people aged 18-24; 17% and 15% of the population compared with England average of 9%.

Wessex has a predominately white British population, though some areas have greater diversity in terms of ethnicity and culture. Wessex is relatively affluent but does include areas of deprivation, based on Indices of Multiple Deprivation (IMD). Figure 7 shows how cancer adds to the inequality in life expectancy based upon deprivation. For example, in Southampton, lung cancer is a large contributing factor both for males and females and contributes to a reduction of a year of life, but breast cancer is clearly associated with the more affluent areas.

Figure 7. Breakdown of the contribution of cancer to the life expectancy gab between most and least deprived quintiles



New cancer diagnoses across Wessex.

To enable us to calculate the level of psychological need across Wessex, we first examined the rates of new cancer diagnoses. New diagnoses per annum are presented by trust for three consecutive years from 2019-20 through to 2021-22 (Table 4).

Table 4. New Cancer Diagnoses by acute Trusts

Trust	19/20	20/21	21/22
Dorset County Hospital NHS Foundation Trust	2466	2233	2628
Hampshire Hospitals NHS Foundation Trust	3239	2950	3496
Isle Of Wight NHS Trust	1457	1242	1397
Portsmouth Hospitals University NHS Trust	3826	4388	4555
University Hospitals Dorset NHS Foundation Trust	2845	2519	3144
University Hospitals Southampton NHS Foundation Trust	4533	4080	4767
Total	**18366**	**17412**	**19987**

The data presented in Table 4 shows that there were almost 20,000 new cancer cases across Wessex in the year 2021-22. Many areas within the Alliance footprint have a higher number of new diagnoses of cancer than the England national average (Dorset, Isle of Wight, South East Hampshire and West Hampshire) with new diagnosis rates >531 per 100,000 population (Fingertips 2019/20). This trend appears consistent and will impact on all aspects of cancer care delivery including increasing demand on psychological support.

Further, the most recent figures (2022 onwards) suggest an increase in the incidence of cancer. These figures do not account for people living with cancer including those advanced disease beyond the first year of diagnosis. Taking these factors into account, we believe that 19,987 is a conservative estimate of the number of new cancer cases across Wessex per annum.

Estimating psychological need

We used data from the year 2021-22 to estimate the level of psychological need for those newly diagnosed with cancer and their families, in the first year following a cancer diagnosis. Results are presented by Trust in Table 5.

Table 5. Estimates of psychological need across Wessex

Trust	Patients		Family members (Levels 3-4)	Total level of need	Total level of need plus 10%
	Level 3	Level 4			
Dorset County Hospital	394	263	131	788	867
Hampshire Hospitals Foundation Trust	524	350	175	1,049	1,154
Isle Of Wight Hospital	210	140	70	419	461
Portsmouth Hospitals University Trust	683	456	228	1,367	1,503
University Hospitals Dorset NHS Foundation Trust	472	314	157	943	1038
University Hospitals Southampton	715	477	238	1,430	1,573
Total:	**2,998**	**1,999**	**999**	**5,996**	**6,596**

The figures presented provide insight into estimated demand on specialist, Level 3 and Level 4, services for the provision of psychological interventions to patients, family members, and in total. In addition, we have projected an increase in need of 10% to account for increased incidence of cancer. The estimated level of need is limited to the first year following diagnosis only. These figures *do not* reflect referrals later in the pathway or associated variations in acuity or complexity, and therefore varying support requirements, and should therefore be considered a starting point for understanding demand.

Table 6. Mapping of psycho-oncology workforce by acute hospital across Wessex

Trust	Level 3 staffing		Level 4 staffing		Total staffing Level 3-4		Details
	N posts	WTE	N posts	WTE	N posts	WTE	
Dorset County Hospital	1	0.60	0	0.00	**1**	**0.60**	• 1 x 0.6 WTE band 6 Level 3 Counsellor post, for all cancers.
Hampshire Hospitals Foundation Trust	3	3.00	2	2.00	**5**	**5.00**	• 2 x 1.0 WTE band 5 and 1 x 1.0 WTE band 6 Level 3 Counsellor posts, for all cancers, based at Basingstoke. • 1 x 1.0 WTE band 8b Level 4 Practitioner Psychologist post for all cancers – **vacant at time of mapping**. • 1 x 1.0 WTE band 8d Level 4 Practitioner Psychologist post, split between all cancers (0.2 WTE) and input to the regional peritoneal malignancy unit (0.8 WTE).
Isle Of Wight Hospital	0	0.00	1	1.00	**1**	**1.00**	• 1 x 1.0 WTE Level 4 Practitioner Psychologist post for all cancers.
Portsmouth Hospitals University Trust	1	0.13	2	1.40	**4**	**1.53**	• 1 x 0.13 WTE band 8c Consultant Nurse providing Level 3 Counselling, for breast cancer patients only. • 1 x 0.4 WTE band 8a Level 4 Practitioner Psychologist for all cancers. • 1 x 1.0 WTE band 8b Level 4 Practitioner Psychologist for all cancers.
University Hospitals Dorset Foundation Trust	4	3.60	1	0.80	**5**	**4.40**	• 2 x 1.0 WTE band 6 Level 3 Counsellors providing input in palliative care bereavement and oncology based at Poole. (0.8 is specifically for Oncology, with the rest of the role dedicated to palliative care and bereavement – post funded by Forest Holme charity) • 1 x 0.6 WTE band 6 & 1 x 1.0 WTE band 7 Level 3 Mental Health Practitioner posts for all cancers • 1 x 0.8 WTE band 8b Level 4 Practitioner Psychologist for all cancers, based at Poole.
University Hospitals Southampton	1	0.40	3	1.90	**4**	**2.30**	• 1 x 0.4 WTE band 7 Specialist Nurse providing Level 3 psychological support for all cancers, for hospital inpatients only. • 1 x 0.4 WTE band 7 Practitioner Psychologist providing Level 4 input for acute leukaemia patients only. • 1 x 1.0 WTE band 8a Practitioner Psychologist providing Level 4 input for Teenage and Young Adult (TYA) cancers only – vacant at time of mapping. • 1 x 0.5 WTE band 8b Practitioner Psychologist providing Level 4 input for Bone Marrow Transplant (BMT) allogenic pathway patients only.

Total:	**10**	**7.73**	**10**	**7.1**	**20**	**14.83**	

Workforce mapping of psycho-oncology services in acute hospitals

Mapping of the Level 3-4 psychological workforce in acute hospitals is presented by Trust in Table 6. The results presented are for salaried posts delivered in NHS acute hospitals only. The results of mapping indicate disparity in terms of Level 3 and 4 services across the Wessex region.

In Dorset, there was no access to Level 4 services for those served by DCH, whereas provision for those served by UHD also included services for those with a life-limiting diagnosis other than cancer, suggesting an overestimate of the psychological support available.

Across Hampshire and the Isle of Wight, there was evidence of disparity in terms of service provision; for example patients of Portsmouth, Southampton and the Isle of Wight had limited access to Level 3 counselling via acute trusts when compared to patients of Hampshire Hospitals; patients of Southampton and to a degree Hampshire Hospitals were also limited in terms of access to Level 4 services, since some of the psychology services provided in these areas were highly specialist and therefore limited to specific patient groups only (haematological cancers, teenage and young adult cancers, and peritoneal cancers).

Another source of disparity is in relation to the banding of posts: some services were led by a Consultant Psychologist (band 8c or above), which is consistent with workforce guidance documentation published by the British Psychological Society (e.g., BPS, 2008; BPS, 2023) and commensurate with the recently updated role descriptions for Consultant Clinical Psychologist posts published by NHS Employers (2023). In contrast, other services (e.g., UHD, UHS) had lead posts banded below Consultant level and which therefore do not conform to the national guidance on job roles.

Workforce activity in acute hospitals

Based on findings from a sample survey conducted with members of the SIG, the average level 3 and 4 practitioner post was found to be 0.8 WTE, approximately 30 hours per week. A breakdown of the activity of Level 3-4 practitioners, in number of hours, is depicted in Figure 8. A detailed breakdown of service activity is also provided in Appendix E; however, it should be noted that data were incomplete or missing in relation to some services provided to people affected by cancer.

Figure 8. Example of work undertaken by psycho-oncology professionals

Direct clinical work

Services saw a range of in and outpatients for consultation or psychological therapy. Figure 8 indicates that for those surveyed, on average, Level 3-4 practitioners spent 27% of their time working clinically with outpatients and an additional 10.7% of their time working clinically with inpatients. Clinicians therefore spent 37.7% of their time delivering direct clinical care to patients.

Only limited data were provided regarding how many patients were seen by Level 3-4 services across each trust per annum. Based on the data available, it appears that clinicians working at Level 3 saw a higher number of patients for fewer appointments each year as compared to those in Level 4 services. This is unlikely due to staffing, since WTE staffing levels were similar across both Levels 3 and 4 and is instead likely to reflect differences in Level 3 and 4 roles. Level 4 practitioners tend to see people with greater levels of psychological need and complexity, which may necessitate longer interventions in accordance with an established evidence base (e.g., it is recommended that therapy for PTSD take place over 8-12 sessions; NICE, 2018). This was reflected in some of the comments shared by Practitioner Psychologists from the SIG. This is also consistent with previously published national data on quality and outcomes in psycho-oncology: while, on average, clinicians may see up to 120 clients per year for an average of four sessions, some services were found to see fewer patients for significantly longer due to complexity (King, 2015). Practitioners at Level 4 were also more likely to have held additional responsibilities outside of direct patient care – for example, leadership activities (see *Leadership and Management,* below).

Data on wait times for starting therapy were incomplete, however the available data indicated a wide range, from up to one week for urgent appointments, through to up to 6 or 7 months for routine psychology appointments. It is considered good practice for services to be responsive and to offer urgent appointments within one week and routine appointments within four weeks (BPS, 2015).

Services were not asked to provide detailed information about the types of psychological interventions offered, however the provision of both counselling and psychology is consistent with NICE guidance (2004a).

Clinically related work with multidisciplinary teams (MDTs) also constitutes direct clinical work (BPS, 2023). It was found that Level 3-4 practitioners spent, on average, 6.7% of their time working into MDTs. This is suggestive of inequity as hospitals will typically have a cancer MDT for each cancer type/ speciality, and attendance of all MDTs would require more than 6.7% of a clinician's time. It is considered best practice to include psychologists in the care pathway/ MDTs for a number of cancers (see summary of NICE guidance, Appendix F) and in shared decision-making around end of life as part of enhanced supportive care (NHS England, 2016).

Indirect clinical work

Training:

Figure8 shows that, on average, Level 3-4 practitioners spent 3.3% of their time per week delivering teaching or training. To understand what this means in practice, we collected data on the number of staff working at Levels 1-2 who received psychologically informed training to support them in their roles. This is important, since work undertaken at the universal and enhanced levels (Levels 1-2) may prevent an escalation of psychological difficulties, and since the specialist work of practitioners at Levels 3-4 underpins the psychological aspects of roles at Levels 1-2.

We sought to understand the provision of training through questions asked in our surveys with Level 3-4 practitioners and with service providers. In acute Trusts, at the universal level (Level 1), psychological training was variable and not standardised. Uptake of training and education packages were not regularly recorded across staffing groups. Table 7 details the training provided or attended for the staff groups operating at this level. More than one training package was available or undertaken in 50% of Trusts in the footprint. However, there was variation between training offered to those with different roles within Trusts and across Wessex – for example, cancer support workers were offered more training and education packages compared with other staff groups.

For enhanced (Level 2) practitioners in acute trusts, there was less variation in the training provided. Two main training packages were available: Advanced Communication Skills and Level 2 Psychological Skills. Staff groups included in the Level 2 category were from the registered workforce including Cancer CNSs and AHPs, with the banding of practitioners varying from AfC band 6 to AfC band 8b.

Table 7. Universal (Level 1) psychologically-informed training offered to the supportive workforce

Type of training	**Number of Trusts offering training, presented by staffing group**			
	Administrative & Clerical	**Cancer Support Workers**	**Therapy Assistants**	**Healthcare Assistants**
Cancer care induction	1	1	0	1
SAGE & THYME	1	3	1	1
Macmillan Healthy Conversations	1	3	0	1
HNA training	1	2	0	0
MECC	0	2	0	0
Psychological skills	0	1*	1	0
End of life	0	0	0	1
None/ unsure	3	0	4	2

Note: *For this trust, two cancer support workers had completed Psychological Skills Level 2 training; note that psychological skills training constitutes a Level 2 training package that had been offered to some members of the supportive workforce.

Table8. Enhanced (Level 2) psychologically informed training offered to the registered workforce.

Training package	**% of Trusts offering package**
Advanced Communication Skills only	33%
Level 2 Psychological Skills	17%
Both packages	50%

Supervision

Figure 8 shows that, on average, Level 3-4 practitioners spent 6.7% of their time delivering supervision and reflective practice. Supervision is particularly important as it is a requirement of the role for those working at Level 2 (NICE, 2004a; national peer review measure).

Our mapping work indicated that the provision of supervision was variable across acute trusts in Wessex. At the time of mapping, psychological supervision was not provided to the unregistered/supportive workforce or to universal (Level 1) practitioners. However, these individuals may still have regular contact with patients and be delivering universal psychological support – for example, cancer support workers or pathway navigators.

For the majority of acute hospital trusts across the footprint, psychological supervision was offered to the CNS and/or AHP workforce involved in providing enhanced (Level 2) support, summarised in Table 9. This supervision was provided by specialist (Level 3-4) practitioners in accordance with NICE (2004a) guidance. However, capacity challenges for Level 3-4 practitioners greatly impacts the availability and provision of psychological supervision (see Section 3.6, Gap Analysis, below). Attendance of psychological supervision was not routinely monitored, but feedback received from the specialist (Level 3-4) practitioners who provided supervision indicated that even when supervision was available to the Level 2 workforce, uptake was variable. Staffing challenges experienced by the nursing and AHP workforce was identified as one possible reason for this.

Table 9. Summary of psychological supervision provided to the enhanced (Level 2) workforce.

Region	Trust	Who provides supervision?	How is supervision delivered?	Is supervision available to the staff group at a minimum of ~1 hour per month?	Uptake of supervision
Dorset	Dorset County Hospital NHS FT	Counsellor	Virtual group meeting Virtual 1:1 Face to face 1:1	Yes	-
	University Hospital Dorset NHS FT	Clinical Psychologist	Face to face /virtual (hybrid) group meeting Virtual 1:1 Face to face 1:1	Yes – Poole site, No – Bournemouth site	-
Hampshire & Isle of Wight	University Hospital Southampton NHS FT	-	-	-	-
	Hampshire Hospitals NHS FT	Clinical Psychologist	Face to face group meeting Virtual group meeting	Yes, mandatory upon appointment of new psychologist	-
	Portsmouth Hospital University NHS FT	Clinical Psychologist	Face to face 1:1 Face to face group meeting	No – capacity issues	Variable
	Isle of Wight NHS FT	Clinical Psychologist	Face to face group meeting Virtual 1:1 Face to face 1:1	Yes	-

Leadership and management

Leadership and management are considered part of the clinical work undertaken by psychological professionals (BPS, 2023). Figure8 indicates that, on average, practitioners spent 27% of their performing leadership and management related activities. This likely reflects the seniority and leadership responsibilities of some of the respondents to the mapping exercise.

Research

Level 3-4 practitioners spent, on average, 1.7% of their time performing research-related activities.

Supportive professional activity and other activities:

Supportive professional activities include continuing professional development (CPD) and work across systems (BPS, 2023). Figure 8 shows that, on average, Level 3-4 practitioners were engaged in CPD for 3.3% of their time. CPD requirements vary across roles, however for practitioner psychologists the British Psychological Society recommends a minimum of 10 days (approx. 75 hours) across the year pro rata (BPS, 2023).

Practitioners spent 13.7% of their time engaged in other activities not characterised above.

Gap analysis of psycho-oncology in acute hospitals

The results of gap analysis are presented in Tables 10 to 14.

Tables 10 and 11 show the gap by Trust and across Wessex for provision of Level 3 and Level 4 services for patients only. As expected from mapping, there is variation across Trusts. However, overall, there is a slightly larger gap at Level 3 than Level 4.

Tables 12 shows what is required across Levels 3 and 4 to meet the needs of patients and family members, while Table 13 shows what is required to additionally provide supervision and training for the Level 2 workforce. Finally, Table 14 estimates workforce requirements to meet an additional capacity of 10% to future-proof services.

Figures across these tables paint a stark picture**, demonstrating a gap of between 35.14 and 51.13 WTE clinicians**. In total, **up to 78% of the workforce requirement for providing specialist (Level 3-4) psychological services was unmet across Wessex**. This severely limits the extent to which services can be provided for patients and families, to support the development of holistic care at other levels, embed holistic care across systems.

Table 10. Gap analysis – Level 3

Trust	Level 3			
	Demand (WTE)	Capacity (WTE)	Gap (WTE)	Gap (%)
Dorset County Hospital	3.29	0.60	2.69	82%
Hampshire Hospitals Foundation Trust	4.37	3.00	1.37	31%
Isle Of Wight Hospital	1.75	0.00	1.75	100%
Portsmouth Hospitals University Trust	5.69	0.13	5.56	98%
University Hospitals Dorset	3.93	3.60	0.33	8%
University Hospitals Southampton	5.96	0.40	5.56	93%
Total:	**24.98**	**7.73**	**17.25**	**69%**

Table 11. Gap analysis – Level 4

Trust	Level 4			
	Demand (WTE)	Capacity (WTE)	Gap (WTE)	Gap (%)
Dorset County Hospital	2.19	0.00	2.19	100%
Hampshire Hospitals Foundation Trust	2.91	2.00	0.91	31%
Isle Of Wight Hospital	1.16	1.00	0.16	14%
Portsmouth Hospitals University Trust	3.80	1.40	2.40	63%
University Hospitals Dorset	2.62	0.80	1.82	69%
University Hospitals Southampton	3.97	1.90	2.07	52%
Total:	**16.65**	**7.10**	**9.55**	**57%**

Table 12. Gap analysis – Level 3-4 combined plus needs of family members.

Trust	Level 3-4: Patients and family members			
	Demand (WTE)	Capacity (WTE)	Gap (WTE)	Gap (%)
Dorset County Hospital	6.57	0.60	5.97	91%
Hampshire Hospitals Foundation Trust	8.74	5.00	3.74	43%
Isle Of Wight Hospital	3.49	1.00	2.49	71%
Portsmouth Hospitals University Trust	11.39	1.53	9.86	87%
University Hospitals Dorset	7.86	4.40	3.46	44%
University Hospitals Southampton	11.92	2.30	9.62	81%
Total:	**49.97**	**14.83**	**35.14**	**70%**

Table 13. Gap analysis – Level 3-4 combined plus needs of family members and workforce requirements for providing supervision and training.

Trust	Level 3-4 direct need plus workforce need			
	Demand (WTE)	Capacity (WTE)	Gap (WTE)	Gap (%)
Dorset County Hospital	7.88	0.60	7.28	92%
Hampshire Hospitals Foundation Trust	10.49	5.00	5.49	52%
Isle Of Wight Hospital	4.19	1.00	3.19	76%
Portsmouth Hospitals University Trust	13.67	1.53	12.14	89%
University Hospitals Dorset	9.43	4.40	5.03	53%
University Hospitals Southampton	14.30	2.30	12.00	84%
Total:	**59.96**	**14.83**	**45.13**	**75%**

Table 14. Gap analysis – Level 3-4 combined plus needs of family members and workforce requirements for providing supervision and training and additional 10% capacity for growth.

Trust	Total need plus 10% for growth			
	Demand (WTE)	Capacity (WTE)	Gap (WTE)	Gap (%)
Dorset County Hospital	8.67	0.60	8.07	93%
Hampshire Hospitals Foundation Trust	11.54	5.00	6.54	57%
Isle Of Wight Hospital	4.61	1.00	3.61	78%
Portsmouth Hospitals University Trust	15.03	1.53	13.50	90%
University Hospitals Dorset	10.38	4.40	5.98	58%
University Hospitals Southampton	15.73	2.30	13.43	85%
Total:	**65.96**	**14.83**	**51.13**	**78%**

Cost utility analysis

Estimated monetised health gain (MHG) based on providing Level 3-4 services is presented in Table 15. This includes estimates of MHG across each hospital, for Wessex as a whole, and for the regions of Dorset, and Hampshire and Isle of Wight.

If each whole-time clinician were to see 120 clients per year, then MHG per-clinician would be expected to range from £84,000 and £198,000. This compares to employment costs per whole-time psychological professional which range from £37,560 (entry step point Band 5, Agenda for Change 2024-25 pay scale, inclusive of on-costs*) to £129,832 (top step point band 8D plus on-costs). An intermediate step point Band 8a post inclusive of on-costs (the median point) is £71,389 – this is lower than the most conservative estimate of monetised health gain, suggesting a cost saving.

Applying this to the Wessex psychological workforce identified through mapping, based on staffing levels, MHG would be expected to range from just over £1.2 million to just over £2.9 million per year. This equates to MHG for Dorset of £420,000 to £990,000, and for Hampshire and the Isle of Wight, MHG of £825,720 to £1,946,340.

If services were provided for patients only and were fully staffed to the level required based on our mapping and gap analysis, then MHG across Wessex would be estimated to range from £3,497,725 to £8,244,639; this equates to MHG for Dorset of £1,010,100 to £2,380,950, and for Hampshire and Isle of Wight, MHG of £2,487,625 to £5,863,689. If services were staffed sufficiently to also provide support to family members, then MHG would increase to range from £4,197,27 to £9,893,565 for Wessex as a whole. This equates to MHG for Dorset of £1,212,120 to £2,857,140, and for Hampshire and Isle of Wight, a range from £2,985,150 to £7,036,425.

Table 15. Estimates of monetised health gain (MHG) through provision of Level 3-4 Psychological Services in Acute Hospital Trusts

Trust	MHG for current Level 3-4 services operating at full capacity		MHG if Level 3-4 services for patients fully staffed		MHG if Level 3-4 services for patients and families fully staffed	
	Lower estimate	Upper estimate	Lower estimate	Upper estimate	Lower estimate	Upper estimate
Dorset County Hospital	£50,400	£118,800	£459,900	£1,084,050	£551,880	£1,300,860
Hampshire Hospitals	£420,000	£990,000	£611,800	£1,442,100	£734,160	£1,730,520
Isle Of Wight Hospital	£84,000	£198,000	£244,475	£576,263	£293,370	£691,515
Portsmouth Hospitals	£128,520	£302,940	£797,125	£1,878,938	£956,550	£2,254,725
University Hospitals Dorset	£369,600	£871,200	£550,200	£1,296,900	£660,240	£1,556,280
University Hospitals Southampton	£193,200	£455,400	£834,225	£1,966,388	£1,001,070	£2,359,665
Total	**£1,245,720**	**£2,936,340**	**£3,497,725**	**£8,244,639**	**£4,197,270**	**£9,893,565**
Total (Dorset only)	£420,000	£990,000	£1,010,100	£2,380,950	£1,212,120	£2,857,140
Total (HIOW only)	£825,720	£1,946,340	£2,487,625	£5,863,689	£2,985,150	£7,036,425

*On-costs included above are from University Hospital Southampton – these are based on Agenda for Change 2024-25 pay rates and inclusive of pay, employer national insurance and pension contributions, and an additional £250 to cover the cost of staff training.

Psychological support in other settings

While our mapping, gap analysis and cost-utility analysis focussed on specialist (Level 3-4) psychological services provided in acute hospitals, we wanted to understand the extent to which specialist psychological support was provided in other areas including in NHS Talking Therapies, Primary Care, Hospice and Palliative Care Services, and the Third Sector. This is because these services contribute to the overall trajectory of cancer psychological support. It was not possible to map these services in full; however, an overview of the support offered across these settings, including any training or supervision provided to support the wider cancer workforce, is provided below.

NHS Talking Therapies

NHS Talking Therapies services were developed work with common mental health difficulties such as anxiety and depression. They provide a range of psychological interventions including cognitive behavioural therapies, dynamic interpersonal therapy, counselling, and eye-movement desensitisation and reprocessing (EMDR). These interventions are broadly consistent with those offered at NICE (2004a) Levels 3-4 in cancer care.

While NHS Talking Therapies services can and do work with people affected by cancer, including via long-term conditions pathways, we found that information about a cancer diagnosis was not systematically recorded. Therefore, it was not possible to map the provision of cancer psychological support by NHS Talking Therapies. There may be many reasons for this including instances where a person is living life after cancer and therefore no longer identifies as a ‘cancer patient,’ even if their psychological difficulties were precipitated or exacerbated by cancer and treatment.

Training

Training for NHS Talking Therapy providers is not cancer specific. Instead, clinicians receive training in working with a range of long-term conditions which includes approximately one day of training on working with cancer.

Integration with psycho-oncology services including access to supervision.

Service leads reported that there were no established referral pathways to psycho-oncology services, with no formal pathway for accessing specialist supervision from colleagues working in psycho-oncology services. These pathways are necessary to implement a personalised model of cancer psychosocial care (see Figure 2, page 15). Ongoing work within Wessex is now highlighting the importance of integration, training, and supervision to support clinicians working with people affected by cancer in NHS Talking Therapies services (see Box 2).

Primary Care

Our mapping work identified roles based in primary care that involve the provision of psychological support for people affected by cancer. These include mental health practitioners, health and wellbeing coaches, social prescribers, and cancer care coordinators; however, these roles do not involve the provision of specialist (Level 3-4) psychological support. Across the Wessex footprint, many of the identified roles provide universal (Level 1) psychological support and are funded as part of the Additional Roles Reimbursement Scheme (ARRS) to support Primary Care Networks (PCNs) to expand their workforce to enable proactive and multidisciplinary personalised care to support. These roles are undoubtedly important but do not address the gaps identified at the specialist level as part of our mapping work.

Training

Primary care respondents did not report having specific training or education packages available in relation to provision of psychological support. Some GPs may have had access to the Macmillan training platform, but it was unclear on the proportion of professionals who could access this and who have completed training packages.

For supportive roles within primary care (e.g., Cancer Care Coordinators, Health & Wellbeing coaches), local training and induction was provided. Formal training was role specific, and most often not specific to cancer.

In semi-structured interviews conducted with primary care representatives, it was highlighted that there was a significant gap in training for cancer psychological support within primary care. This may extend further than GP practices and may include other organisations such as community hospitals and pharmacies.

Supervision

In primary care, psychological supervision is not mandatory or readily available, and attending psychological supervision is not part of job planning. We found that private supervision had been obtained in place of regular access to psychological supervision in some settings, however it was emphasised that access to any form of supervision was a personal choice. It was not clear that privately obtained supervision was psychological in focus (i.e., delivered by psychological practitioners, driven by psychological theory, or provided to improve psychological support of patients and families), nor was it clear that this supervision was specifically for the workforce supporting people affected by cancer.

Emerging roles in primary care, such as cancer care coordinators and social prescribers may seek psychological supervision from mental health practitioner where there is provision in the Primary Care Network (PCN). There were no systematic offers for psychological supervision to the level 1 and 2 workforce for primary care.

Hospice and Palliative Care

Some hospice and palliative care services provide support to people affected by cancer including patients, their family members, and carers. We attempted to include these services in mapping, however only respondent provided sufficient information on staffing provision for specialist (Level 3 and 4) psychological support. Where psychological services were available, there was reportedly low or no waiting list to access psychological support. Funding for posts came from the Integrated Care Board and from the hospice themselves.

The role of hospice and palliative care psychological therapies services is of enormous importance in meeting the needs of people affected by cancer, however based on the information we received we believe the provision of such services is inconsistent across Wessex. Even where specialist palliative care psychology services do exist, they are not solely for people affected by cancer. Moreover, because our gap analysis focussed on the needs of people in the first year following a diagnosis of cancer, and not of those living with advanced disease, we believe that there is still significant unmet psychological need among the cancer population even once hospice and palliative care services are accounted for.

Training

Respondents from hospice and palliative care largely conducted in house training packages, which covered topics such as bereavement theory and person-centred support for both universal (Level 1) and enhanced (Level 2) practitioners. One organisation listed SAGE & THYME available for health care support workers in addition to in house training. Education and training within this group was not cancer specific.

Supervision

For respondents based in hospice and palliative care services, there was some provision of psychological supervision for the universal and enhanced (Levels 1-2) workforce, although volunteers providing universal (Level 1) support were not obliged to attend supervision. Supervision was not standardised or widely available across all organisations or areas of practice. Access to psychological supervision in hospice and palliative care settings was dependent on the staffing provision for specialist (Level 3 and 4) services and whether there were enough practitioners to facilitate and lead supervision sessions.

Third Sector – Cancer Support and Information Centre

Across the footprint, we found that counselling was offered in all cancer support and information centres, with one centre also providing access to a clinical psychologist. Cancer information and support centres therefore provide some specialist (typically Level 3, some Level 4) psychological services. The criteria to access support varied but was generally dependent on a needs-based assessment. Support was primarily delivered via face-to-face consultation. Funding of these posts was through charitable means, with a minority of centres having volunteer (unpaid) counsellor roles. We have not included third-sector services in our mapping as they are not commissioned and not provided by the NHS. Therefore, while these services are undoubtedly a source of cancer psychological support, they may not be sustainable as funding and provision of services may fluctuate – this is especially the case in centres that rely on volunteer counsellors to deliver Level 3 psychological support.

All centres were additionally found to offer complementary therapies and other forms of holistic support to people affected by cancer (e.g., hypnotherapy, reflexology, and massage), often delivered by volunteers. These facets of support were not included in mapping as although they may enhance wellbeing, they are not evidence-based psychological interventions. Some centres were found to provide other supportive services – for example, financial advice – which is important to patients and families, but which is not enhanced psychological support. It is clearly important, therefore, to ensure that an overt distinction is made between specialist (Level 3-4) psychological interventions and the complementary, holistic, and other supportive services offered in cancer information and support centres. This distinction needs to be made by centres themselves and should be clear to the patients and families who use the centres. Moreover, complementary support should not be offered in place of evidence-based, NICE-consistent psychological interventions.

Training

Cancer support and information centres had a variety of training packages available for practitioners working at the universal level. Most of the packages delivered were in-house education covering key topics such as safeguarding, boundaries and an introduction to working with cancer. These were undertaken by volunteers, support workers and some complimentary therapists. In one centre, a mental health first aider was identified.

Supervision

In cancer support and information centres, the provision of psychological supervision was variable, and attendance was not mandatory for members of staff or volunteers. The examples of supervision in cancer information and support centres that we identified include:

- One centre reported providing supervision for practitioners working at Levels 1-3.

- In two centres that had counselling provision, it was mandatory for the counsellors to attend supervision on at least a monthly basis.
- Two centres reported that a private or external service were used to provide psychological supervision, on an ad hoc basis.
- Two centres provided no psychological supervision for their workforce, although staff and volunteers were supported through 1:1 meetings with centre leads or their line manager.

It is important, here, to distinguish psychological supervision from other forms of supervision, which may be supportive or managerial but may not draw on psychological theory and evidence in enhance and develop psychological practice. There is no suggestion in NICE (2004a) guidance that volunteers and staff providing universal (Level 1) support in cancer information and support centres should have access to psychological supervision, however any staff identified as working at Level 2 (i.e., providing an enhanced form of psychological assessment and/or support) should have psychological supervision included in their job plans. It is also clear that any psychological staff delivering specialist (Level 3-4) interventions in cancer information and support centres must have access to their own supervision in accordance with professional guidelines.

Measuring cancer-related psychological difficulties

The ways in which psychological difficulties are measured across psycho-oncology settings is known to vary (King, 2015). As a final step in mapping, we sought to understand how different services capture psychological distress and the extent to which there was consistency in use of psychometric measures.

We found some consistency in the use of common screening and assessment tools by psycho-oncology services in acute hospitals across the Wessex footprint and those used in other services. Across settings, the Patient Health Questionnaire (PHQ-9), Generalised Anxiety Disorder (GAD-7), and Hospital Anxiety and Depression Scale (HADS) were the most frequently used tools. We also found that different services used a range of additional, specialist measures, which were not consistent across services. These similarities and differences are summarised in Table 16.

It is important to note that while most of the assessment tools used across settings were validated psychometric measures, some tools were not – for example, the Holistic Needs Assessment (HNA) or Cancer Concerns Checklist. These unvalidated measures do not provide a score, or metric, that can be interpreted to quantify or objectively measure psychological distress.

The use of screening tools is important as a means of understanding what drives psychological difficulties and distress in relation to cancer, and to measure outcomes for patients in relation to psychological interventions. Within Wessex, we have been supporting work to understand how best to measure the psychological impact of cancer (see Box 4).

Table 16. Screening and assessment tools used for the identification and management of psychological distress reported by respondents.

	Acute hospital psycho-oncology services	**Primary care**	**Cancer support and information centres**	**Hospices and palliative care**	**NHS Talking Therapies**
Common tools used for screening and assessment of psychological distress	HADS	-	HADS	HADS	HADS
	PHQ-9	PHQ-9	PHQ-9	PHQ-9	PHQ-9
	GAD-7	GAD-7	GAD-7	GAD-7	GAD-7
	HNA/ Concerns checklist	-	-	-	-
Specialist tools used for screening and assessment of psychological distress	PsyFlex Fear of Cancer Recurrence – 7 item (FCR-7) Work and Social Adjustment Scale (WSAS) Impact of Event Scale - Revised (IES-R) Post Traumatic Stress Disorder Checklist 5 (PCL-5) Clinical Outcomes in Routine Evaluations – Outcome Measure (CORE-OM) Connor-Davidson Resilience Scale (CD-RISC-25) Quality of Life measures; EORTC-QLQ-C30, FACT-BMT Distress Thermometer	Cornell scale for depression in dementia Consultation skills of observation and active listening	Burns Anxiety/Depression In house screening tools Experiences befrienders and staff	Adult Attitude to Grief (AAG)	Specific condition focused measures Work and social adjustment scale (W&SAS) IAPT Long Term Health Conditions Questionnaire IAPT Anxiety Disorder Specific Measure (ADSM)

Conclusions and recommendations

The primary objective of this scoping exercise was to determine the extent to which specialist (Level 3-4) psychological support services are required by people affected by cancer across Wessex and the extent to which these services are provided. We looked at cancer diagnoses and mapped the available services provided by and for acute hospitals in the year 2022-23. We undertook gap analysis to estimate the gap in psychology provision and to calculate how many additional whole-time equivalent practitioners are required to address unmet psychological need. We finally undertook economic analysis to determine the monetised health gain associated with provision of services.

Unmet psychological need

Of the 19,987 people diagnosed with a new cancer in the year 2021-22, 4,997 patients were expected to have required specialist (Level 3 or 4) psychological support, with a further 999 family members also requiring support. We found that we would require an additional 39.64 WTE practitioners at Levels 3-4 to provide this. This figure rises to 50.63 WTE practitioners when accounting for the provision of indirect psychological care including MDT input, training, and supervision. These numbers are stark, and we recognise that, at the time of writing, the economic climate makes it extremely difficult to recruit this many additional practitioners in the short-to-medium term. Nonetheless, the gap analysis clearly demonstrates how under-resourced we are as a region. The reality is that this increases and prolongs the suffering experienced by people affected by cancer, by either delaying or preventing access to psychological care, leading to reduced quality of life, impaired day-to-day functioning and in some cases, early death. We must accept this uncomfortable position as a difficult starting point from which to build as we seek to improve cancer psychosocial care.

The findings of this report indicate that even where Level 3 and 4 services do exist, there is significant disparity across the Wessex region. Some trusts (e.g. DCH) have no access to Level 4 services, while others (e.g., PHU) have limited access to Level 3. Some trusts (e.g., UHS) have developed Level 4 services to support specific cancers only, which creates inequity of service. Disparities were also present in relation to the banding of Level 4 posts, with evidence of some services (e.g., UHD, UHS) led by practitioner psychologists at band 8b, below consultant level and at odds with workforce guidance. At Level 3, we noticed that across Wessex, there were fewer practitioners than required – this increases demand on Level 4 services, which are more expensive to provide. To achieve equity, it is clear that there should be minimum provision of Level 3 and 4 services in acute hospitals across Wessex, with a range of bandings and equivalent leadership structures across all six trusts. We therefore believe that setting and meeting a minimum staffing standard across Levels 3-4 is an important next step.

Our economic analysis shows that the potential cost-savings associated with the provision of services is significant. Even when assuming only modest improvements in the psychological health for just half of the patients and family members who receive psychological care, the monetised health gain (MHG) is in the region of £4,197,270 to £9,893,565. Our analysis also shows that the potential monetised health gain is greater than the cost of employing psychological professionals, suggesting a cost-saving associated with the provision of services. This is reflected in research demonstrating a significant economic cost in relation to unmet mental health needs among people affected by cancer including increased utilisation of primary and secondary care, (van Beek et al., 2021).

Because the gap in service provision is so significant, we recognise there is a need to look more broadly at the range of services that provide psychological support to people affected by cancer. While we were not able to include these services in mapping and gap analysis, we found that there is psychological support available to patients and families affected by cancer via NHS Talking Therapies Services, Hospice and Palliative Care Psychology Services, primary care, and via cancer information and support centres in the third sector. Across these settings, the provision of psychological support for people affected by cancer was variable and not standardised, and the evidence we collated suggests these services cannot and do not fill the gaps in specialist service provision identified across acute hospitals. Therefore, even with these services in place, there remains a need to grow and develop the specialist (Level 3-4) cancer psychological workforce in our acute hospitals. There are several important reasons for this.

Why specialist psycho-oncology services in acute hospitals are essential:

Acute and community services address different cancer-related psychosocial needs.

This mapping work is based on the psychological needs of people affected by cancer in the first year following a new diagnosis. Typically, these individuals will be reliant on hospital-based cancer care and are therefore more likely to require psychological support via the acute hospital. In contrast, psychological services provided by the third sector and NHS Talking Therapies (TTs) are community based and more likely to be involved in supporting patients after their acute care and treatment has finished, particularly in the survivorship period. Third sector services can offer cancer-specific care in the community but do not consistently offer the different levels of specialist psychological intervention as were found in acute psycho-oncology services. NHS TTs are set up to work with anxiety and depression across different tiers of intervention and so may work with cancer in this context as part of their broader offer of support around long-term conditions. These community-based services are therefore important but are set up to address different cancer-related psychological concerns than are acute psycho-oncology services.

Hospice and palliative care services offer a range of level 3-4 services to support people affected by cancer in the community, but with a focus on helping people impacted by a life-limiting cancer diagnosis. This will necessarily include some people in the first year following a diagnosis (for example, those whose cancer is diagnosed at a late stage) but also includes people after the first year of a cancer diagnosis who are living with incurable disease or who experience recurrence. Additionally, hospice and palliative care psychology services may have a broad remit and work with a range of life-limiting conditions beyond cancer. Hospices and palliative care services therefore play an equivalent role to specialist psycho-oncology services in terms of level of intervention, but with a different remit.

Research shows that long-term survivorship, a poor prognosis, and advanced disease are all associated with additional psychological and mental health needs (Macmillan, 2006; Forbes et al, 2007). On this basis, we are satisfied that there is a psychological burden associated with cancer survivorship and end of life care that was not captured in this mapping, and which must be addressed by services in the community. This necessarily means that the acute psychological needs of people at and immediately after cancer diagnosis and treatment need to be met in the acute hospital setting.

Integration with the cancer MDT

A unique and inimitable aspect of specialist acute psycho-oncology services is integration with the wider cancer MDT. Acute cancer care should be holistic, which means psychological support should form part of a multimodal approach delivered alongside medical and nursing care, nutritional care, and physical and functional rehabilitation. Psychological care should also be integrated as part of multimodal prehabilitation to support people to prepare for and access cancer treatment (Macmillan, 2020). Integrated psychological care includes direct interventions delivered to patients and indirect care that may be delivered with or via the wider cancer MDT, as well as consultations with the MDT to embed psychologically-informed practice. The delivery of such integrated care helps differentiate specialist psycho-oncology services from community-based services, which cannot replicate this role.

Provision of training and supervision

Related to the need for integration, our mapping clearly highlights a role for the specialist (Level 3-4) acute psycho-oncology workforce in providing psychological assessment skills training and associated supervision for the cancer workforce. This includes developing universal awareness and understanding of cancer-related psychological distress (the ability of all people working in acute cancer services to appropriately recognise and respond to signs of distress – i.e., level 1 skills), and we found a significant gap in the offer of training for the unregistered workforce operating at this level.

An integrated psycho-oncology services is also essential to support the development of enhanced (Level 2) interventional skills, through both training and supervision. We found variation in access to training and supervision within our acute hospitals, and a discrepancy in clarity of the purpose of supervision and the method of delivery. Supervision is a requirement to maintain Level 2 practitioner status and organisations have a responsibility to deliver supervision facilitated by a Level 3 or 4 practitioner. Barriers to attending supervision included competing clinical demands and personal commitments. Other concerns related to fears around confidentiality and a scepticism relating to the benefits of supervision. We believe these barriers can be best overcome when supervision is embedded within the acute hospital.

We anticipate further national guidance on the role of Level 2 practitioners including training and supervision needs, and we are already aware of the need for registered nurses and AHPs to develop and maintain psychological skills capabilities in accordance with the new ACCEND framework (2023). Our psychologists and counsellors in acute trusts are best placed to develop and embed these skills and levels of care in hospital systems.

Escalation pathways and expertise

A final reason for integrating specialist psychological support in the acute setting is to build expertise around cancer care. There is, after all, a short-hand approach to understanding cancer-related psychological difficulties that comes from a more specialised awareness of cancer (for example, an awareness of how cancer treatment may cause difficulties with eating, a change in appearance, or fatigue, and for which psychological support may be required; or, an awareness of how the end of treatment may lead to relationship difficulties related to role transitions, lasting changes in sexual functioning, and differences in beliefs about the meaning of ending treatment). Patients and family members often value this perspective it means they do not have to educate their therapist about the nuances of treatment and the cancer pathway. Relatedly, the presence of psychological expertise within the acute hospital environment ensures that higher levels of psychological complexity can be escalated by enhanced (Level 2) practitioners to specialist (Level 3-4) psychological teams, which is central to NICE (2004a) guidance. Recognising specialist psycho-oncology services as expert teams who can be consulted with or escalated to is also an important part of the integrated cancer psychosocial support model (see Figure 3, page 15), enabling teams in the community to liaise with specialist services when required.

Growing the psychological workforce

The clearest implication of this mapping is that we must do more to support people affected by cancer. This necessitates a coordinated approach to developing services, beginning in the acute hospital, psycho-oncology setting and using this as a basis for delivering a hub-and-spoke model.

Commissioning of specialist psycho-oncology services in acute settings

To grow and develop specialist (Level 3-4) psychological services, a strategy for commissioning is now required. Commissioning for psychological support for people with cancer is present within commissioning for cancer care services, and there was wide acknowledgment current provision is not enough to meet growing demand. Respondents highlighted concerns around sustainability of service provision and the need for longer term commissioning agreements, to support recruitment, retention, and service development. These concerns have downstream effects – without established and stable Level 3-4 services, it is impossible to establish a consistent offer of level 1 or Level 2 support.

Current governance structures to escalate risk within organisations poorly represent the risks associated with psychological distress associated with cancer. Senior management, Trust Boards and Commissioners may not be fully informed in relation to the deficits in psycho-oncology services and the impact that this has on people impacted by cancer. Limited funding provides uncertainty for the services delivering psychological support. Substantive, NHS-based posts are required to build a sustainable cancer psychological workforce and to ensure there is effective leadership and governance around the services provided in acute trusts. We believe that representatives from the Wessex Cancer Alliance, provider Trusts and ICB should work together as stakeholders to develop such posts.

Working with specialist hospice and palliative care

While this report has highlighted psychological need in the acute sector, the role of specialist hospice and palliative care psychological support is vital, and our scoping suggests the psychological workforce in these settings is also under-resourced. Psychological services in these settings hold high levels of psychological expertise, not only in relation to cancer care but in relation to supporting patients and their families with the broad range of psychological difficulties that can present during and after the end of life. Respondents from hospices highlight that due to delayed diagnoses and rapid deterioration of patients, waiting lists for existing psychological services mean that patients may die before their needs are met. This can have implications for the surviving family members who may have witnessed a patient's psychological suffering. The remit of our hospice and palliative care services is broad and we therefore anticipate that further work will be required in future to develop and invest in this workforce.

Working with NHS Talking Therapies and the Third Sector

The third sector, charities and cancer information and support centres across Wessex hold cancer-related expertise but are not commissioned and may not be able to offer a full range of psychological therapies when compared to other services. Psychological support is often passed to third sector colleagues where there are gaps in healthcare services, however this is not a sustainable model, with concerns of governance, disutility of care, lack of integration and shared records, and escalation protocols, exposing people and services to risk. NHS Talking Therapies services are used by people affected by cancer but not widely. These services can offer a broad range of interventions to address anxiety and depression in the context of long-term conditions, however services provide little in the way of specific training and ongoing supervision and support to work with cancer. Empowering the third sector and NHS Talking Therapies seems important as we seek to grow the cancer psychological workforce, as part of a hub-and-spoke model. To do this, it is important to understand what each service can do well, and to improve inter-agency referrals. We see a need for greater integration and awareness of services on the ground, which we aim to develop and support.

Working with services for children and young people

This report has focussed on the psychological needs of adults affected by cancer, but we recognise that children and young people are also affected by cancer and need support. This includes support for children and teenagers diagnosed with cancer and for their parents and siblings, support for those who experience late effects from childhood treatments (particularly in relation to cognitive development), and support for children and young people who have a parent, relative or friend diagnosed with cancer. Getting support right for children and young people affected by cancer can have a lasting effect and may prevent psychological difficulties from developing in later in life. We believe that follow-up mapping of services for children and young people in Wessex will be required.

Growing and developing the aspirant cancer psychological workforce

Whether specialist (Level 3-4) cancer psychological support services are provided by NHS acute hospital trusts, NHS Talking Therapies services, specialist hospice and palliative care settings, or the third sector, there is a need to grow and develop the aspirant cancer psychological workforce across Wessex to future-proof our services. A key consideration is how we attract those working in the psychological professions (Practitioner Psychologists, Counsellors, Psychotherapists, others) to work in cancer care. To do this well, we believe we need to engage with the psychological workforce from the stage of pre-qualification (e.g., undergraduate psychologists, aspiring counsellors), during formal training (e.g., through the provision of teaching and placements), through to attracting and developing newly qualified staff in cancer care (e.g., through training, CPD, or even preceptorship programmes), through to attracting and retaining the best qualified and experienced clinicians to deliver and lead services (i.e., having clear career trajectories up to and including consultant grade posts in psycho-oncology).

The advent of the Psychological Professions Network (PPN) in England has seen an increase in training places for practitioner psychologists and other psychological professions, coupled with a widening of roles that people can develop into through apprenticeship schemes (e.g., Clinical Associate Psychologists). We believe we should be implementing a cancer psychological workforce strategy within Wessex so that we can meet our objectives, and that this should be tied to forthcoming guidance on developing the Level 4 workforce in cancer care. Recent publications from NHS Employers (2023) and the British Psychological Society (BPS, 2023) help make the case for different roles in cancer psychological care and should therefore also be consulted as this strategy is developed.

Recommendations and implementation plan

To begin to address the gaps identified in this report, we have made five recommendations. Table 17. sets out these recommendations and associated goals, in addition to actions and responsibilities we will pursue over the next 12 months.

Table 17. Recommendations, goals and actions

RECOMMENDATION	SMART GOALS	IMMEDIATE ACTIONS AND RESPONSIBILITIES
1. A consensus plan for the commissioning and delivery of specialist (Level 3-4) psychological support, with equity across the region. We want equity of access to Level 3 and 4 acute psycho-oncology services for patients and families across Wessex. We want all acute psycho-oncology services to be led by practitioner psychologists working at Consultant Level, in accordance with the national picture and workforce recommendations. We want to support the development of the cancer psychological workforce, piloting new ways of working and inspiring new practitioners to enter the field.	To achieve at least 50% of the workforce requirement for Level 3 and Level 4 services within all acute hospitals by 2030. To ensure there is a lead Consultant Practitioner Psychologist for cancer in each acute trust in Wessex by 2026. To ensure that each service has a plan for the delivery of Level 2 supervision and for implementation of prehabilitation. To approach Macmillan for 2–3-year seed funding (pump-priming) of new posts, agreeing a clear plan for pick-up and substantive funding where this is the case. To work with local professional training courses to ensure teaching on cancer psychological support is included in the curriculum by the academic year 2025-26.	a) **Dorset:** WCA, Dorset ICB, DCH and UHD to convene a task and finish group by March 2025. b) **Hampshire and Isle of Wight:** WCA, HIOW ICB, HHFT, IWT, PHU and UHS to convene a convene a task and finish group by March 2025. c) Regional T&F groups to hold respective monthly meetings over a 12-month period (financial year 2025-26), to agree a plan for the commissioning and delivery of Level 3-4 services over a five-year period. d) Stakeholders for both groups should include: WCA executive sponsor, WCA lead for psychology, Macmillan, ICB lead for cancer, ICB lead for mental health, trust lead for cancer (e.g., lead cancer nurse, head of cancer services), trust lead for psychology, trust executive sponsor. Both groups must include one or more experts by experience. e) WCA Workforce and Education workstream to publish a psychological workforce strategy by September 2025. f) WCA psychology lead to have met leads for relevant training courses (CBT, clinical psychology, counselling, health psychology) at Universities of Bournemouth, Chichester, Exeter, Portsmouth Southampton, and Winchester by September 2025.
2. To embed psychosocial care through the provision of psychological training and supervision for the universal (Level 1) and enhanced (Level 2) workforce.	Across all acute trusts, to roll out a package of universal (Level 1) training on recognising and responding to psychological distress for the unregistered workforce, by the end of the 2025-26 financial year.	a) All acute trusts to be asked to audit of current Level 1 and 2 practice, to identify the number of staff trained, supervised, and working at each level. b) All acute trusts to pilot the Level 1 training course over the next 12 months.

We want to support the development and implementation of Level 1 and 2 training and delivered by specialist (Level 3-4) practitioners within the region, and to link this to nationally developed standards set by ACCEND and NHS England. We want to ensure that psychological supervision is provided for the Level 2 workforce. We want to ensure reflective practice and other forms of supervision and support are available to staff delivering cancer care.	By the end of the 2025-26 financial year, to ensure that there is a rolling programme of Level 2 psychological assessment skills training available in each acute trust, which is delivered by recognised Level 3-4 practitioners. To continue to promote the psychological skills in cancer care module delivered by the University of Southampton. For all acute trusts to provide enough psychological supervision for the Level 2 CNS workforce by Level 3-4 practitioners, by 2030. To ensure that all new Level 3-4 posts developed in acute hospitals include Level 2 training and supervision in the job plan. To endorse national guidance on Level 2 training and supervision when it becomes available, publishing an implementation plan for Wessex.	c) To agree with acute trusts the definition and function of Level 2 supervision by September 2025. d) All trusts to identify a CNS or AHP to act as a Level 2 champion, attending supervision and training and promoting this within the organisation. e) Relevant Task and Finish groups to agree an approach to the provision of Level 2 supervision across Wessex as part of commissioning (see Recommendation 1).
3. To implement a hub-and-spoke model of comprehensive personalised cancer psychosocial support, with different levels of intervention across community and acute settings. We want our specialist acute psycho-oncology services to work more closely with specialist hospice and palliative care psychology services, to improve interagency referrals and end of life cancer care. We want to empower NHS Talking Therapies and the third sector to work with cancer survivorship in the community.	To support the development of virtual, place-based cancer psychosocial hubs across Wessex by the end of financial year 2025-26. Across place, to adopt a consistent approach to inter-agency psychological referrals between the acute hospital, hospices, NHS community services and the third sector, by financial year-end 2025-26. To work with local CBT training courses to ensure teaching on cancer psychological support is included in the curriculum by the academic year 2025-26.	a) Each place-based locality to convene a psychosocial hub working group that includes representatives from psychological services in the acute hospital, hospices, and NHS Talking Therapies by March 2025 b) WCA to work with third sector organisations to understand what levels and types of psychological interventions are offered, by July 2025. c) WCA to reinstate the cancer psychosocial SIG, using this as a monthly meeting to provide CPD and for clinicians from across services to network. To achieve this by March 2025. d) WCA psychology lead to have met leads for relevant CBT training courses at Universities of Exeter and Southampton, by March 2025.

We want to ensure people affected by cancer can access the right, evidence-based intervention at the right time, whether this is in the hospital, hospice, or community.	To work with hospice psychology leads to understand levels of psychological support for people affected by a life-limiting cancer diagnosis.	e) WCA to collect data on psychological services for people affected by cancer in hospice settings.
4. To take a standardised approach to measuring the impact of services We want psychological services for people affected by cancer to be effective and acceptable. We want to understand the impact of services on healthcare utilisation. We want to use data to evaluate the services we provide.	By September 2025, to support all services to use the PHQ-9 and GAD-7 as routine outcome measures. By September 2025, to introduce a patient feedback form/ set of core questions to ask patients as part of assessing acceptability of psychological services. To include in this form a question asking patients about access to services. By 2030, to have collected data on the impact of acute hospital psychology provision on service use.	a) WCA to work with the national programme to look at COSD data on psychological support. b) WCA psychology lead to take outcome measurement to the next psychology CAG for discussion. c) WCA psychology lead to use next CAG to devise service evaluation questionnaire. d) WCA to work with ICB and providers to agree a process for measuring healthcare utilisation.
5. To develop services that are inclusive, improving access to cancer psychological care across the communities we serve. We want to deliver culturally inclusive cancer care. We want to pilot new ways of working, reaching out to underrepresented communities and to tackle health inequalities.	To support all psychologists and counsellors working in cancer care to access training on culturally competent therapy and supervision. To learn from Right by You, rolling out similar posts in other areas of Wessex. To pilot new initiatives using a community psychology approach.	a) WCA to work with all psycho-oncology services to look at access data, to understand whether services are accessible and whether people using services are representative of the wider population with respect to age, gender, ethnicity, religion, and levels of deprivation. b) WCA to consider how to pilot new ways of working as transformation projects.

References

Baker, Ellis (2023) An Investigation into the Relationship between Burnout and Wellbeing and its Association with Individual and Organizational Factors. *University of Southampton, Doctoral Thesis*, 123pp. https://doi.org/10.5258/SOTON/D2765

Benedict, C., Walsh, E.A., Penedo, F.J. (2022). Psychosocial Interventions in Cancer. *Psychological Aspects of Cancer,* 159-196. https://doi.org/10.1007/978-3-030-85702-8_10

Berman, R. (2016). *Enhanced Supportive Care Makes Excellent Cancer Care Possible.* NHS England. Available from: https://www.england.nhs.uk/blog/richard-berman/

Brebach, R., Sharpe, L., Costa D.S.J., Rhodes, P., & Butow, P. (2016). Psychological Intervention Targeting Distress for Cancer Patients: a Meta-Analytic Study Investigating Uptake and Adherence. *Psycho-Oncology, 25*(8), 882-890. https://doi.org/10.1002/pon.4099

British Medical Association (BMA) (2024). *"It's Broken: Doctors' Experiences on the Front Line of a Failing Mental Healthcare System.* London: British Medical Association.

British Psychological Society (BPS) (2008). *DCP Briefing Paper No. 27: Clinical Health Psychologists in the NHS.* Leicester: British Psychological Society. https://doi.org/10.53841/bpsrep.2008.inf120

British Psychological Society (BPS) (2015). *Demonstrating Quality and Outcomes in Psycho-oncology.* Leicester: British Psychological Society. https://doi.org/10.53841/bpsrep.2015.inf237

British Psychological Society (BPS) (2018). Guideline for the Role of Practitioner Psychologists in the Assessment and Support of Women Considering Risk-Reducing breast surgery. Leicester: British Psychological Society. https://doi.org/10.53841/bpsrep.2018.rep123

Burnham, J. (2012). Developments in Social GRRRAAACCEEESSS: Visible-Invisible and Voiced-Unvoiced. In I.-B. Krause (Ed.), *Culture and reflexivity in systematic psychotherapy: Mutual perspectives* (139-160). London: Karnac Books.

Calati, R., Di Mattei, V., & Courtet, P. (2017). Risk of Suicide Mortality Among Cancer Patients: A Meta-Analysis of Observational Studies. *European Psychiatry, 41*(S1), S290-S291. http://dx.doi.org/10.1016/j.eurpsy.2017.02.157

Carlson, L.E., & Bultz, B.D. (2004). Efficacy in Medical Cost Offset of Psychosocial Interventions in Cancer Care: Making the Case for Economic Analyses. *Psycho-Oncology, 13*(12), 837-849. https://doi.org/10.1002/pon.832

Challinor, J.M., Alqudimat, M.R., Teixeira, T.O.A., & Oldenmenger, W.H. (2020). Oncology Nursing Workforce: Challenges, Solutions, and Future Strategies. *The Lancet Oncology, 21*(12), e564-e574. https://doi.org/10.1016/S1470-2045(20)30605-7

Chiles, J.A., Lambert, M.J., & Hatch, A.L. (1999). The Impact of Psychological Interventions on Medical Cost Offset: A Meta-Analytic Review. *Clinical Psychology: Science and Practice, 6*(2), 204. https://psycnet.apa.org/buy/1999-03053-005

Delgadillo, J., Ali, S., Fleck, K., Agnew, C., Southgate, A., Parkhouse, L., Cohen, Z.D., DeRubeis, R.J., & Barkham, M. (2022). Stratified Care vs Stepped Care for Depression A Cluster Randomized Clinical Trial. *JAMA Psychiatry, 79*(2), 101-108. https://doi.org/10.1001/jamapsychiatry.2021.3539

Dr Foster (2019). *High intensity users: Reducing the Burden on Accident and Emergency Departments.* Retrieved from: https://www.drfoster.com/wp-content/uploads/2019/01/Dr-Foster_High-intensity-users-report-FINAL_WEB.pdf

Engel, G.L. (1977). The Need for a New Medical Model: A Challenge for Biomedicine. *Science, 196,* 129-136.

Faller, H., Schuler, M., Richard, M., Heckl, U., Weis, J., & Küffner, R. (2013). Effects of Psycho-Oncologic Interventions on Emotional Distress and Quality of Life in Adult Patients With Cancer: Systematic Review and Meta-Analysis. *Journal of Clinical Oncology, 31*(6), 782-793. https://doi.org/10.1200/JCO.2011.40.8922

Forbes, H., Carreira, H., Funston, G., Andresen, K., Bhatia, U., Strongman, H., Abrol, E., Bowen, L., Giles, C., & Bhaskaran, K. (2024). Early, Medium and Long-Term Mental Health in Cancer Survivors compared with Cancer-free Comparators: Matched Cohort Study using Linked UK Electronic Health Records. *eClinicalMedicine, 76,* 102-826. https://doi.org/10.1016/j.eclinm.2024.102826

Foster, C., Grimmett, C., Haviland, J., Winter, J., Calman, L., Din, A., Richardson, A., & Smith, P.W.F. (2016). Colorectal Cancer Patient's Self-Efficacy for Managing Illness-Related Problems in the First Two Years after Diagnosis: Results from the ColoREctal Well-being (CREW) Study. *Journal of Cancer Survivorship, 11,* 634-642. http://dx.doi.org/10.1007/s11764-017-0636-x

Fu, F., Zhao, H., Tong, F., & Chi, I. (2017). A Systematic Review of Psychosocial Interventions to Cancer Caregivers. *Frontiers in Psychology, 8,* 1-12. https://doi.org/10.3389/fpsyg.2017.00834

Fu, W.W., Popovic, M., Agarwal, A., Milakovic, M., Fu, T.S., McDonald, R., Fu, G., Lam, M., Chow, R., Cheon, S., Pulenzas, N., Lam, H., DeAngelis, C., Chow, E. (2016). The Impact of Psychosocial Intervention on Survival in Cancer: a Meta-Analysis. *Annals of Palliative Medicine, 5*(2), 9306-9106.

Gabriel, I., Creedy, D., & Coyne, E. (2020). A Systematic Review of Psychosocial Interventions to Improve Quality of Life of People with Cancer and their Family Caregivers. *Nursing Open, 7*(5), 1299-1312. https://doi.org/10.1002/nop2.543

Gribben, L., & Semple, C.J. (2021). Prevalence and Predictors of Burnout and Work-Life Balance within the Haematology Cancer Nursing Workforce. *European Journal of Oncology Nursing, 52,* 101-973. https://doi.org/10.1016/j.ejon.2021.101973

Gruszczyńska, M., Sosnowska M.B., & Szemik, S. (2020). Selected Psychological Aspects and Medication Adherence in Oncological Patients. *Cancer Medicine, 9*(3), 943-950. https://doi.org/10.1002/cam4.2691

HaGani, N., Yagil, D., & Cohen, M. (2022). Burnout Among Oncologists and Oncology Nurses: A systematic review and meta-analysis. *Health Psychology, 41*(1), 53-64. https://doi.org/10.1037/hea0001155

Health Education England (2023). *Aspirant Cancer Career and Education Development (ACCEND) Programme.* Available from: https://www.hee.nhs.uk/sites/default/files/documents/ACCEND%20Career%20Pathway%2C%20Core%20Cancer%20Capabilities%20and%20Education%20Framework.pdf

Hession, N., & Habenicht, A. (2020). Clinical Supervision in Oncology: A Narrative Review. *Health Psychology Research, 8*(1). https://doi.org/10.4081/hpr.2020.8651

Hulbert-Williams, N.J., Hulbert-Williams, L., Patterson, P., Suleman, S., & Howells, L. (2021). Acceptance and Commitment Therapy (ACT) - Enhanced Communication Skills: Development and Evaluation of a Novel Training Programme. *BMJ Supportive and Palliative Care.* https://doi.org/10.1136/bmjspcare-2020-002786

Jacobsen, P.B., Donovan, K.A., Small, B.J., Jim, H.S., Munster, P.N., & Andrykowski, M.A. (2007). Fatigue After Treatment for Early Stage Breast Cancer. *Cancer, 110*(8), 1641-1875. https://doi.org/10.1002/cncr.22993

Jansen, F., Verdonck-de Leeuw, I.M., Cuijpers, P., Leemans, C.R., Waterboer, T., Pawlita, M., Penfold, C., Thomas, S.J., Waylen, A., & Ness, A.R. (2018). Depressive Symptoms in relation to Overall Survival in Poople with Head and Neck Cancer: A Longitudinal Cohort Study. *Psycho-Oncology, 27*(9), 2061-2302. http://dx.doi.org/10.1002/pon.4816

Jenkins, K. & North, N. (2008). *Psychological Assessment Skills: A Training Course for all Health and Social Care Staff Working in Cancer Services.* Salisbury: Salisbury NHS Foundation Trust.

Kelly-Brown, J., Palmer Kelly, E., Obeng-Gyasi, S., Chen, J. C., & Pawlik, T.M. (2022). Intersectionality in Cancer Care: A Systematic Review of Current Research and Future Directions. *Psycho-Oncology, 31*(5), 705-716. https://doi.org/10.1002/pon.5890

Kerrison, R.S., Jones, A., Peng, J., Price, G., Verne, J., Barley, E. A., & Lugton, C. (2023). Inequalities in Cancer Screening Participation Between Adults with and without Severe Mental Illness: Results from a Cross-sectional Analysis of Primary Care Data on English Screening Programmes. *British Journal of Cancer, 129*(1), 81-93. https://doi.org/10.1038/s41416-023-02249-3

Kowalczuk, K., Krajewska-Kułak, E., & Sobolewski, M. (2020). Working Excessively and Burnout Among Nurses in the Context of Sick Leaves. *Frontiers in Psychology, 11,* 285. https://doi.org/10.3389/fpsyg.2020.00285

Levett, D.Z.H., & Grimmett, C. (2019). Psychological Factors, Prehabilitation and Surgical Outcomes: Evidence and Future Directions. *Anaesthesia, 74*(S1), 36-42. https://doi.org/10.1111/anae.14507

Lleras de Frutos, M., Medina, J.C., Vives, J., Casellas-Grau, A., Marzo, J.L., Borras, J.M., Ochoa-Arnedo, C. (2020). Video conference vs face-to-face group psychotherapy for distressed cancer survivors: A randomized controlled trial. *Psycho-Oncology, 29*(12), 1995-2003. https://doi.org/10.1002/pon.5457

Lo, C., Calzavara, A., Kurdyak, P., Barbera, L., Shepherd, F., Zimmermann, C., Moore, M.J., & Rodin, G. (2013). Depression and use of health care services in patients with advanced cancer. *Canadian Family Physician, 59*(3), e168-e174. https://doi.org/10.1002/pon.4133

Macmillan Cancer Support (2006). *Worried Sick: The Emotional Impact of Cancer.* Available from: https://www.macmillan.org.uk/documents/getinvolved/campaigns/campaigns/impact_of_cancer_english.pdf

Macmillan Cancer Support (2015). *Impact Brief.* Available from: https://www.macmillan.org.uk/_images/information-resources_tcm9-283176.pdf

Mausbach, B.T., & Irwin, S.A. (2017). Depression and Healthcare Service Utilisation in Patients with Cancer. *Psycho-Oncology, 26*(8), 1133-1139. https://doi.org/10.1002/pon.4133

McManus S, Bebbington P, Jenkins R, Brugha T. (eds.) (2016) Mental health and wellbeing in England: Adult Psychiatric Morbidity Survey 2014. Leeds: NHS Digital.

Mcmillan, K., Butow, P., Turner, J., Yates, P., White, K., Lambert, S., Stephens, M. and Lawsin, C. (2016). Burnout and the Provision of Psychosocial Care amongst Australian Cancer Nurses. European Journal of Oncology Nursing, 22, pp. 37-45.

Mental Health Task Force. (2016). The Five Year Forward View for Mental Health. In The Five Year Forward View for Mental Health (england.nhs.uk)

National Cancer Peer Review Programme (2012). *National Cancer Peer Review Programme Report 2011/2012.* Available from: http://data.parliament.uk/DepositedPapers/Files/DEP2013-0562/National_Cancer_Peer_Review_Programme_Report_2011-12.pdf

National Institute for Health and Care Excellence (NICE) (2002). *Improving Outcomes in Breast Cancer (CSG1).* Available from: https://www.nice.org.uk/guidance/csg1/resources/improving-outcomes-in-breast-cancer-update-pdf-773371117

National Institute for Health and Care Excellence (NICE) (2002). I*mproving Outcomes in Urological Cancers (CSG2).* Available from: https://www.nice.org.uk/guidance/csg2/resources/improving-outcomes-in-urological-cancers-pdf-773372413

National Institute for Health and Care Excellence (NICE) (2004a). *Improving Supportive and Palliative Care for Adults with Cancer*. Available from: https://www.nice.org.uk/guidance/csg4/resources/improving-supportive-and-palliative-care-for-adults-with-cancer-pdf-773375005

National Institute for Health and Care Excellence (NICE) (2004b). *Improving outcomes in Head and Neck Cancers (CSG6).* Available from: https://www.nice.org.uk/guidance/csg6/resources/improving-outcomes-in-head-and-neck-cancers-update-pdf-773377597

National Institute for Health and Care Excellence (NICE) (2006). *Improving Outcome for People with Brain and other Central Nervous Systems Tumours (CSG10).* Available from: https://www.nice.org.uk/guidance/csg10/resources/improving-outcomes-for-people-with-brain-and-other-central-nervous-system-tumours-update-pdf-27841361437

National Institute for Health and Care Excellence (NICE) (2006). *Improving Outcomes for People with Sarcoma (CSG9).* Available from: https://www.nice.org.uk/guidance/csg9/resources/improving-outcomes-for-people-with-sarcoma-update-pdf-773381485

National Institute for Health and Care Excellence (NICE) (2008). *Metastatic Spinal Cord Compression in Adults: Risk Assessment, Diagnosis, and Management (CG75).* Available from: https://www.nice.org.uk/guidance/cg75/resources/metastatic-spinal-cord-compression-in-adults-risk-assessment-diagnosis-and-management-pdf-975630102469

National Institute for Health and Care Excellence (NICE) (2009). A*dvanced Breast Cancer (CG81).* Available from: https://www.nice.org.uk/guidance/cg81/resources/advanced-breast-cancer-diagnosis-and-treatment-pdf-975683850181

National Institute for Health and Care Excellence (NICE) (2010). *Metastatic Malignant Disease of Unknown Primary Origin in Adults: Diagnosis and Management (CG104).* Available from: https://www.nice.org.uk/guidance/cg104/resources/metastatic-malignant-disease-of-unknown-primary-origin-in-adults-diagnosis-and-management-pdf-35109328970437

National Institute for Health and Care Excellence (NICE) (2015). *Melanoma: assessment and management (NG14*). Available from: https://www.nice.org.uk/guidance/ng14/resources/melanoma-assessment-and-management-pdf-1837271430853

National Institute for Health and Care Excellence (NICE) (2016). *Haematological Cancers: Improving Outcomes (NG47).* Available from: https://www.nice.org.uk/guidance/ng47/resources/haematological-cancers-improving-outcomes-pdf-1837457868229

National Institute for Health and Care Excellence (NICE) (2018). *Early and Locally Advanced Breast Cancer: Diagnosis and Management (NG101).* Available from: https://www.nice.org.uk/guidance/ng101/resources/early-and-locally-advanced-breast-cancer-diagnosis-and-management-pdf-66141532913605

National Institute for Health and Care Excellence (NICE) (2018). *Oesophago-gastric Cancer: Assessment and Management in Adults (NG83)*. Available from: https://www.nice.org.uk/guidance/ng83/resources/oesophagogastric-cancer-assessment-and-management-in-adults-pdf-1837693014469

National Institute for Health and Care Excellence (NICE) (2018). *Pancreatic Cancer in Adults: Diagnosis and Management, 2018 (NG85).* Available from: https://www.nice.org.uk/guidance/ng85/resources/pancreatic-cancer-in-adults-diagnosis-and-management-pdf-1837696373701

National Institute for Health and Care Excellence (NICE) (2018). *Post-Traumatic Stress Disorder (NG116).* Available from: https://www.nice.org.uk/guidance/ng116

National Institute for Health and Care Excellence (NICE) (2019). *Familial Breast Cancer: Classification, Care and Managing Breast Cancer and Related Risks in People with a Family History of Breast Cancer (CG164).* Available from: https://www.nice.org.uk/guidance/cg164/resources/familial-breast-cancer-classification-care-and-managing-breast-cancer-and-related-risks-in-people-with-a-family-history-of-breast-cancer-pdf-35109691767493

National Institute for Health and Care Excellence (NICE) (2019). *Prostate Cancer: Diagnosis and Management (NG131).* Available from: https://www.nice.org.uk/guidance/ng131/resources/prostate-cancer-diagnosis-and-management-pdf-66141714312133

National Institute for Health and Care Excellence (NICE) (2021). *Chronic Pain (Primary and Secondary) in Over 16s: Assessment of all Chronic Pain and Management of Chronic Primary Pain. (NG193).* Available from: https://www.nice.org.uk/guidance/ng193

Naylor, C., Parsonage, M., McDaid, D., Knapp, M., Fossey, M., & Galea, A. (2012). *Long-term conditions and mental health The cost of co-morbidities.* Long-term condition and mental health Chris Naylor February 2012 (kingsfund.org.uk)

NHS Employers (2023). *National profiles for Psychological Professions.* Available from: https://www.nhsemployers.org/system/files/2024-07/Psychological%20professions%20July%202024_0.pdf

NHS England (2018). *The Comprehensive Model of Personalised Care.* Available from: https://www.england.nhs.uk/wp-content/uploads/2019/02/comprehensive-model-of-personalised-care.pdf

NHS England (2019). *The NHS Long Term Plan.* Available from: https://www.longtermplan.nhs.uk/wp-content/uploads/2019/08/nhs-long-term-plan-version-1.2.pdf

NHS England (2020). We are the NHS: People Plan 2020/21- Action for All of Us. Available from: https://www.england.nhs.uk/wp-content/uploads/2020/07/We-Are-The-NHS-Action-For-All-Of-Us-FINAL-March-21.pdf

NHS England (cited 2024). *Psychological therapy helps people with long-term conditions to Live Well in Buckinghamshire.* Available from: https://www.england.nhs.uk/mental-health/case-studies/improving-access-to-psychological-therapies-iapt-case-studies/buckinghamshire/

Paley, C.A., Boland, J.W., Santarelli, M., Murtagh, F.E.M., Ziegler, L., & Chapman, E.J. (2023). Non-Pharmacological Interventions to Manage Psychological Distress in Patients Living with Cancer: A Systematic Review. *BMC Palliative Care, 22*(1), 88. https://doi.org/10.1186/s12904-023-01202-8

Palmer, B., & Rolewicz, L. (2023, June 29). *All is Not Well: Sickness Absence in the NHS in England.* Nuffield Trust. All is not well: Sickness absence in the NHS in England | Nuffield Trust

Pan, X., & Sambamoorthi, U. (2015). Health Care Expenditures Associated with Depression in Adults with Cancer. *The Journal of Community and Supportive Oncology, 13*(7), 240. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4576451/

Proctor, B. (2008). *Group supervision: A Guide to Creative Practice.* London: Sage.

Singer, S., Das-Munshi, J., & Brähler, E. (2010). Prevalence of Mental Health Conditions in Cancer Patients in Acute Care: A Meta-Analysis. *Annals of Oncology, 21*(5), 925-930. https://doi.org/10.1093/annonc/mdp515

Smith, M.Y., Redd, W.H., Peyser, C., & Vogl, D. (1999). Post-Traumatic Stress Disorder in Cancer: A Review. *Psycho-Oncology, 8*(6), 521-537. https://doi.org/10.1002/(SICI)1099-1611(199911/12)8:6<521::AID-PON423>3.0.CO;2-X

Sulmasy, D.P. (2002). A Biopsychosocial-Spiritual Model for the Care of Patients at the End of Life. *The Gerontologist, 42*, 24-33. https://doi.org/10.1093/geront/42.suppl_3.24

Syrjala, K.L., Jensen, M.P., Mendoza, M.E., Yi, J.C., Fisher, H.M., & Keefe, F.J. (2014). Psychological and Behavioral Approaches to Cancer Pain Management. *Journal of Clinical Oncology, 32*(16), 1703-1711. https://doi.org/10.1200/JCO.2013.54.4825

Theofilou, P & Panagiotaki, H. (2012). A Literature Review to Investigate the Link between Psychosocial Characteristics and Treatment Adherence in Cancer Patients. *Oncology Reviews, 6*(1). https://doi.org/10.4081/oncol.2012.e5

Transforming Cancer Services Team (TCST) (2020). Pan London Mapping of Psycho-Oncology Services. Available from: https://www.transformationpartnersinhealthandcare.nhs.uk/wp-content/uploads/2020/02/Mapping-Report_Psychological-Services-Final.pdf

Van Beek, F.E., Wijnhoven, L.M.A., Holtmaat, K., Custers, J.A.E., Prins, J.B., Leeuw, I.M.V., Jansen, F. (2021). Psychological Problems Among Cancer Patients in Relation to Healthcare and Societal Costs: A Systematic Review. *Psycho-Oncology, 30*(11), 1801-1835. https://doi.org/10.1002/pon.5753

Wessex Cancer Alliance (2020). *Our Cancer Plan for Wessex 2019-2024.* Available from: https://wessexcanceralliance.nhs.uk/wp-content/uploads/2020/11/CS51005-WCS-Wessex-Cancer-5-year-plan-UPDATE-PRF3.pdf

Wilkes, C.M. (2022). Using Debriefs to Reduce Nursing Burnout in Nurses Caring for the Oncology Population. *MSN Capstone Projects.* http://hdl.handle.net/10950/4116

Highlight boxes

Box 1: Psychological skills in cancer care – MSc module

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The aim of this MSc level module is to support students to develop an in-depth understanding of assessing psychological wellbeing, and of planning and delivering psychologically-informed care for people living with cancer. Over 6 study days students learn to provide timely and sensitive care based on theory and evidence i.e., Level 2 psychological support (NICE 2004a). This includes delivering low-intensity interventions including psychological information and psychoeducation for patients and families, support people to self-manage and adjust to life situations, problem solving and managing crises. The assessment is skills based, involving a conversation with a simulated patient (actor) and with an academic to assess underpinning knowledge.

The module has run twice (May 2023 and Jan 2024) and 30 students have completed. For both cohorts the module evaluation has indicated that students feel more confident in recognising, assessing and communicating with people experiencing distress and more confident in providing appropriate and effective support.

Students have indicated that they would change their practice based on the learning from the module e.g.:

'I have found this a brilliant way to learn new skills and gain confidence in using them. I have recommended this course to members of my team and other colleagues and I am sure that my patients will really benefit. The challenge of being out of the clinical area for 6-7 days in completely justified by the knowledge and skills that I have brought back to patient care and clinical practice.'

'Recognising sign of distress, anxiety in patients and approach conversations with more confidence.'

'Assessing risk when cues are given Giving the appropriate time/space to delve into people's psychological concerns Not just fixing a problem!'

'It really has made a huge impact on my practice and I have been able to acknowledge and reflect on my own behaviour/stresses & values.'

Box 2: Working with NHS Talking Therapies to Improve Psychological Support for People affected by Cancer in Portsmouth

This quality improvement project aimed to understand the experiences of people affected by cancer who had accessed the psycho-oncology service at Queen Alexandra hospital, Portsmouth and the local NHS Talking Therapies Service (Talking Therapies Portsmouth). Using an experience-based co-design (EBCD) methodology, we aimed to bring staff and patients together to identify key improvement areas and co-design solutions with the longer term hope of creating an effective pathway between both services.

People affected by cancer shared their experiences and improvement ideas via recorded video interviews. Staff members were also interviewed about their experiences of working within their respective services, supporting people affected by cancer. Key themes from both sets of interviews were highlighted, with a catalyst film made from the patient interviews. This was then shared with patients and staff, to prompt discussions about the key things that needed to be improved. From these discussions 3 key improvement themes were highlighted:

- Discussing psychological support right from the start – *How can we ensure that from the point of diagnosis, and at regular points throughout people are talking about and normalising psychological support?*
- Demystifying & developing awareness of psychological support – *How can we ensure people have information about what support is out there, which service helps when and what they might expect when they get there?*
- Staff training – *What is it important for staff to know when working with people affected by cancer? How might we develop this? How can we raise staff awareness of the other service?*

Co-design groups were established for the above themes, including people affected by cancer and staff from both services. The groups met over a 6-week period to start to unpick the questions above, and to begin to explore and design solutions. Thanks to these groups, a clear direction of travel has now been set for each theme, with short, medium and long term goals that we are now working towards. Some of the these include: establishment of training for Talking Therapies staff on working with cancer, with lived experience at it’s heart; the creation of a “Cancer hub” – a website to include explanatory videos about psychological support available across the NHS and third sector; and co-location and delivery of some aspects of care – for example, a joint fear of cancer recurrence therapy group.

Box 3: The role of psychological support – clinician and patient perspectives

"One thing I am always struck by is how patients often understand, instinctively, how the psychological aspect of their care is completely fundamental. They know that there is little point in everyone working so hard to keep them alive if the quality of their life is so poor that they cannot enjoy it or make good use of the extra time they have with family and friends. The people we look after need psychological care to be woven into their healthcare from the first investigation they have, through diagnosis, treatment and any complications, until the day they die. Surely this is something it would be reasonable for us all to expect? This is not to say that all psychological care is purely down to designated, highly skilled professionals, such as Clinical Psychologists, quite the reverse in fact. All the professionals I work with are responsible for the psychological wellbeing of their patients on a day-to-day basis and they take this very seriously, often going over and above (at what cost?). However, for gold standard care across cancer, patients should have access to psychological care which is fully integrated into the MDT. This enables a psychological approach to be embedded into how the service functions, giving all professionals access to training, supervision, and reflective practice to support them in delivering the holistic care they strive to provide. In addition to this, patients should have access to specialist psychological assessment and treatment from NHS staff who are a core part of the team around them rather than relying on the generosity of third sector provision alone. "

"I have found discussions around attachment theory really useful to understand how and why some patients interact with health care professionals the way they do and how to best communicate with people with different attachment styles and that in certain situations giving the patient more time will actually make them more dependant…I have also found its been good to make time for myself monthly to talk about difficult patient relationships or difficult relationships with staff but from a non-clinical point of view…I have found that every situation one of our group has raised has been relevant to me and I have had similar situations so even if I don't think I have anything to discuss at supervision.

It was really important to set out rules for the group when we first started and that the group members has remained fairly consistent, so we are able to have frank discussions and what is discussed at psych supervision stays at psych supervision!"- Commentary provided by an oncology dietician working in secondary care on the benefits of psychological supervision for the cancer workforce.

"Unfortunately, due to the long wait time to see a counsellor, many potential clients report that 'the moment has passed' and they needed support at the time of request, or in some cases, their mental health has deteriorated, and their issues have become more complex as it is harder for them to look for help. Also, it has been the case that potential clients have died without receiving the support they so desperately needed. As the counsellor, it has been hard to carry this wating list and the knowledge that you are not meeting the needs of patients in a timely fashion."

Box 4: Screening for psychological distress – The PACC study

Patient and personal stories from original report, which I cannot currently access, to go here.

Box 5: Prehabilitation and Rehabilitation

In 2022/23, Wessex Cancer Alliance (WCA) conducted a scoping exercise of prehabilitation and rehabilitation services providing physical activity, nutritional or psychosocial support to people with cancer across Wessex. A greater understanding of services where available was identified across Hampshire, the Isle of Wight and Dorset across NHS, local authority and third sector organisations and the gaps in service provision were determined. Building on the scoping findings, WCA, have recognised a need to develop accessible and equitable prehabilitation and rehabilitation services providing universal, targeted and specialist services, based on a patients-needs, as a key component of personalised care.

The purpose of effective prehabilitation and rehabilitation in cancer is to:

- Empower people with cancer to enhance their own physical and mental health and wellbeing.
- Use as teachable moments to support changes to lifestyle behaviours such as smoking cessation.
- Enable preparation for cancer treatment and enhance recovery following cancer treatment.
- Reduce complications and side effects from diseased and/or treatment
- Address practical problems caused by disease or treatment, enabling people to remain as independent as possible.
- Improve overall quality of life.

Prehabilitation and rehabilitation services support the integrated care agenda of physical, mental health and social needs plus integration across services and care environments . These services provide a range of benefits for the wider healthcare economy; including supporting early discharge from hospital, reduced length of stay and readmission, and providing care closer to home.

The NHS England Cancer Quality of Life survey reports increasing concerns across differing aspects of health e.g. anxiety and depression, mobility and fatigue for people with cancer in comparison to the general population. Across Wessex, we have observed an increase in cancer diagnosis, increasing the requirement for prehabilitation and rehabilitation needs-based prescribing.

Box 6: Right by You Wessex

Right by You Wessex (RbYW) was developed to enhance patient care through the development and testing of an integrated approach to supporting people living with cancer. The intervention delivers personalised, integrated care across Southampton, Hampshire and Portland, Dorset. Longitudinal therapeutic needs assessments and tailored interventions and support are provided across primary, secondary and community services, delivered by experienced Cancer Support Workers (CSWs) and Cancer Clinical Nurse Specialists (CNSs). Assessments and support provision are undertaken in the service users' preferred location, typically their home. This enables effective responses to verbal and non-verbal cues of need. It also helps to establish rapport and build the foundations of an effective longitudinal therapeutic relationship. Central to the support model is the offer to families / carers, to enable continued support at home. The specialist nature of the experience of the cancer nursing team enhance the care offered by recognising and managing symptoms, treatment related toxicity, early intervention to prevent emergency presentation and decision-making support.

Focus on Psychological Support

CNSs are trained in Acceptance and Commitment Therapy (ACT) techniques and have received Managing Cancer and Living Meaningfully (CALM) training. They can deliver highly skilled psychosocial interventions personalised to service user requirements. RbYW provides NICE level 2+ psychological care that integrates with the limited local services available and provides support where these are absent. Independent evaluation found that secondary care professionals typically referred people to RbYW due to high levels of complex psychological need, beyond those that can be supported in secondary care. In January 2024 a Mental Health Practitioner joined RbYW, enhancing the level of mental health support provided by the service to those living with mental illnesses alongside their cancer.

Key Successes

- As of April 2024, RbYW has **supported over 650 individuals across Southampton and Portland**, working in and out of acute services to provide integrated, complex, continuous approaches to care.
- **Complex Emotional and psychological support**: An important area of need identified by service users; psychological support interventions are delivered across most visits. Confidence to facilitate difficult conversations amongst families are a key component of the skills and capabilities of the team.
- **Health and wellbeing:** Service users report improved psychological wellbeing, increased self-efficacy, increased confidence to access services and improved support for carers and family members.
- **Integrated care**: Service users experience better patient-centred care because of improved health service integration. RbYW facilitate improved communication, acting as a conduit for sharing information and facilitating improved relationships between care sectors.
- **Health service use**: Efficiencies in health service delivery have been demonstrated, including reduced attendance (e.g., unscheduled admissions, GP appointments), fewer inappropriate referrals and the prevention of care duplication.
- **Crisis de-escalation:** Proactive identification and response to unmet need, prevents crisis escalation with resulting efficiencies to the NHS (e.g., avoiding unplanned admission). Management and de-escalation of psychological needs within the community obviates the need to refer to psychological services.

Appendices

Appendix A: Psychosocial support special interest group (SIG) membership

Name	***Role***	***Organisation***
Abi Desouza	Quality Improvement Lead (Personalised Care)	Wessex Cancer Alliance
June Davis	Director and Project Lead for Prehabilitation and Rehabilitation Scoping	Allied Health Solutions, Wessex Cancer Alliance
Steph Heath	Personalised Care Programme Manager (Vice chair)	Wessex Cancer Alliance
Jane Winter	Lead for Nursing and AHPs (Chair)	Wessex Cancer Alliance
Alison Farmer	Psycho-oncology Clinical Nurse Specialist	University Hospitals Southampton
Andrew Merwood	Principal Clinical Psychologist	Portsmouth Hospitals University NHS Trust
Sylvia Carpenter	Counsellor, Cancer Services	Dorset County Hospital NHS FT
Helen Moorey	Project Lead	Wessex Cancer Alliance
Nancy Vanderpuye	Consultant Clinical Psychologist	Hampshire Hospitals NHS FT

Lynn Calman	Associate Professor & Deputy director of the Centre of Psychosocial Research in Cancer (CentRIC)	University of Southampton
Melissa Girling	Clinical Psychologist & Team Lead	University Hospitals Dorset Foundation Trust
Alison Pearce	UHS Lead Consultant Clinical Psychologist for Adult Psychology	Southern Health NHS FT
Beth George	Principal Clinical Psychologist	Southern Health NHS FT
Helen Aiston	Clinical Psychologist (Haematology)	University Hospital Southampton NHS FT
Helen Perry	Education, Project Lead for CNS module development	University Hospital Southampton NHS FT, Wessex Cancer Alliance
Claire Smith	Lead Cancer Nurse	University Hospital Dorset NHS FT
Jane Hazeldine	Lead Psychologist	Mountbatten Hospice
Paul Beadon	Lead Psychologist	Rowans Hospice
Shirley Crofts	Counselling Psychologist	Maggie's Southampton
Sinead Parry	Macmillan Partnership Manager	Macmillan Cancer Support

Maria Noblet	Consultant Nurse & Counsellor	Portsmouth University Hospitals NHS FT, Wessex Cancer Alliance
Jaana Jeffery	Macmillan Supportive Care Lead and PIFU Project Lead	Hampshire Hospitals NHS FT
Chloe Grimmett	Behavioural scientist & Senior research fellow	University of Southampton

Appendix B: Summary of National guidance for psychological support provision

Guidance	Tumour sites	Psychological support provision
National Institute for Health and Care Excellence NICE Improving outcomes in urological cancers, 2002 (CSG2)	Prostate, testicular, penile, bladder, urothelial, kidney	• Specialist MDT team should have access to critical care facilities & maintain close contact with other professionals who may be actively involved in supporting patients or carrying out the management strategy…. Liaison psychiatrist, clinical psychologist trained in psychotherapy and cognitive behaviour therapy, counsellor with expertise in treating psychosexual problems. • From the time of diagnosis, each patient should have access to a specialist cancer nurse who can offer psychosocial support. • The nurse specialist, or another member of each MDT, should be trained in counselling patients and couples who may have to live with impotence or other sexual problems, loss of fertility, incontinence, or stomas after treatment for cancer. • Counselling should be available when required from an individual who has specific expertise in dealing with psychosexual and body-image issues; this should be available to help patients and their partners to cope with such problems after treatment and for as long as it is needed.

National Institute for Health and Care Excellence NICE Haematological cancers: improving outcomes, 2016 (NG47)	Haematological cancer	• All haemato-oncology MDTs should have access to liaison psychiatrist and/or clinical psychologist, social worker, bereavement counsellor.
National Institute for Health and Care Excellence NICE Improving outcome for people with brain and other central nervous systems tumours, 2006 (CSG10)	Brain, central nervous system	• Ready access to specialist neuropsychology and neuropsychiatry for assessment and management of complex cognitive and behavioural problems. • Rapid access to allied health professional assessment and rehabilitation services, including specialist neurorehabilitation as appropriate. • Core membership of the MDT should include a neuropsychologist, with extended member as require psychology/psychiatry. • It is important to have regular assessment of psychological needs of patients to monitor cognitive and personality changes. • Neuropsychology and neuropsychiatry services should be adequately resourced to enable referral of patients who require specialist intervention for cognitive, behavioural, or emotional problems. • Ongoing training should be provided for all staff providing psychological support.
National Institute for Health and Care Excellence NICE Early and locally advanced breast cancer: diagnosis and management, 2023 (NG101)	Breast	• Offer access to specialist psychological support and psychiatric services where appropriate.
National Institute for Health and Care Excellence NICE Familial breast cancer: classification, care and managing breast cancer and related risks in people with a family history of breast cancer, 2019 (CG164)	Breast	• Standard written information about risk-reducing surgery including physical and psychological impact. • Risk counselling, psychological counselling should be offered to women who are not eligible for referral or surveillance based on age, or risk level and have ongoing concerns. • MDT should include access to psychological assessment and counselling. • Risk reducing mastectomy for women with no personal history of breast cancer (1.7.36) – preoperative counselling about psychosocial and sexual consequences of bilateral risk-reducing mastectomy should be undertaken. • Risk reducing breast or ovarian surgery for people with a personal history of breast cancer (1.7.55) – Refer women with a personal history of breast cancer who wish to consider risk-reducing surgery for appropriate genetic and psychological counselling before surgery.
National Institute for Health and Care Excellence NICE Advanced breast cancer, 2009 (CG81)	Breast	• Uncontrolled local disease (1.5.13) – A palliative care team should assess all patients with uncontrolled local disease to plan a symptom management strategy and provide psychological support.

National Institute for Health and Care Excellence NICE Improving outcomes in Breast Cancer, 2002 (CSG1)	Breast	• Psychosocial support should be available at all stages, healthcare staff should have training to improve their ability to recognise the psychological need of patients and treat as appropriate. • Providers should demonstrate provision of services designed to meet the psychosocial needs of the patients. • Resource implications – breast care nurse and lead clinicians may need additional training in identifying patients' psychosocial needs, counselling skills and communications skills. • Breast care nurses should also be available to offer support and arrange counselling for patients – including those who have been released from follow-up – who develop psychological problems linked with their experience of cancer. • MDT should have ready access to counselling for patients and carers/relatives and psychologists/psychiatrist where appropriate. There is compelling evidence demonstrating the value of specialist nurses (B). They play a variety of important roles, and their work produces lasting beneficial. outcomes. Findings from a range of studies reveal the following benefits accruing. from the nurse's role in providing information and psychosocial support: ▪ Improved understanding by the patient of her condition (B) ▪ Enhanced patient involvement in decision-making (B) ▪ Reduced anxiety and depression and increased levels of self-esteem among ▪ patients (A) ▪ Improved general health and reduced somatic symptoms (A)
National Institute for Health and Care Excellence NICE Improving outcomes in Head and Neck cancers, 2004 (CSG6)	Head & Neck	• Extended MDT member involvement from psychiatric and/or psychological services; liaison psychiatrist, clinical psychologist, counsellor. • Role of CNS for head and neck cancers includes psychosocial support in addition to coordination of care. • CNS requires highly developed communication and psychosocial skills and identify patients who would benefit from referral to other professionals e.g. clinical psychologist, liaison psychiatrist. • There should be close liaison between all MDT members (in particular CNS) and psychological support services.
National Institute for Health and Care Excellence NICE Metastatic malignant disease of unknown primary origin in adults: diagnosis and management, 2010 (CG104)	CUP	• Provide appropriate emotional and psychological support, information about CUP, treatment options and palliative care.
National Institute for Health and Care Excellence NICE Metastatic	MSCC	• Offer patients with MSCC and their families and carers specialist psychological and/or spiritual support appropriate to their needs at diagnosis, at other key points during treatment and on discharge.

spinal cord compression in adults: risk assessment, diagnosis, and management, 2008 (CG75)		
National Institute for Health and Care Excellence NICE Oesophago-gastric cancer: assessment and management in adults, 2018 (NG83)	Oesophageal	• Provide psychosocial support to the person with oesophago-gastric cancer and those important to them as appropriate.
National Institute for Health and Care Excellence NICE Pancreatic cancer in adults: diagnosis and management, 2018 (NG85)	Pancreas	• Provide people and their family members or carers (as appropriate) with information and support to help them manage the psychological impact of pancreatic cancer on their lives and daily activities.
National Institute for Health and Care Excellence NICE Prostate cancer: diagnosis and management, 2019 (NG131)	Prostate	• Offer people with prostate cancer, and their partners or carers access to talk to a healthcare professional experienced in dealing with psychosexual issues at any stage of the condition and its treatment. • Consider referring people who are having long-term androgen deprivation therapy, and their partners, for psychosexual counselling.
National Institute for Health and Care Excellence NICE Improving outcomes for people with sarcoma, 2006 (CSG9)	Sarcoma	• Patients and their carers should be offered appropriate psychological support. • Extended MDT member involvement from specialised Allied Health Professionals plus access to clinical psychologists and counsellor.
National Institute for Health and Care Excellence NICE Melanoma: assessment and management, 2015 (NG14)	Skin	• Discuss the psychological and emotional impact of melanoma with the person, ask whether they have any psychological or support care needs, and offer to carry out a holistic needs assessment. • Ensure that each local skin cancer MDT and specialist skin cancer MDT has access to psychological support services for people with melanoma.
National Institute for Health and Care Excellence NICE Improving supportive and palliative care for adults with cancer, 2004	All	• Assessment and discussion of patients' needs for physical, psychological, social, spiritual, and financial support should be undertaken at key points (such as at diagnosis; at commencement, during, and at the end of treatment; at relapse; and when death is approaching). • Commissioners and providers of cancer services, working through Cancer Networks, should ensure that all patients undergo systematic psychological assessment at key points and have access to appropriate psychological support. A four-level model of professional psychological assessment and intervention is suggested to achieve this. • Staff providing psychological care should be adequately trained and supervised, and mechanisms to ensure support should be available. • A four-level model of professional psychological assessment and intervention should be developed and implemented in each Cancer Network

		• Professional psychological support at Levels 1 and 2 should, in the first instance, be provided by health and social care professionals directly responsible for the care of people with cancer. More severe psychological distress (Levels 3 and 4) should be managed by a variety of psychological specialists, including counsellors, mental health nurses, clinical and health psychologists, psychotherapists, and liaison psychiatrists. • GPs, oncologists, and palliative care physicians also have a significant role in the psychological care of patients and carers, which includes the prescription of antidepressant and other psychotropic medication. • An individual (or individuals) should be identified within each cancer site-specific and specialist palliative care team to take responsibility for providing Level 2 care (that is, screening for psychological distress and using simple psychological techniques). • All staff providing psychological support within the recommended model will require training and ongoing supervision. Those working at the higher levels of the model should normally provide training, supervision, and opportunities for continuing professional development for those operating at the lower levels.