



Service Specification
Psychological Support Services

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Context

Introduction

The cancer care providers of north east London, north central London and west Essex agreed in July 2011 to develop an integrated cancer system (ICS) in response to the requirements of London's Strategic Health Authority and commissioners. Since April 2012 this ICS, *London Cancer*, has brought together the area's secondary and tertiary care providers in a formal governance structure, working with primary care and also harnessing the expertise of leading cancer academics and charities. Its mission is to drive superior outcomes and experience for our resident population of 3.5 million, and position its staff as leaders in cancer care – locally, nationally and globally.

Psychological aspects of care are considered both by the tumour specific *Pathway Boards* and the crosscutting *Psychosocial Expert Reference Group*.

Cancer and Psychological Distress

Cancer affects patients and their families at an emotional level and its effects are particularly evident at key points of the cancer pathway. All patients benefit from good psychological care from every healthcare worker they meet. A spectrum of psychological distress from normal worry to severe levels of depression and anxiety is evident, sometimes requiring the intervention of specialist psychological services.

In the year following diagnosis, around one in ten patients will experience symptoms severe enough to warrant intervention by specialist psychological/psychiatric services. Such symptoms can also be seen in 10-15% of patients with advanced disease⁽¹⁾.

Psychological barriers to surgical and oncological treatments

A range of psychosocial variables can mediate access physical investigations and treatments. Anxiety and aversive *conditioned responses* can delay and/or inhibit engagement with tests or treatments. Psychological and psychiatric interventions are utilised to help overcome these obstacles to good surgical and oncological care. Decision making in relation to risk-reducing procedures is another domain in which there is an increasing demand for psychological practitioners to provide specialist assessments.

Recognition of the need for psychological assessment and support in cancer

Numerous national guidance documents highlight the importance of psychological assessment and support in this context:

- **The Cancer Plan** identified and incorporated the need for psychological assessment, support and self-help.⁽²⁾
- **The NICE Guidance on Improving Supportive and Palliative Care for Adults with Cancer** acknowledges there are insufficient numbers of trained professionals to provide psychological support and there is little co-ordination between professionals who are offering different types of psychological interventions. The guidance identifies a 4-tier model to be implemented network wide.⁽¹⁾
- **Improving Outcomes Guidance** for specific tumour groups (e.g. breast, colorectal, urology, Skin, and head & neck) makes specific reference to:
 - The need for assessment
 - The provision of clinical psychology services
 - The various psychological support interventions

In other tumour groups, there are additional requirements. *Brain and other CNS tumours* specify “ready access to specialist neuropsychology and neuropsychiatry services” and guidance relating to urology and gynaecological cancers identify a need for specialist psychosexual provision.⁽³⁾

- **Psychological Support Measures for Cancer (NCAT 2010)** provides the detailed peer review measures for psychological support in cancer based on the 4-tier model described in the 2004 NICE guidance.⁽⁴⁾
- **NICE Guidelines on Familial Breast Cancer (CG14)** cites access to psychological support and assessment as a key part of service provision.⁽⁵⁾
- **The National Service Framework for Older People (June 2005)** acknowledges that older people frequently suffer from both physical and mental disorders and need access to appropriate and co-ordinated services. Of the incidence of cancer diagnosed in 2003, 74% occurred in patients over the age of sixty.⁽⁶⁾
- **The National Service Framework for Supporting People with Long Term Conditions to Self Care: A guide to developing local strategies and good practice (February 2006)** states that services need to focus on empowerment of patients to enable them to:
 - Access care and support
 - Deal with side effects and treatment
 - Improve their quality of life.⁽⁷⁾

- **The Cancer Reform Strategy (2008)** highlights the need for psychological support both during and after active treatment.⁽⁸⁾
- **The NICE clinical guideline 91 - Depression in adults with a chronic physical health problem (October 2009)** makes recommendations on the identification, treatment and management of depression in adults who also have a chronic physical health problem (such as cancer, heart disease, diabetes, or a musculoskeletal, respiratory or neurological disorder). This guideline is published alongside ‘Depression: the treatment and management of depression in adults (update)’ (NICE clinical guideline 90), which makes recommendations on the identification, treatment and management of depression in primary and secondary care.⁽⁹⁾
- **The NICE clinical guideline 90 Depression: the treatment and management of depression in adults (October 2009)** is a partial update of NICE clinical guideline 23 (published December 2004, revised April 2007) and replaces it.⁽¹⁰⁾

Background to the development of this service specification

The Psychological Support Measures for Cancer⁽⁴⁾ requires all cancer networks to produce *Baseline Mapping, Service Specifications, Needs Assessments and Development Strategies*. Mapping of *London Cancer services*⁽¹¹⁾ was completed in 2013 and this document follows on from that work.

In defining this specification, the Psychosocial Expert Reference Group drew on six primary sources:

- IoG: Supportive and Palliative Care for Adults with Cancer⁽¹⁾
- IoG: Supportive and Palliative Care for Adults with Cancer: *Economic Review*⁽¹²⁾
- Psychological Support Measures for Cancer⁽⁴⁾
- *London Cancer: Baseline Mapping of Psychological Support Services*⁽¹¹⁾
- *London Cancer – Incidence of cancers by pathway*⁽¹⁴⁾
- *London Cancer – Patient priorities*⁽¹³⁾
- A review of other regional Service Specifications⁽¹⁵⁾

The Expert reference group developed the specification in early 2014. A full list of members can be found in appendix A.

The Psychological Support Measures for Cancer⁽⁴⁾ state that specifications should quantify the level of psychological support required “*taking into account the estimate of 10% of cancer patients needing access to level 4 psychological intervention in the year following diagnosis, 15% needing access to Level 3 psychological intervention in the year following diagnosis and 10% needing support with advanced disease*”. In addition to quantifying resources, there is also a requirement to provide a description of how services should be configured and delivered across different settings.

It has been agreed by London Cancer pathway directors that this specification clarifies the nature of the psychological services required to deliver the holistic care across the pathways. It therefore stands as an appendix to pathway specific specifications.

The 4-Tier Model

The 2004 NICE guidelines⁽¹⁾ describe a 4-tier model. It recognises that all patients have psychological needs and that all staff have a role to play in assessing and responding to these needs.

The 2013 London Cancer baseline mapping⁽¹¹⁾ considered all staff operating at levels 2, 3 and 4.

Level	Group	Assessment	Support / Intervention
1	All health and social care professionals	Recognition of psychological needs	Effective information giving, compassionate communication and general psychological support
2	Health and social care professionals with additional expertise	Screening for psychological distress	Psychological techniques such as problem solving
3	Trained and accredited professionals	Assessing for psychological distress and diagnosis of some psychopathology	Counselling and specific psychological interventions such as anxiety management and solution-focused therapy, delivered according to an explicit theoretical framework
4	Mental health specialists	Diagnosis of psychopathology	Specialist psychological and psychiatric interventions such as psychotherapy, including cognitive behavioural therapy (CBT)

- Psychological support at Levels 1 and 2 should 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, clinical psychologists, psychotherapists and liaison psychiatrists.
- Each Cancer Network is required to develop and implement a four-level model of professional psychological assessment and support, to ensure that all patients undergo systematic psychological assessment at key points in the care pathway and can obtain an appropriate level of psychological support
- Each Cancer Network is required to consider workforce development issues, including training in screening for psychological distress and the delivery of basic psychological interventions and supervision. Training should be provided by experts in psychological care with extensive experience in cancer, particularly those delivering more complex aspects of psychological care.

Specification: Description of services

Integrated Support Services

Trusts should seek to ensure that psychological provision is well integrated with other supportive care functions. Physical spaces that bring together informal 'drop in' facilities, first-line emotional support, information provision and benefits advice allow patients and families to access help in a simple, comfortable and non-threatening manner.

One would expect these facilities to be more comprehensive at cancer centres, however, the principal of integration should still apply at the DGH where it is reasonable to expect there to be a dedicated Information and Support Centre.

For a portion of the population, there is still a stigma associated with accessing anything that might be perceived as mental health services. Integrated support centres (ISCs) can help circumvent this barrier. The informality of the environment and the opportunity to just 'chat' to staff offers an alternative mechanism for identifying unmet psychosocial need.

So, in addition to other referral pathways (via the MDT or ward staff), the ISC can help to identify patients who require level 3/4 support. If this is coupled with straightforward referral pathways, and psychological specialists operating within or close to the unit, then patients who might not otherwise access higher-level interventions can be helped.

This emphasis on integration should not detract from psychological therapists being members of MDTs and engaged in service delivery in clinical areas such as inpatient wards and radiotherapy units.

Cancer Centres

Cancer Centres should be providing Integrated Support Services as described above. Examples of such provision are the Macmillan Centre at UCH and the Maggie's Centre at Charring Cross Hospital. All patients within London Cancer should have access to such facilities and all trusts (whether they include a cancer centre or not) should ensure that patients are aware of their nearest centre. While this 'open access' policy is required, it is recognised that there may be some specialist services (e.g. Level 3 / 4 support) funded by the host trust that are only available through internal referral. However, this should not lead to inequity of service as all trusts are required to have some local Level 3 / 4 provision of their own.

Clinical Nurse Specialists

The Clinical Nurse Specialists (CNS) role is central to improving the psychological wellbeing of patients. Three factors combine to make this the case:

- **Skill set:** Their existing experience and knowledge means that they are already well placed to receive the additional training and support to help them function as Level 2 practitioners.
- **Coverage:** There is commitment across London Cancer to ensure that all patients should have good access to a CNS.
- **Engagement:** Surveys consistently report that their involvement is highly valued by patients.

CNSs who have attended the Level 2 training and supervision have an enhanced ability to screen for psychological difficulties, intervene where appropriate and refer on when Level 3 / 4 input is required. This means that limited specialist services are used most effectively and that patients are not subjected to unnecessary referrals.

Peer review requires one person from each MDT to receive level 2 training and supervision. While this requirement has helped drive the relevant developments, limiting it to one person per MDT (usually a CNS) generates problems of inequity – i.e. some patients will benefit from a level 2 CNS while others won't. To overcome this issue and ensure that every patient is being properly assessed, it is critical that all CNSs are supported to function at Level 2.

While London Cancer does have sufficient Level 3 / 4 capacity to train all CNSs, it is not possible to provide the essential on-going supervision using the current model. Alternative approaches need to be developed if the whole patient population is to benefit from having a level 2 CNS.

Specialist Provision

All Trusts providing cancer treatment should have an appropriate mix of level 3 / 4 specialists who:

- Respond rapidly (within 48 hours, Monday - Friday) to inpatient referrals.
- Help patients access physical investigations/treatments where psychological factors (e.g. anxiety) act as a barrier.
- Have close working relationships with the MDT, providing management advice and support.
- Provide outpatient services that integrate with other aspects of care (i.e. psychological therapy sessions that dovetail with radiotherapy appointments). These should have wait times to treatment of no more than 4 weeks.
- Provide level 2 training and supervision.

In order to provide this service, professionals need to be physically based at the hospital site alongside other members of the MDT.

Hospital and Community Provision

Most community provision of psychological care consists of generic therapy services such as IAPT¹. These services have an increasing role to play as more people are living longer after a diagnosis of cancer. Defining when hospital based services are no longer appropriate should occur at cancer pathway level. Some hospital services limit aspects their input to one-year post treatment. However, where there are consequences of treatment (such as Graft-versus-Host Disease, peripheral neuropathy and psychosexual dysfunction) or concerns regarding likely recurrence, it may be more appropriate for hospital-based specialists to have more protracted involvement. Late effects clinics will see patients many years after treatment (including adult survivors of childhood cancers) and psychological care should be part of the holistic approach to this work.

As community services seek to enhance their skills (with initiatives such as 'Long term conditions' IAPT), hospital based specialists should be available to provide relevant training and consultation to ensure that core knowledge and skills in psycho-oncology are transferred to community practitioners. With this in place, there should be scope for triaging some patients earlier in their care where individual circumstances mean that the ease of accessing local services outweighs the benefits of seeing a specialist.

For palliative care services, there is a strong argument for developing specialist posts that are not necessarily hospital based. These roles can provide seamless care across hospital / community / hospice and have scope for providing domiciliary visits to patients who are too unwell to leave the home.

Liaison Psychiatry provision

All Trusts providing cancer treatment should ensure that there is adequately resourced Liaison Psychiatry Services to provide:

- A timely responsive service to inpatient referrals
- An outpatient service. [The complexity of some disease processes and the side effects associated with oncological treatments mean that a proportion of patients will benefit from maintaining contact with hospital-based liaison psychiatry rather than being transferred to generic community services. This outpatient provision is also preferable where psychological interventions are being applied as it helps to support a more co-ordinated approach to care]

¹ Improving Access to Psychological Therapies: a generic stepped care approach to psychological interventions delivered in the community

Multidisciplinary working

- There should be structures and/or processes in place to ensure that psychiatric and psychological care services within hospitals are well co-ordinated.
- There should also be processes in place to ensure that patients are offered psychological or where necessary, psychiatric support, that is likely to benefit them regardless of where referrals are initially directed.

Level 4 Specialist functions

Some skills such as neuropsychological assessment involve additional training and require regular application to maintain competency. Where patient volumes cannot justify every trust employing appropriately skilled staff, there should be agreed referral pathways to ensure that access to specialist assessment is equitable.

Use of volunteers

Appropriately trained and supported volunteers can make a significant contribution to enhancing the psychological wellbeing of patients. Delivering Level 1 services, they can help in providing both information and support.

All Level 3 / 4 staff should seek to develop links to relevant training institutions and if possible, offer placements where a mutually beneficial exchange between the service and the trainee can take place.

Holistic Needs Assessment

The use of the pan-London Holistic Needs Assessment tool is an essential component of efforts to improve screening and patient experience. Details regarding its implementation are documented in the Living with and Beyond Cancer Annual Plan 2014/2015.

Research and related commentaries⁽⁵⁸⁻⁶¹⁾ have demonstrated that where HNA is poorly implemented there are no measureable gains in terms of quality of life and health cost savings. It is therefore essential, that implementation includes adequate training and that professionals make appropriate use of service directories where onward referral is indicated.

Families and Carers

The 2004 NICE guidelines⁽¹⁾ are explicit in specifying that psychological services should also be made available to families and carers.

Some of this support will be delivered by generic community services. However, psychological difficulties within families are often more helpfully addressed by systemic and co-ordinated approaches. In such cases, care is best delivered by the psychological specialists who are also supporting the patient and advising the medical team.

Families and carers should therefore have some access to Level 3/4 resources within the acute setting.

Evidence Based treatments

The NICE guidance^(1,9) make explicit reference to the evidence base that underpin the treatments offered by Level 3 and 4 specialists and the following table provides a relevant summary:

Relaxation techniques, alone or combined with education/skills training, are effective in preventing or relieving:

Anxiety^(16,17) and depression⁽¹⁶⁻¹⁸⁾ in newly diagnosed patients
Anxiety⁽¹⁹⁾ and depression⁽¹⁹⁾ in patients in the terminal phase of illness
Anxiety⁽²⁰⁻²⁵⁾ and depression^(20-22,24) in patients undergoing chemotherapy
Anxiety^(26,27) and depression⁽²⁶⁻²⁸⁾ in patients undergoing radiotherapy
Anxiety^(29,30) and depression^(30,31) in patients undergoing surgery
Anxiety⁽³²⁾ and depression⁽³³⁾ following completion of active treatment

Psycho-education is effective in preventing or relieving:

Anxiety^(34,35) and depression⁽³⁴⁾ in newly diagnosed patients
Anxiety⁽³⁶⁾ and depression⁽³⁷⁾ in patients undergoing surgery
Anxiety⁽³⁸⁾ in patients undergoing chemotherapy
Depression⁽³⁹⁾ in patients undergoing chemotherapy

Supportive and supportive-expressive therapies are effective in preventing or relieving:

Anxiety^(40,41) and depression^(40,42) in patients with metastatic disease
Anxiety⁽²⁴⁾ and depression⁽²⁴⁾ in patients undergoing chemotherapy
Anxiety⁽²⁷⁾ and depression⁽²⁷⁾ in patients undergoing radiotherapy
Depression⁽⁴³⁾ in patients undergoing surgery

Couples counseling is effective in preventing or relieving:

Depression⁽⁴⁴⁾ in patients undergoing surgery

Cognitive-behavioral therapy is effective in preventing or relieving:

Depression⁽⁴²⁾ in patients with metastatic disease
Anxiety⁽⁴⁵⁾ in patients undergoing surgery

Cognitive therapy is effective in preventing or relieving:

Depression⁽⁴⁶⁾ in patients undergoing chemotherapy

Short-term Psychodynamic therapy is effective in preventing or relieving:

Depression in breast cancer patients⁽⁵⁷⁾

Mindfulness based therapy is effective in preventing or relieving:

Anxiety⁽⁵⁶⁾ and depression^(55,56) at a various points in the patient pathway

Meta-analyses demonstrate that psychological interventions improve patient outcomes on a number of important clinical dimensions⁽⁵⁰⁻⁵²⁾ and it should be stressed, that this includes adherence to medical treatments⁽⁵³⁾.

Evidence based interventions for anxiety are relevant to cost savings in the acute setting as it is well established that high levels of anxiety are associated with greater length of stay (LoS)⁽⁴⁸⁾ and increased use of analgesia⁽⁴⁹⁾. Similarly, studies have identified a relationship between depression and LoS. Depressed patients have been shown to have an increased LoS of between 8 and 40%^(47, 54)

Interventions

Individual differences mean that we do not have a definitive evidence base regarding exactly *what* and *how much* therapy should be provided for all presenting problems. However, in the interest of efficiency and equity, there does need to be consistency in provision across *London Cancer* and the available evidence must inform this. The Psychosocial expert reference group will be providing further guidance on this matter in 2014/15.

Measuring Satisfaction and Outcomes

Across *London Cancer* there is an agreed approach to measuring outcome and satisfaction. Specific questionnaires with guidance notes are provided and Level 3 / 4 services are required to use them and have collated data available in an easily accessible form.

Specification: Resourcing

Methodology

The specification for resourcing draws on two sources:

- IoG: supportive and palliative care for adults with cancer: Economic review⁽¹²⁾
- Six existing regional services specifications⁽¹⁵⁾

The existing specifications were identified as part of a systematic review carried out in 2013. All six specifications used the data presented in the IoG as the basis for their calculations. However, the guidance only quantifies the need for interventions with psychological morbidity in the first year of treatment and following any recurrence. It does not provide the data necessary to calculate the resources required to deliver the full breadth of services that it recommends (or that are required in the relevant Peer Review measures⁽⁴⁾). These include:

- Living with and Beyond Cancer: patients still in treatment a year or more after diagnosis
- Interventions for family / carers
- Psychosexual therapy
- Provision of training to generalist staff
- On-going delivery of supervision to Level 2 staff
- The impact of systematic use of holistic needs assessment on referral rates
- Psychological assessment in relation to surgery

This lack of detail has led to significant disparity in estimates of the overall resourcing requirement. *Appendix B* provides a summary of the calculations used in other networks and relevant standardisation. While none of them explicitly take account of all of the above demands, between them there is an attempt to arrive at a realistic quantification of the minimum resource required.

As no new data or information is available to improve on the existing estimates, the *London Cancer* approach has been to review and standardise specifications from elsewhere in the UK. This has ensured that recommendations take account of previous work and local estimates do not deviate towards the extremes.

Data Sources

The Baseline Mapping of Psychological Support Services⁽¹¹⁾ conducted in 2013 drew on trust level data to calculate the overall annual incidence for all tumour types. Following the publication of the mapping, there were requests from pathways boards to have data presented at both trust and pathway levels. In seeking to accommodate this request, the most recent incidence data for the *London Cancer* region was accessed. Notably, these data included new cases that had been omitted at the trust level. Rather than there being an overall incidence of 12,053, it would now appear that in 2010 there were actually 13,738 new cases (see *Appendices C and D*).

The obvious implication is that some or all of the trusts have underreported new cases treated. It therefore follows that as trusts review their staffing requirements for Level 3 /4 professionals they need to ensure that their current incidence data is accurate.

Requirement

For the six existing regional services specification, the median and mean standardised Level 3/4 (wte1.0) provision per 1000 are 2.8 and 2.7 respectively. Using the lower of these two values suggests that London Cancer requires 37.1wte specialist Level 3 /4 staff across the whole region². *Appendices C and D* describe the requirement by pathway and trust respectively. *Appendix E* quantifies the shortfall at a trust/locality level.

It should be noted that some of the existing resource is not *dedicated* psychological support for the cancer population – i.e. there are posts that currently provide input to cancer services without being clearly commissioned to do so. For both existing and new Level 3/4 resource, there should be work at a trust level to produce explicit documentation to register the dedicated nature of the provision thereby inhibiting redirection the resource without there being an accompanying change in commissioning intent.

Cancer Centres

Where cancer centres offer a breadth of service to patients across the system, it is to be expected that that they will have greater staffing needs though one would not expect this to go beyond the range identified in the specifications detailed in *Appendix B*.

Community / Hospice Provision

The 37.1wte figure relates to acute provision during treatment and for the early stages of post-treatment survivorship. It does not take account of later work that one would expect to occur via Community IAPT³ (and where appropriate, secondary mental health care) provision. Developments such as specialist *Long-Term Conditions* IAPT services (whilst currently in their infancy) are especially relevant and their resourcing will need to take account of the increasing needs of this population.

While hospice services contribute to the end of the care pathway, this specification does not seek to recommend a quantifiable level of provision. The psychological services they provide are in some respects broader than the acute setting, normally extending to care for non-malignant conditions and bereavement support. However, local benchmarking data is provided in *Mapping of psychological Service for Cancer Palliative Care*⁽¹¹⁾

² Based on the 2010 annual incidence across all tumour types of 13,738 (see *Appendix C*)

³ Improving Access to Psychological Therapies: a generic stepped care approach to psychological interventions delivered in the community

Skills Mix

The NICE guidance describes a model with a ratio of 3:2 for Level 4 and 3 practitioners⁴. This is not a definitive ratio but as services develop, they should seek to include representation from both levels of provision

In cancer centres where one would expect there to be more resource, it is important that an appropriate skills mix is in place. However, wherever staffing is more limited (either in a DGH or at a cancer centre with underdeveloped provision) service development should start with the recruitment of Level 4 practitioners. Without this, some essential aspects of provision (e.g. psychological assessment in relation to surgery) will be absent.

Level 3 / 4 specialist functions

In the course of 2014/5, specific recommendations relating to specialist assessments/interventions will be produced. Where centres offer a 'regional' service there should be funding mechanisms to ensure that the additional provision is appropriately supported.

Whilst a detailed specification of provision is not yet available, it should be noted that national guidance is already clear that the following specialist functions are required:

- Psychosexual therapy
- Neuropsychological assessment
- Assessments relating to risk reducing procedures

⁴ With Level 4 including both applied psychology and psychiatry.

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Appendix A:
Psychosocial Expert reference Group

Mark Barrington	Consultant Clinical Psychologist & Chair	Barts Health
Mary Burgess	Consultant Clinical Psychologist	UCLH
Lallita Carballo	Joint Clinical Head for the Macmillan Support and Information Service	UCLH
Sharon Cavanagh	Macmillan AHP and Living with and beyond Cancer Lead	<i>London Cancer</i>
Caroline Dancyger	Lead Clinical Psychologist in Cancer Care	Barts Health
Daphne Earl	Patient Representative	Patient Representative
Aleda Erskine	Consultant Clinical Psychologist	Camden & Islington
Sue Gessler	Consultant Clinical Psychologist	UCLH
Elaine Heywood	Macmillan Counsellor	Royal Free
Pauline McCulloch	Colorectal Nurse Lead	Homerton
Fiona McKenzie	Patient Experience Project Manager	<i>London Cancer</i>
Sara McNally	Consultant Liaison Psychiatrist	RNOH
Hilary Plant	Joint Clinical Head for the Macmillan Support and Information Service	UCLH
Peter Southern	Palliative Care Social Worker	Barts Health
Clare Stevenson	Clinical Psychologist in Cancer Care	Homerton

Appendix B:
Calculations of service need across cancer networks

Cancer Network	Newly Diagnosed Per Annum (2008 data)	Proportion of Patients estimated to require L3/4 Input (and how this is calculated in each network)	Calculated L3/4 Service Need (wte) (using network-specific calculation)	Standardised L3/4 Need per 1000 newly diagnosed (wte)*	Key Features of Method
Arden	5238	25% (15% in year after diagnosis for L3, 10% in year after diagnosis for L4)	13.03 (7.8 at L3, 5.23 at L4)	2.49	Does not factor in supervision/training and those outside of 'year after diagnosis'
East Midlands	2011** <i>(+10082 'palliative patients')</i>	25% (15% in year after diagnosis for L3, 10% in year after diagnosis for L4) <i>Same proportions applied to 'palliative' patients (cancer deaths per annum)</i>	77.7 (37.5 at L3, 40.2 at L4) +37.2 (18 at L3, 19.2 at L4)	3.69 +3.69	Second analysis uses deaths per annum as palliative patients (imprecise but does at least allow for estimate of some further work beyond 'first year of diagnosis') Does not factor in supervision/training
Birmingham	8299	25% (15% in year after diagnosis for L3, 10% in year after diagnosis for L4)	20.8 (12.5 at L3, 8.3 at L4)	2.51	Does not factor in supervision/training and those after 'year after diagnosis'
Lancashire & South Cumbria	8349	35% (15% in year after diagnosis for L3, 10% in year after diagnosis for L4, 10% survivorship)	25.85 (12.5 at L3, 8.35 at L4, 5.0 extra for survivorship, supervision & training)	3.10	Factors in supervision/training and those outside of 'year after diagnosis' Deducts cancer deaths from newly diagnosed to estimate the 10% and 15% figures for L3/4
North East Yorkshire & Humber	6058	35% (15% in year after diagnosis for L3, 10% in year after diagnosis for L4, 10% for advanced disease + 1 family member or carer per patient)	6.7	1.11	Factors in 1 family member or carer per patient also needing L3/4 Factors in advanced disease but not necessarily survivorship/recurrence. Does not factor in supervision/training
Yorkshire	11415	Not provided	38	3.33	Based on 1 wte per 300 patients (rationale unclear)

Appendix C:

Annual incidence of new cancers by tumour type, London Cancer region. (2010)

Source: *National Cancer Intelligence Network* (Data drawn from their “Cancer Commissioning Toolkit”)

Tumour Type	Incidence	%	Level 3/4 requirement based on 2.7wte per 1000
Brain/CNS	243	2	0.7
Breast	2218	16	6.0
Endocrine	182	1	0.5
Gynae	1903	14	5.1
Haematology	1187	9	3.2
Head and neck	381	3	1.0
Lower GI	1378	10	3.7
Lung	1586	12	4.3
Other	359	3	1.0
Sarcoma	152	1	0.4
Skin	310	2	0.8
Upper GI	1168	9	3.2
Urology	2671	19	7.2
Total:	13738		37.1

Appendix D:

Annual incidence by provider trust with associated Level 3/4 staffing requirements

Source: *National Cancer Intelligence Network* (Data drawn from their “Cancer Commissioning Toolkit”)

Trust	Annual 1 st treatment cases	L3/4 wte requirement	Illustrative correction to ‘L3/4 wte requirement’ utilising tumour level incidence data ¹
BHRUT	2280	6.2	7.0
Barts Health	2727	7.4	8.4
North Middlesex	816	2.2	2.5
Royal Free	1112	3.0	3.4
UCLH	1468	4.0	4.5
Barnet & Chase Farm	1593	4.3	4.9
Homerton	319	0.9	1.0
Princess Alexandra	935	2.5	2.9
RNOH ²	360	1.0	1.1
Whittington	443	1.2	1.4
Total:	12053	32.7 wte	37.1 wte

Moorfields Eye Hospital has very small throughput, served by generic therapy services and are therefore excluded from these dedicated

- 1 *Data Sources* (page 12) describes the deficiencies of trust level data. While it is unclear which trusts have underreported ‘new cases treated’, the tumour level data indicates that there is a mean underestimate of approximately 14%. The ‘illustrative correction’ is based on this figure.
- 2 Nb: Correction to data reported in *Mapping of London Cancer Services*⁽¹¹⁾

Appendix E:
Level 3/4 needs assessment by provider trusts

Mapping of London Cancer Services⁽¹¹⁾ provides a detailed description of level 3/4 provision, for cancer centres, general hospitals, community and hospice settings.

The following table focuses on cancer specific services in the acute setting. Figures exclude community, voluntary and hospice provision. Detailed planning for any specific locality would need to make reference to this additional resource, especially in relation to the psychological support in End of Life Care provided by hospices.

Trust	Level 3/4 wte Requirement¹	2013 wte Provision⁵	Resource (wte) shortfall
BHRUT	7.0	2.0	5.0
Barts Health	8.4	4.1	4.3
North Middlesex	2.5	0.3	2.2
Royal Free ²	3.4	2.6	0.8
UCLH	4.5	4.2	0.3
Barnet & Chase Farm ²	4.9	-	4.9
Homerton	1.0	0.6	0.4
Princess Alexandra ³	2.9	-	2.9
RNOH ⁴	1.1	0.2	0.9
Whittington	1.4	0.3	1.1

- 1 Utilising the corrected Level 3/4 requirement as recorded in Appendix D
- 2 *Mapping of London Cancer Services*⁽¹¹⁾ presented Royal Free / Barnet & Chase Farm data separately. At end of 2014, no amalgamation of psychological services in cancer had yet occurred. Therefore, for consistency, the resourcing levels continue to be presented separately for the legacy trusts.
- 3 While Princess Alexandra has no in-house provision, there is 0.2wte of Level 3 counselling offered by a third sector provider 5 miles from the hospital site.
- 4 RNOH has no 'dedicated' Level 3 / 4 resource. However, non-dedicated services currently provide approximately 0.2wte at level 4 to cancer patients.
- 5 Figures refer to Q1-3 2013