Psycho-education
for the cancer workforce
Who needs to know?

Dr Alex King

Consultant Clinical Psychologist

Imperial College Healthcare, London

our vision

healthcare that is psychologically minded

Recommended model of professional psychological assessment and support

Self help and informal support

Level	Group	Assessment	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	Assessed for pychological distress and diagnosis of some psychopathology	Couselling and specific psychological interventions such as anxiety management and solution-focused therapy, delivered according to an explicit theoretical framework
3	Mental health specialists	Diagnosis of psychopathology	Specialist psychological and psychiatric interventions such as psychotherapy, including cognitive behavioural therapy (CBT)

Table 8. Specialist cancer nurse workforce by Cancer Alliance, vacancy rates, WTE, England 2017

Cancer Alliance	Filled	Vacant	Total	Vacancy rate	Not known
Cheshire and Merseyside	223	16	239	7.0	0
East Midlands	244	9	253	3.7	0
East of England	404	16	419	3.9	0
Humber, Coast and Vale	105	2	107	1.9	0
Isle of Man	4	0	4	-	0
Kent and Medway	68	4	71	5.3	0
Lancashire and South Cumbria	128	1	129	0.8	0
National Cancer Vanguard: Greater Manchester	328	12	339	3.6	0
National Cancer Vanguard: North Central and North East London	197	15	212	7.4	2
National Cancer Vanguard: North West and South West London	282	30	312	10.8	0
North East and Cumbria	254	11	265	4.3	0
Peninsula	120	4	124	3.0	1
Somerset, Wiltshire, Avon and Gloucestershire	207	4	211	1.9	0
South East London	122	2	124	2.0	0
South Yorkshire, Bassetlaw, North Derbyshire and Hardwick	110	5	115	4.8	0
Surrey and Sussex	190	8	197	4.0	0
Thames Valley	128	9	137	7.0	0
Wessex	157	4	161	2.4	0
West Midlands	407	13	419	3.1	0
West Yorkshire	174	4	178	2.1	0
Total	**3,851**	**166**	**4,017**	**4.3**	**3**

Cancer Workforce Plan

Phase 1: Delivering the cancer strategy to 2021

the model

Brennan, J. (2001)

Adjustment to Cancer – Coping or Personal Transition

Psycho-oncology, 10, 1-18.

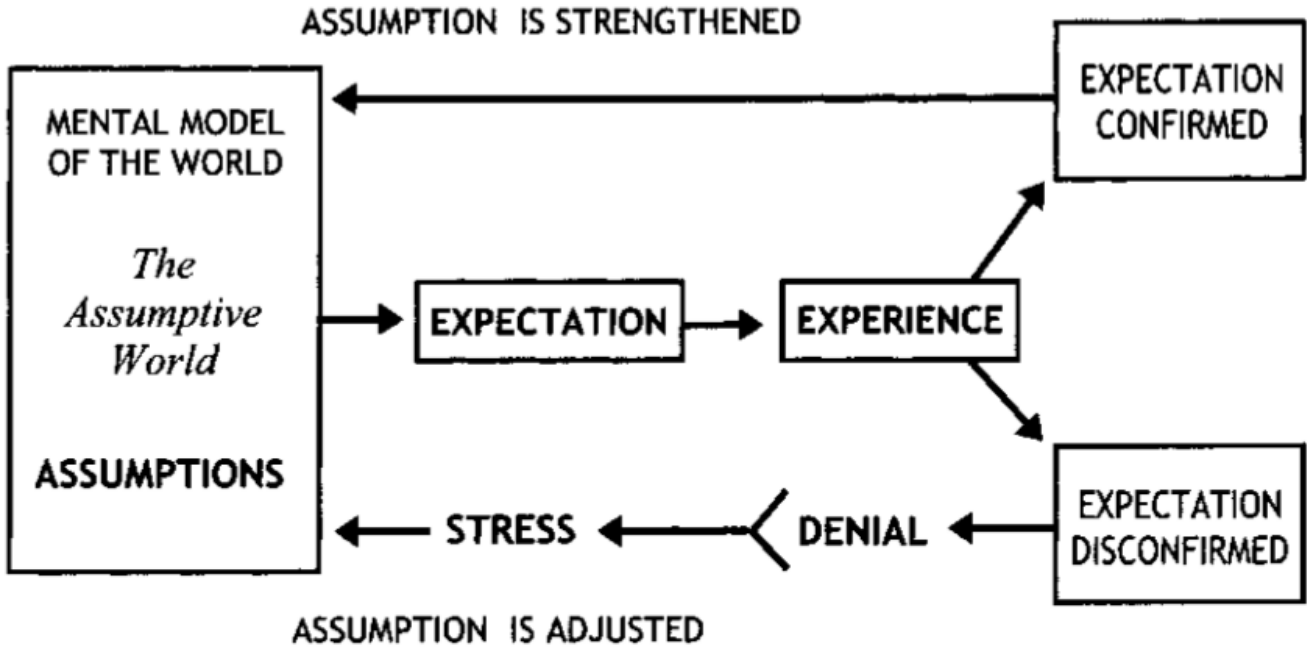


Figure 1. The Social-Cognitive Transition Model of Adjustment.

universal

universal

communication skills

attachment

(emotional) self-efficacy

a language of adjustment

with them; and 72% of respondents said that the possible side effects of treatment(s) were definitely explained to them in a way they could understand (which meant that over a quarter didn't completely understand).

However, when things go wrong, communication is often cited as the cause, Marie Curie's 'A long and winding road' provides us with some of the evidence to support this. There is a wealth of communication skills training available, but although the NHS often develops the content, others roll out the training so that NHS employers end up paying to access that content.

In the short term, HEE will produce a best practice resource guide in March 2018 identifying best practice in communication skills and bring it together in one place.

Communication skills training is included in all curricula but how it is taught, the length of teaching and content vary considerably *so in the longer term HEE* will work with the regulators to focus on the delivery of training, the experiential elements and what good looks like in terms of delivery. We will also work with the regulators and other Arms Length Bodies to ascertain the feasibility and desirability of encouraging annual update training in communication skills given the need to align levers to achieve this.

Cochrane Library

Cochrane Database of Systematic Reviews

Communication skills training for healthcare professionals working with people who have cancer (Review)

Moore PM, Rivera S, Bravo-Soto GA, Olivares C, Lawrie TA

Moore PM, Rivera S, Bravo-Soto GA, Olivares C, Lawrie TA.
Communication skills training for healthcare professionals working with people who have cancer.
Cochrane Database of Systematic Reviews 2018, Issue 7. Art. No.: CD003751.
DOI: 10.1002/14651858.CD003751.pub4.

www.cochranelibrary.com

communication

"*CST*

appears to have

little measurable benefit

to the mental or physical health,

and satisfaction of people with cancer and

does not appear to reduce 'burnout'

in HCPs"

bjh review

A clinical review of communication training for haematologists and haemato-oncologists: a case of art *versus* science

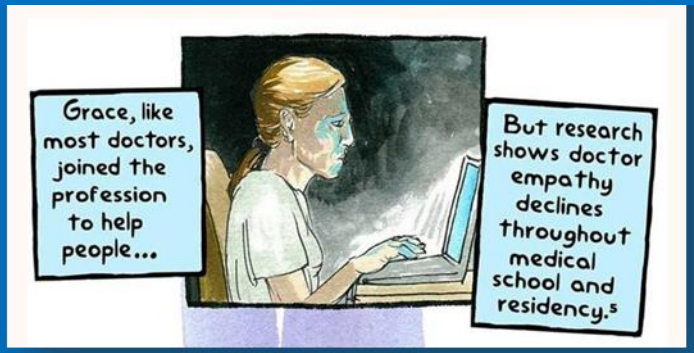
Deborah Christie[1,2] **and Sarah Glew**[1]

[1]*Department of Child and Adolescent Psychological Services, UCLH NHS Foundation Trust, and* [2]*UCL Institute of Epidemiology and Public Health, London, UK*

Summary

The art of communication at times seems at odds with the science of medicine. Poor communication is associated with risks for patient and physician. Communication skills are highly relevant for haematologists and are associated with increased physician and patient satisfaction, positive psychosocial outcomes and possible health outcomes. Medical communication training has recently become widespread but is largely restricted to junior medical professionals. In medicine, where physicians had little to offer aside from comfort and empathy, medical professionals today have immense healing capacity at their disposal. Whilst it may be self- evident that "*empathy and compassion without expertise in healthcare is 'quackery'*", the reverse is far less obvious (DiMatteo, 1979). In the context of the broadening scientific basis of medicine over the last 100 years, observers have commented on how the historical art of physician-patient communication has declined (Feinmann, 2002; Maguire & Pitceathly, 2002). Illich (1974) argued that over-medicalisa-

Christie & Glew, 2017 - 10.1111/bjh.14606


Grace, like most doctors, joined the profession to help people...
But research shows doctor empathy declines throughout medical school and residency.[5]


Ok Sameer. Ummm...The anaesthetist will be along shortly.
In medical school sessions are run on breaking bad news to patients...


But it is all about saying the right things to an actor, not about how to really listen to people or to hold space for their suffering.

Peter Salmon & team

2017 Salmon & Young – goals, not 'skills'

"Similarly, whereas communication literature currently urges clinicians to engage patients in emotional discussion to comfort them, attachment theory reminds us that the key to comforting patients is helping them feel safe. Therefore, it explains why cancer patients and their families appreciate clinicians who are calm, confident and authoritative rather than engaging in emotional talk. It explains why clinical relationships in cancer need not be 'built' by clinicians' communication but can be present from the start in patients' minds, arising from their own dependence and the clinicians' expertise."

Simon

self-efficacy

Sage & Thyme

Mike Connolly, Manchester

self-efficacy

Sage & Thyme

Mike Connolly, Manchester

The SAGE & THYME model	
SETTING	If you notice concern - think first of the setting, create some privacy - sit down.
ASK	"Can I ask what you are concerned about?"
GATHER	Gather all of the concerns - not just the first few - "Is there something else?"
EMPATHY	Respond sensitively - "You have a lot on your mind."
TALK	"Who do you have to talk to or support you?"
HELP	"How do they help?"
YOU	"What do YOU think would help?"
ME	"Is there something you would like ME to do?"
END	Summarize and close - "Can we leave it there?"

self-efficacy

Sage & Thyme

Mike Connolly, Manchester

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ME	"Is there something you would like ME to do?"
END	Summarize and close - "Can we leave it there?"

does it scale?

does it stick?

does it 'help'?

adjustment

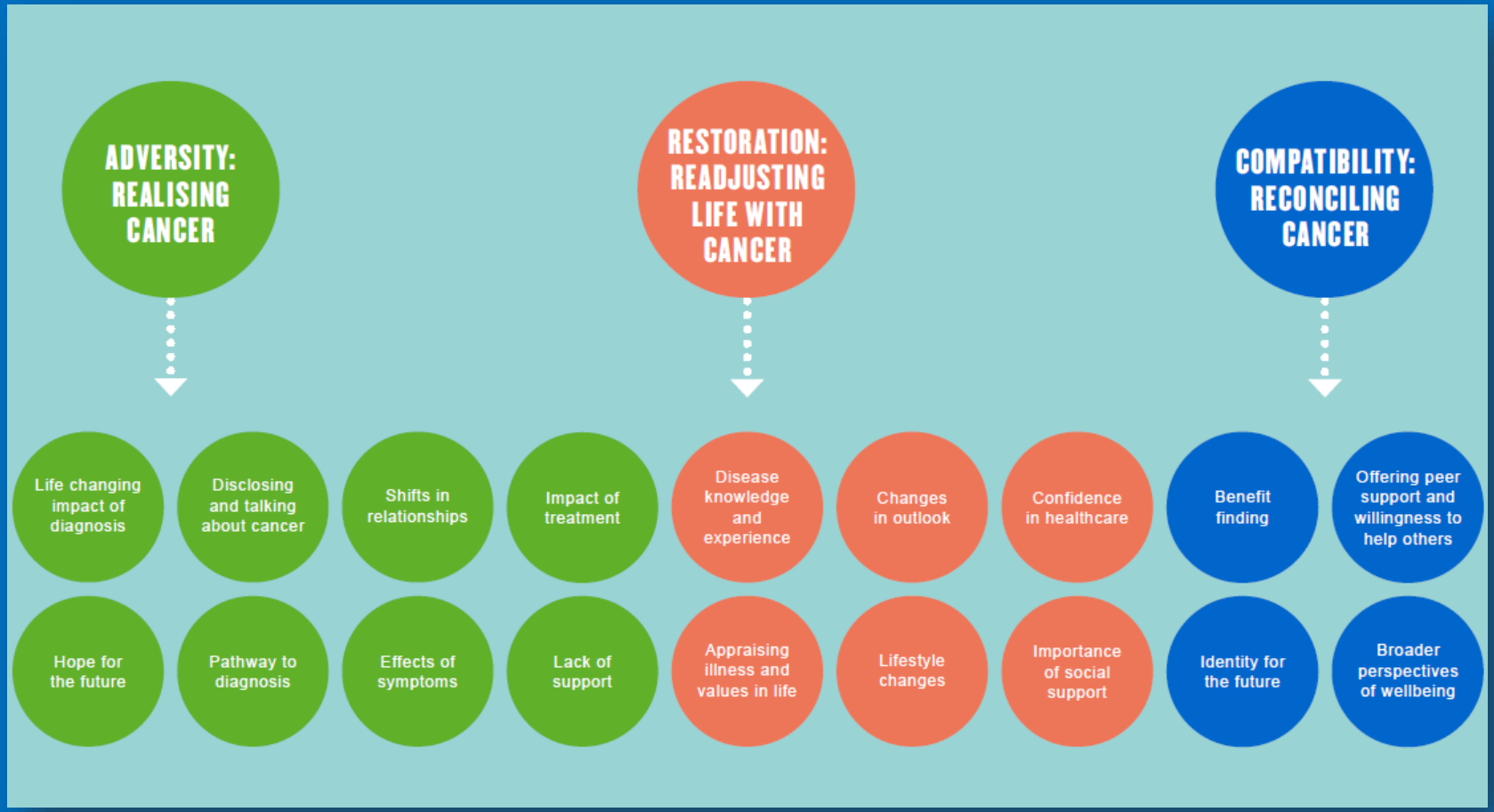
*A*daptation

*R*estoration

*C*ompatibility

LeBoutillier et al (in press) "Conceptual framework for living with and beyond cancer: A systematic review and narrative synthesis" . Psycho-oncology. doi 10.1002/pon.5046

adjustment


ADVERSITY: REALISING CANCER
RESTORATION: READJUSTING LIFE WITH CANCER
COMPATIBILITY: RECONCILING CANCER
Life changing impact of diagnosis
Disclosing and talking about cancer
Shifts in relationships
Impact of treatment
Disease knowledge and experience
Changes in outlook
Confidence in healthcare
Benefit finding
Offering peer support and willingness to help others
Hope for the future
Pathway to diagnosis
Effects of symptoms
Lack of support
Appraising illness and values in life
Lifestyle changes
Importance of social support
Identity for the future
Broader perspectives of wellbeing

universal

we need:

- relational vs. transactional

- real-world impact

- minimum for effective implementation

enhanced

Recommended model of professional psychological assessment and support

Level	Group	Assessment	Intervention
1	All health and social care professionals	Recognition of psychological needs	Effective information giving, compassionate communication and general psychological support
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enhanced

communication skills

attachment

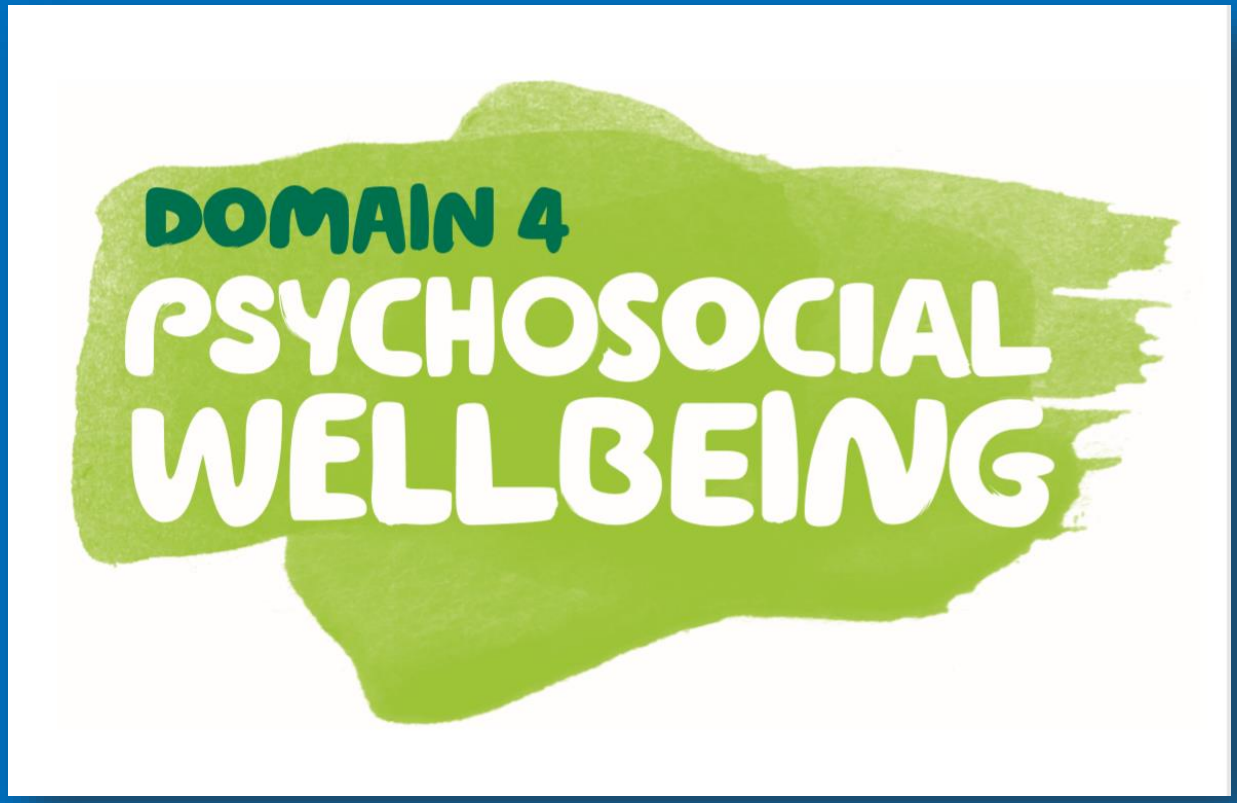
self-efficacy

adjustment

holistic assessment procedure

first-line psychological care skills

enhanced



enhanced

Essential

- Demonstrates knowledge of the psychological effects of cancer and its treatment on individuals, particularly in relation to loss of confidence and fear of recurrence
- Understands the psychosocial consequences associated with living with and beyond cancer
- Communicates effectively and appropriate
- cultural and socio-economic backgrounds
- Makes appropriate decisions to seek help
- individual's mental wellbeing
- Uses local pathways to refer individuals wi
- appropriate ser
- Understands
- individuals li
- leisure activi
- Has an awa
- the Equality

Specialist

As essential, plus:

- Has a comprehensive under
- associated with living with a
- Applies knowledge and exp
- effects, survivorship and foll
- wide range of diverse issues
- Supports individual patients
- them as they live with and b
- Helps patients to develop a
- mental wellbeing
- Provides advice and interver
- of cancer and its treatment
- Makes appropriate intervent
- inappropriately disadvantag
- and treatment
- Uses different approaches t
- thermometer, SPARC, conc
- Uses complex strategies to
- bad news about relapse and
- Identifies when patients have mental health needs that require referral to specialist services and facilitates this process eg psychiatric or clinical psychology services
- Works with other agencies and services to ensure that cancer, late effects and survivorship care is fully integrated into the care plans of individuals with new and pre-existing mental health illness

Leadership

As specialist, plus:

- Demonstrates advanced communication skills eg counselling and motivational interviewing techniques
- Acts as an expert resource for other HCPs when dealing with complex and challenging communication issues
- Develops, implements and evaluates different approaches to assessing psychosocial needs eg distress thermometer, SPARC
- Works with other agencies to develop clear pathways for complex psychosocial support needs for individuals living with and beyond cancer
- Evaluates care and services developed to support psychological wellbeing in terms of patient outcomes and the effectiveness of service delivery

holistic assessment

LONDON CANCER ALLIANCE West and South LCA

LONDON CANCER NORTH AND EAST

London Holistic Needs Assessment

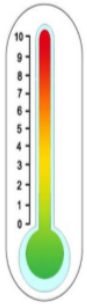
For each item below, please tick **yes** or **no** if they have been a concern for you during the last week, including today. Please also tick **discuss** if you wish to speak about it with your health professional.

Choose not to complete the assessment today by ticking this box ☐

Date:	
Name:	
Hospital/NHS number:	

Please **tick the number** that best describes the overall level of distress you have been feeling during the last week, including today:

10 ☐ **Extreme distress**
9 ☐
8 ☐
7 ☐
6 ☐
5 ☐
4 ☐
3 ☐
2 ☐
1 ☐
0 ☐ **No distress**



For health professional use

Date of diagnosis:	
Diagnosis:	
Pathway point:	

Practical concerns	Yes	No	Discuss
Caring responsibilities	☐	☐	☐
Housing or finances	☐	☐	☐
Transport or parking	☐	☐	☐
Work or education	☐	☐	☐
Information needs	☐	☐	☐
Difficulty making plans	☐	☐	☐
Grocery shopping	☐	☐	☐
Preparing food	☐	☐	☐
Bathing or dressing	☐	☐	☐
Laundry or housework	☐	☐	☐
Family concerns			
Relationship with children	☐	☐	☐
Relationship with partner	☐	☐	☐
Relationship with others	☐	☐	☐
Emotional concerns			
Loneliness or isolation	☐	☐	☐
Sadness or depression	☐	☐	☐
Worry, fear or anxiety	☐	☐	☐
Anger, frustration or guilt	☐	☐	☐
Memory or concentration	☐	☐	☐
Hopelessness	☐	☐	☐
Sexual concerns	☐	☐	☐
Spiritual concerns			
Regret about the past	☐	☐	☐
Loss of faith or other spiritual concern	☐	☐	☐
Loss of meaning or purpose in life	☐	☐	☐

Physical concerns	Yes	No	Discuss
High temperature	☐	☐	☐
Wound care	☐	☐	☐
Passing urine	☐	☐	☐
Constipation or diarrhoea	☐	☐	☐
Indigestion	☐	☐	☐
Nausea and/or vomiting	☐	☐	☐
Cough	☐	☐	☐
Changes in weight	☐	☐	☐
Eating or appetite	☐	☐	☐
Changes in taste	☐	☐	☐
Sore or dry mouth	☐	☐	☐
Feeling swollen	☐	☐	☐
Breathlessness	☐	☐	☐
Pain	☐	☐	☐
Dry, itchy or sore skin	☐	☐	☐
Tingling in hands or feet	☐	☐	☐
Hot flushes	☐	☐	☐
Moving around or walking	☐	☐	☐
Fatigue	☐	☐	☐
Sleep problems	☐	☐	☐
Communication	☐	☐	☐
Personal appearance	☐	☐	☐
Other medical condition	☐	☐	☐

Psycho-Oncology
Psycho-Oncology **20**: 1076–1083 (2011)
Published online 4 August 2010 in Wiley Online Library (wileyonlinelibrary.com). **DOI**: 10.1002/pon.1815

Identification of patient-reported distress by clinical nurse specialists in routine oncology practice: a multicentre UK study

Alex J. Mitchell[1,2]*, Nadia Hussain[3], Lorraine Grainger[4] and Paul Symonds[2]
[1]*Leicester General Hospital, Leicester, UK*
[2]*Department of Cancer and Molecular Medicine, Leicester Royal Infirmary, Leicester, UK*
[3]*Medical School, University of Leicester, Leicester, UK*
[4]*Chemotherapy Department, University Hospitals of Leicester NHS Trust, Leicester, UK*

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Received: 17 November 2009
Revised: 16 June 2010
Accepted: 19 June 2010

Abstract

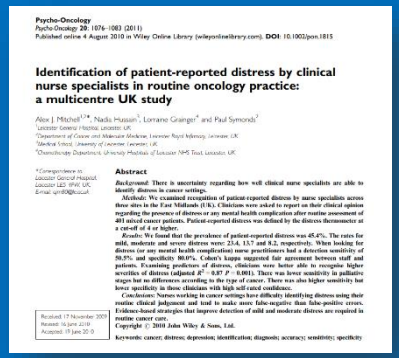
***Background*: There is uncertainty regarding how well clinical nurse specialists are able to identify distress in cancer settings.**

***Methods*: We examined recognition of patient-reported distress by nurse specialists across three sites in the East Midlands (UK). Clinicians were asked to report on their clinical opinion regarding the presence of distress or any mental health complication after routine assessment of 401 mixed cancer patients. Patient-reported distress was defined by the distress thermometer at a cut-off of 4 or higher.**

***Results*: We found that the prevalence of patient-reported distress was 45.4%. The rates for mild, moderate and severe distress were: 23.4, 13.7 and 8.2, respectively. When looking for distress (or any mental health complication) nurse practitioners had a detection sensitivity of 50.5% and specificity 80.0%. Cohen's kappa suggested fair agreement between staff and patients. Examining predictors of distress, clinicians were better able to recognise higher severities of distress (adjusted $R^2 = 0.87$ $P = 0.001$). There was lower sensitivity in palliative stages but no differences according to the type of cancer. There was also higher sensitivity but lower specificity in those clinicians with high self-rated confidence.**

***Conclusions*: Nurses working in cancer settings have difficulty identifying distress using their routine clinical judgement and tend to make more false-negative than false-positive errors. Evidence-based strategies that improve detection of mild and moderate distress are required in routine cancer care.**

Keywords: cancer; distress; depression; identification; diagnosis; accuracy; sensitivity; specificity



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[4]Chemotherapy Department, University Hospitals of Leicester NHS Trust, Leicester, UK

*Correspondence to: Leicester General Hospital, Leicester LE5 4PW, UK. E-mail: am80@le.ac.uk

Abstract

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Results: We found that the prevalence of patient-reported distress was 45.4%. The rates for mild, moderate and severe distress were: 23.4, 13.7 and 8.2, respectively. When looking for distress (or any mental health complication) nurse practitioners had a detection sensitivity of 58.5% and specificity 80.0%. Cohen's kappa suggested fair agreement between staff and patients. Examining predictors of distress, clinicians were better able to recognise higher severities of distress (adjusted $R^2 = 0.07$ $P = 0.001$). There was lower sensitivity in palliative stages but no differences according to the type of cancer. There was also higher sensitivity but lower specificity in those clinicians with high self-rated confidence.

Conclusions: Nurses working in cancer settings have difficulty identifying distress using their routine clinical judgement and tend to make more false-negative than false-positive errors. Evidence-based strategies that improve detection of mild and moderate distress are required in routine cancer care.

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Keywords: cancer; distress; depression; identification; diagnosis; accuracy; sensitivity; specificity

clinical nurse specialists identified:

40/94 people with mild distress (43%)

27/56 people with moderate distress (50%)

25/33 people with severe distress (76%)

holistic assessment

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JOURNAL OF CLINICAL ONCOLOGY

ORIGINAL REPORT

VOLUME 31 · NUMBER 29 · OCTOBER 10 2013

JOURNAL OF CLINICAL ONCOLOGY

EDITORIAL

Screening Alone Is Not Enough: The Importance of Appropriate Triage, Referral, and Evidence-Based Treatment of Distress and Common Problems

Linda E. Carlson, *University of Calgary, Calgary, Canada*

See accompanying article on page 3631

Health Research, or the Department of Health.

Authors' disclosures of potential conflicts of interest and author contributions are found at the end of this article.

Clinical trial information: NCT00960466.

Corresponding author: William Hollingworth, PhD, School of Social and Community Medicine, Canynge Hall, 39

in either arm of the trial were referred to a clinical psychologist.

Conclusion

Patients with cancer have a high prevalence of distress. Needs assessment can be performed quickly and inexpensively. However, the DT&PL was not cost effective in improving patient mood states. It is important to explore the reasons for this so that oncology units can design better services to support patients.

J Clin Oncol 31:3631-3638. © 2013 by American Society of Clinical Oncology

psychological skills

training!

Jenkins & North

Canada / McLeod

FA-CBT / Mannix

SMART trial

Palliative & Supportive Care

Volume 8, Issue 1 March 2010 , pp. 27-33

Beyond communication: The development of a training program for hospital and hospice staff in the detection and management of psychological distress—Preliminary results

Kate Jenkins [a1], Beccy Alberry [a1], Jane Daniel [a1], Laura Dixie [a1] ...

https://doi.org/10.1017/S1478951509990678 Published online: 01 February 2010

Abstract

In the United Kingdom, a Four-Tier Model of Psychological Support has been recommended for all patients with cancer and their families. This model suggests that staff at Tier 2, such as nurses, doctors, and allied health professionals, should be proficient in screening for psychological distress and intervening with techniques such as psycho-education and problem solving. Research has suggested that although communication skills training is essential for staff working in cancer services, it does not necessarily improve the detection of specific psychological disorder or staff confidence in intervening with highly distressed patients. The objective was therefore to design a training program that addressed this deficit and was easily accessible to hospital staff.

Method:. A training package was developed to train staff in the recommended skills. A literature review of teaching modalities and the effectiveness of different formats was conducted. A four-session program was developed, to be administered by staff at Tiers 3 and 4 of the model, such as clinical psychologists and counsellors.
Over 3 years, 255 sets of data were collected from staff who attended the course. Precourse, postcourse, and 6-month follow-up data were collected through the use of confidence questionnaires, developed from the literature. The data show a significant improvement in staff confidence across all domains measured, including confidence in the detection and management of psychological distress (p =.0001).
Although the results have limitations and the data are subjective, we can conclude that this course significantly improves staff confidence in dealing with psychological distress and that this increased confidence is maintained over a 6-month follow-up period.

Keywords:

Cancer Oncology Teaching Distress Communication

psychological skills

Knowledge

Understand stress, e.g. fight or flight model

Depression interventions: activity scheduling
Anxiety: breathing exercises, relaxation, distraction techniques
Sleep hygiene
Referral process

Skills

Developing a supportive relationship with patient/relative
Effective use of listening skills
Using screening tools
Making solution-focussed interventions, e.g. in strengths + resource
Using interventions, e.g. worry tree
Problem-solving with patients
Risk assessment, e.g. suicide

Attitudes

non-judgemental positive regard
importance of follow-up
importance of timely referrals/escalation

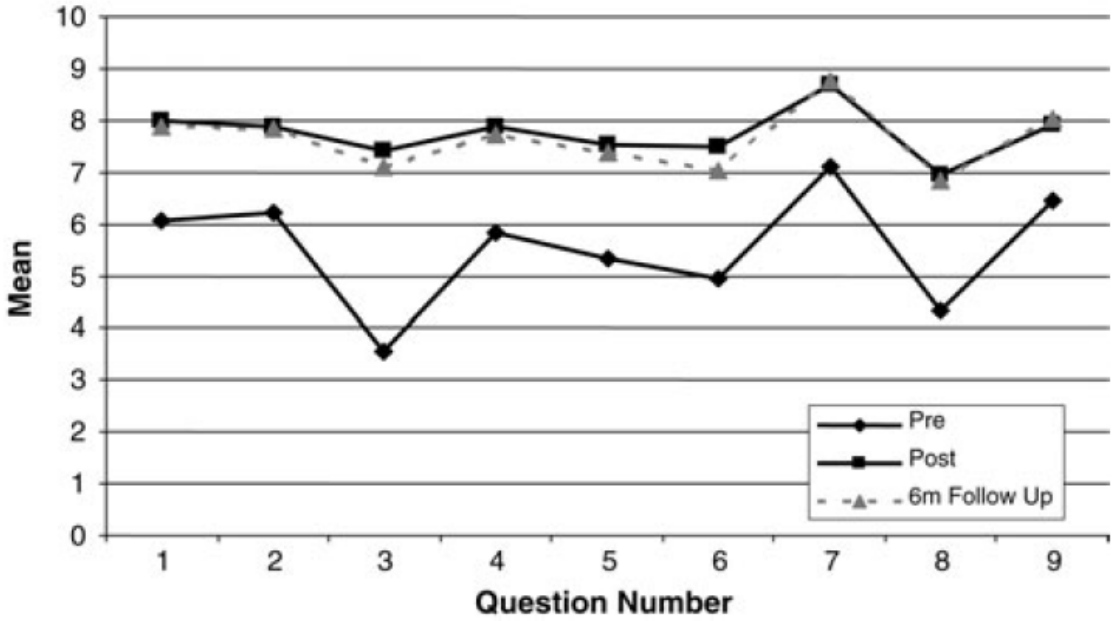
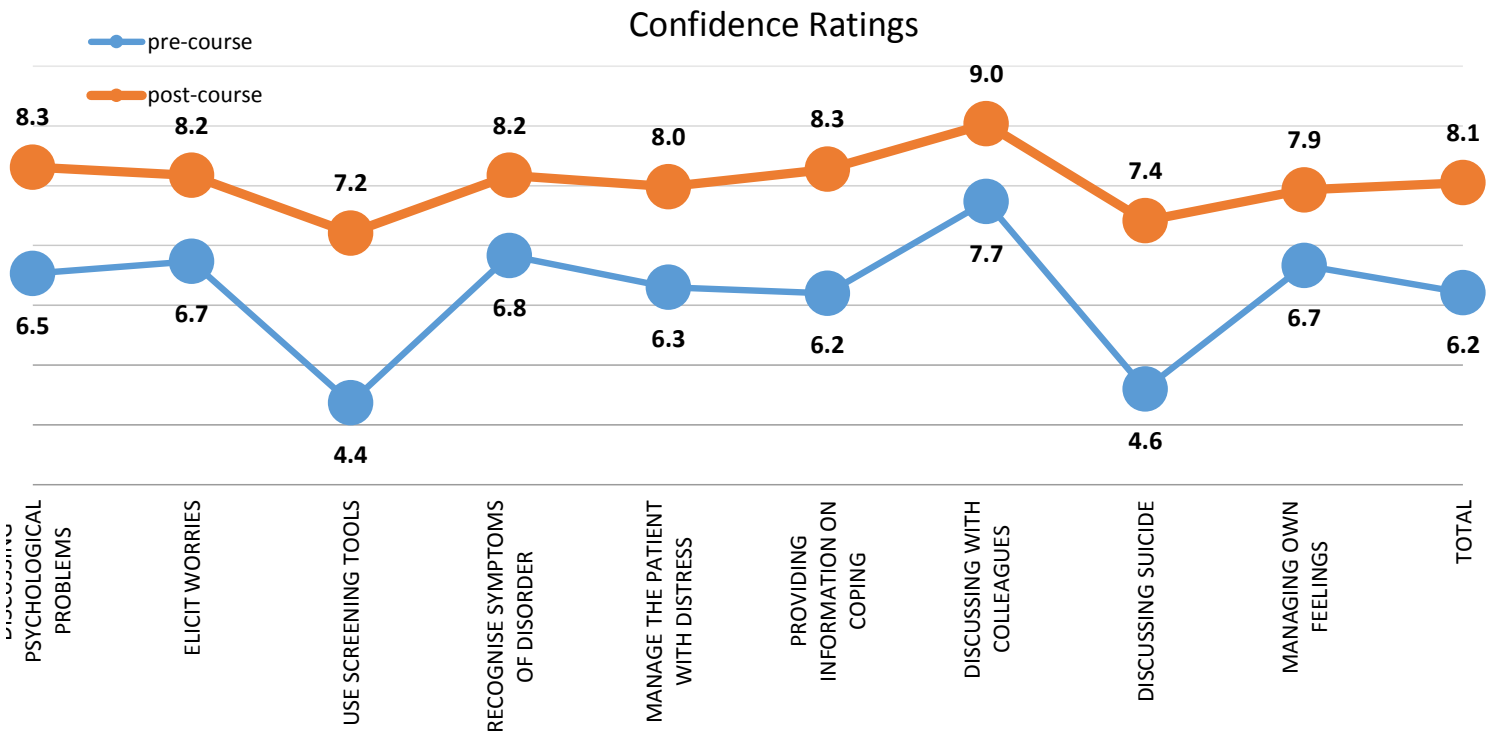
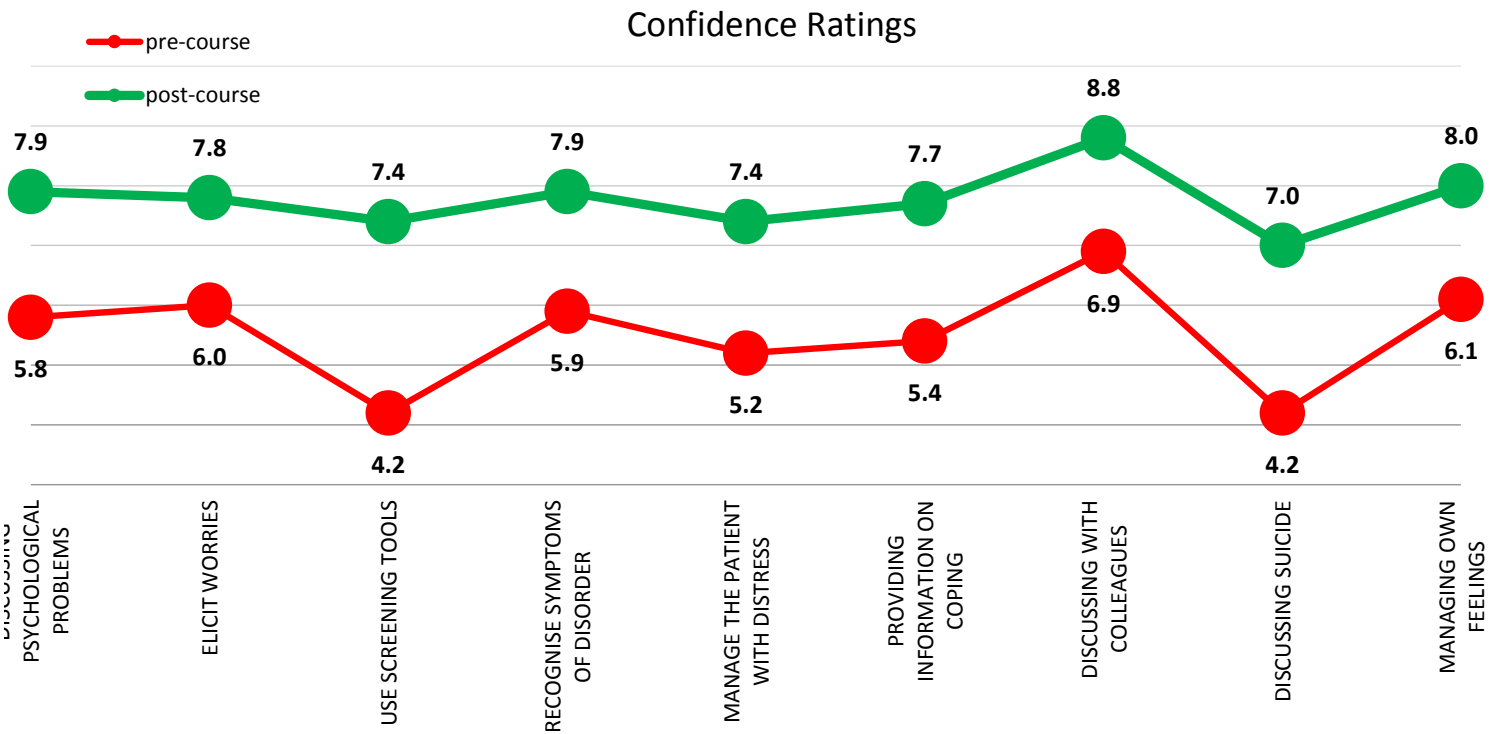


Fig. 1. Precourse, postcourse, and 6-month follow-up mean scores. Pre- and postcourse, $N = 255$; 6-month follow-up, $N = 66$. 1 = not at all confident, 10 = very confident.


Confidence Ratings
pre-course
post-course
8.3
8.2
7.2
8.2
8.0
8.3
9.0
7.4
7.9
8.1
6.5
6.7
4.4
6.8
6.3
6.2
7.7
4.6
6.7
6.2
PSYCHOLOGICAL PROBLEMS
ELICIT WORRIES
USE SCREENING TOOLS
RECOGNISE SYMPTOMS OF DISORDER
MANAGE THE PATIENT WITH DISTRESS
PROVIDING INFORMATION ON COPING
DISCUSSING WITH COLLEAGUES
DISCUSSING SUICIDE
MANAGING OWN FEELINGS
TOTAL


Confidence Ratings
pre-course
post-course
7.9
7.8
7.4
7.9
7.4
7.7
8.8
7.0
8.0
5.8
6.0
4.2
5.9
5.2
5.4
6.9
4.2
6.1
PSYCHOLOGICAL PROBLEMS
ELICIT WORRIES
USE SCREENING TOOLS
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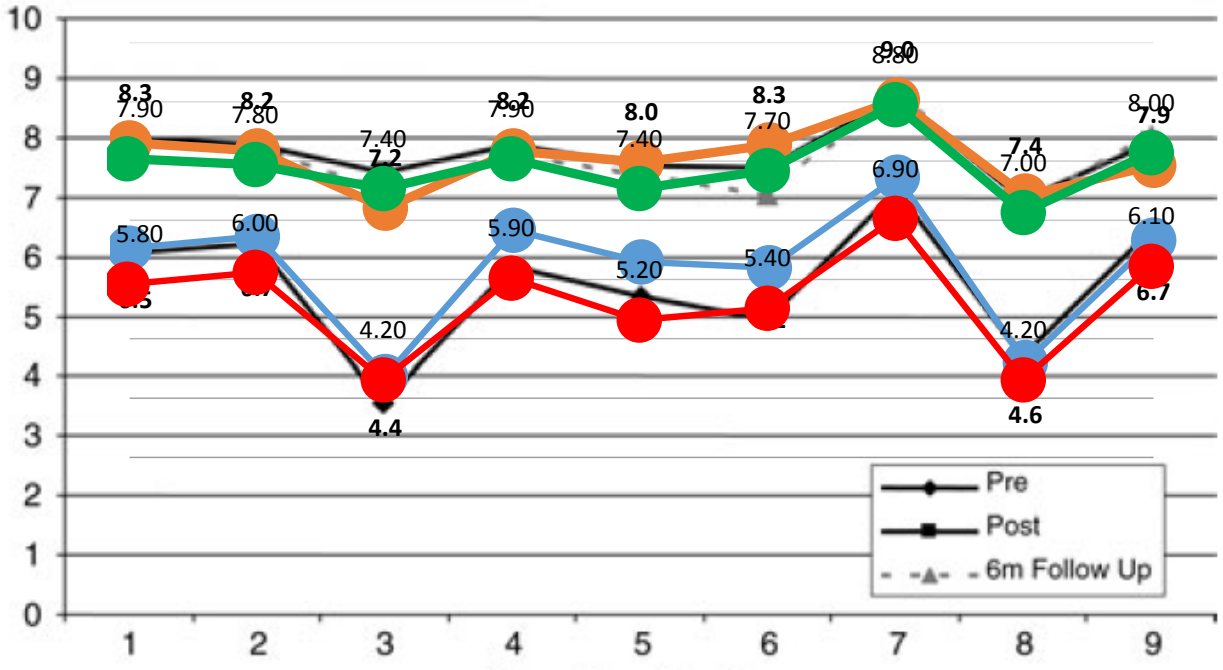
PROVIDING INFORMATION ON COPING
DISCUSSING WITH COLLEAGUES
DISCUSSING SUICIDE
MANAGING OWN FEELINGS


10
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7
8
9
8.3
7.90
8.2
7.80
7.40
7.2
8.2
7.90
8.0
7.40
8.3
7.70
9.0
8.80
7.4
7.00
8.00
7.9
5.80
6.00
4.20
4.4
5.90
5.20
5.40
6.90
4.20
4.6
6.10
6.7
Pre
Post
6m Follow Up

psychological skills

P. diagnosed with follicular lymphoma – initially advised to watch and wait.

Very distressed by concept of W&W, second opinion offered radiotherapy, now completed.

Reported always being a very anxious person, struggled pre radiotherapy with diagnosis but reported this as distress relating to W&W.

Information given on diagnosis and attended 3 x 1-1 sessions with CNS. Discussed worry tree and use, discussed online support, support worker number – none of these accessed.

Suggested course of antidepressants but declined.

Reviewed today - remains very tearful. Feels stuck, unable to move on.

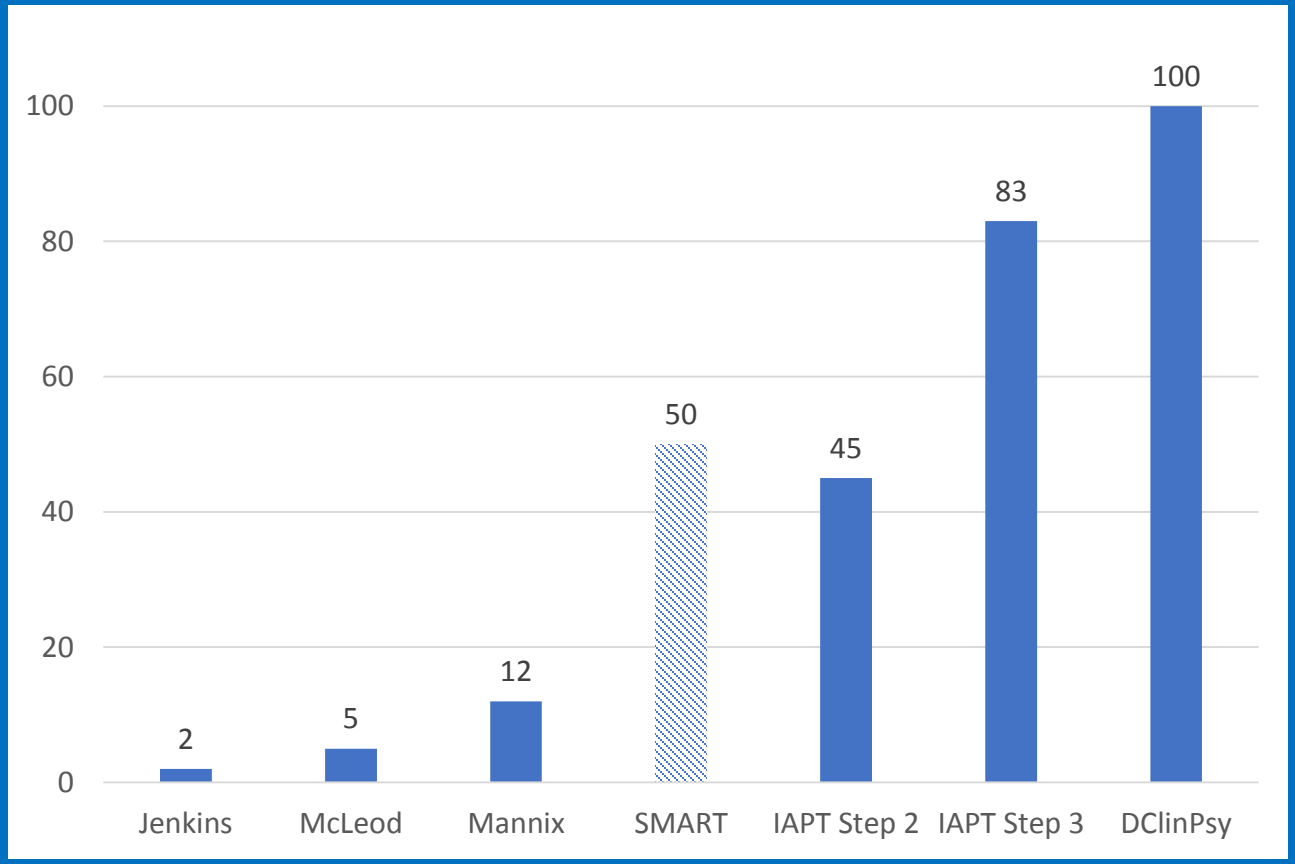
From a CNS point of view: K has had a start of treatment HNA and this has continued as per K's requirements.

She is aware of level 2 strategies ie worry tree, visualization and mindfulness.

She expressed to me several times that her friends were like family to her.

The fact that this bond has been strained and given her metastatic diagnosis it would be in her best interests to have formal assessment from a member of your team.

Level 2


100
80
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83
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Jenkins
McLeod
Mannix
SMART
IAPT Step 2
IAPT Step 3
DClinPsy

psychological skills

current development:

Jonnie Raynes / Bristol & SW

driver : implementation gap

what training will lead to different behaviour from professionals and patients?

QI-methodology : co-design, iterative

psychological skills

supervision!

our experience

COPD CBT paper (Barker 2014)

overly complex cases

restorative function

practical priorities

little bring-back

enhanced

IAPT!

our experience

Can Talk paper (Hassan 2018)

specialist pathway/medical knowledge

personal impact

adequacy of supervision

practicalities, flexibility – no protocol

negotiating iatrogenic distress

need for specialist services

enhanced

we need:

- *well-mapped competences*
- *ecologically valid training*
- *evidence of pathway impact*
- *fit for multimorbidity – flexible*

specialist

Level 3	Level 4
• Completed a substantive training in one or more psychotherapeutic models and holds full HCPC/UKCP/BACP accreditation. • Completed specialist training (e.g. through in-role teaching and close supervision, and relevant formal courses) with specific reference to cancer care.	• Completed a substantive mental health training that provides an in-depth understanding of the biopsychosocial evidence base. • Completed specialist training (e.g. through in-role teaching and close supervision, and relevant formal courses) with specific reference to cancer care. • Knowledge, through training and experience, of other mental health services. • In addition to being accredited to deliver interventions across a range of modalities, the professional is able to use formal methods to adapt, evaluate and disseminate interventions.
Includes: psychotherapists, family therapists, counsellors, mental health therapists accredited in a particular modality (e.g. CBT accreditation by BABCP), social workers and mental health nurses with an accredited psychotherapeutic training.	**Includes:** clinical psychologists, consultant liaison psychiatrists, counselling psychologists
• Assess and intervene with complex presentations that include psychosocial variables. • Provide triaging with complex presentations that include psychosocial variables. • Contribute to service developments aimed at enhancing the biopsychosocial care delivered by the organisation. • Provide supervision/consultation/training relating to psychosocial variables. • Provide training placements to trainees in their professional discipline to develop the future workforce	• Assess and intervene with complex presentations that include a combination of physical, social and psychological variables. • Able to make differential diagnoses / construct biopsychosocial formulations. • Lead the triaging process that includes complex biopsychosocial presentations. • Provide supervision/consultation/training relating to severe and enduring mental health issues especially in the context of risk • Lead service developments aimed at enhancing the biopsychosocial care delivered by the organisation. • Lead Psycho-oncology teams/services • Liaise with, and work in combination with other services and agencies (e.g. IAPT, community mental health) • Provide training placements to trainees in their professional discipline to develop the future workforce

specialist

we need :

- *postgrad psycho-oncology program*
- *cancer curriculum for mental health staff*
- *inpatients?*
- *decision-making?*
- *prescribing?*

specialist

we need evidence on clinical options that is segmented for adversity

our vision

healthcare that is psychologically minded

we need

optimise not minimise

real-world impact

adjustment-informed endpoints

specialist training

Psycho-education
for the cancer workforce
Who needs to know?

Thank you now get to work

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alex.king@nhs.net

https://www.imperial.nhs.uk/our-services/cancer-services/psycho-oncology

References

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Macmillan Competence Framework for Nurses 2014

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Jenkins - https://doi.org/10.1017/S1478951509990678

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SMART trial - https://www.thelancet.com/cms/10.1016/S0140-6736(14)61231-9/attachment/6319f102-44d5-4397-af81-4ab714088166/mmc1.pdf

etc... https://www.mendeley.com/community/bpos2019/