

# **Draft Rehabilitation Measure for the Manual for Cancer Service**

## **Consultation**

Prepared by Cancer Action Team

## DH Information Reader Box

Policy HR/Workforce Management Planning Clinical	Estates Performance IM & T Finance Partnership working
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<b>Target audience:</b>	PCT's CEs, NHS Trust CEs, Cancer Network Lead Clinicians, Lead Nurses, Lead Managers
<b>Circulation list:</b>	
<b>Description:</b>	A draft version of Rehabilitation Measures is being issued for a three month consultation (Start Date 1 <sup>st</sup> October 2007 Close Date: 11 <sup>th</sup> January 2008). A copy of the draft measures can be found in the Cancer Section on the Department of Health web-site <a href="http://www.dh.gov.uk">www.dh.gov.uk</a> or the CQuINS web-site <a href="http://www.cquins.nhs.uk">www.cquins.nhs.uk</a>
<b>Cross ref:</b>	The Manual for Cancer Services 2004
<b>Superseded docs:</b>	
<b>Action required:</b>	Comments invited on the contents of the draft measures
<b>Timing:</b>	<b>Consultation ends 11 January 2008</b>
<b>Contact details:</b>	Tamika Chung Consultation Co-ordinator Cancer Peer Review Dept of Palliative Medicine St Thomas' Hospital, Lambeth Palace Road London SE1 7EH Email: <a href="mailto:tamika.chung@gstt.nhs.uk">tamika.chung@gstt.nhs.uk</a>

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# Executive summary

Dear Colleague,

## **Draft Rehabilitation Measures for the Manual for Cancer Services: Consultation (Start Date 1<sup>st</sup> October 2007 Close Date: 11<sup>th</sup> January 2008)**

I am writing to let you know that a draft version of Rehabilitation Measures is being issued today for a three month consultation (Start Date 1<sup>st</sup> October 2007 Close Date: 11<sup>th</sup> January 2008). A copy of the draft measures can be found in the Cancer Section on the Department of Health web-site [www.dh.gov.uk](http://www.dh.gov.uk) or the CQuINS web-site [www.cquins.nhs.uk](http://www.cquins.nhs.uk).

It is the intention to add the Rehabilitation Measures to the Manual for Cancer Service 2004.

### **The Purpose of the Manual for Cancer Service 2004**

The Manual for Cancer Services is the enabling vehicle for both self and peer review assessment of the quality of Cancer Services. The first national round of peer review visits took place in 2001 and was followed by a detailed evaluation by the Controls Assurance Support Unit (CASU).

This recommended Cancer Peer Review should continue and Strategic Health Authorities have, therefore, commissioned this further round of peer review. The Manual has not been centrally imposed.

The Manual for Cancer Services 2004 has been updated to reflect both positive feedback from the 2001 peer review process as well as new Improving Outcomes Guidance that is now available. The purpose of the Manual is to set out measures, which define the characteristics of a good service, based on the recommendations of the NICE Improving Outcomes Guidance and other national guidance. These concentrate on aspects of service most likely to have significant impact on health outcomes. As with NICE IOG, the manual is intended to help those involved in planning, commissioning, organising and providing cancer services to identify gaps in provision; as well as check the appropriateness and quality of existing services.

The quality measures contained within this manual are applicable to all commissioners and providers of services to NHS patients with cancer throughout England. It is important, therefore, that all networks, organisations and teams take this opportunity to read the draft measures and let us have

comments so that these can be considered, and, where appropriate, incorporated into the final revisions.

The Department of Health, Cancer Action Team and the Healthcare Commission are actively working together to build a partnership between the Manual, Cancer Peer Review and Healthcare Commission Reviews.

Whilst Peer Review is expected to evolve over time, the Manual provides a ready mechanism by which cancer services will be able to demonstrate that they are meeting the Standards for Better Health<sup>1</sup>, in particular, in the domains of safety, clinical and cost effectiveness, governance and patient focus.

Cancer peer review is described in more detail in the introduction to the Manual. Its principal function is to accelerate the pace of improvement in the quality of cancer services across the whole system of patient care and the patient and carer experience. It is acknowledged that the Manual continues to relate largely to secondary and tertiary services, except where quality measures pertain to the role and responsibilities of Primary Care Trusts. Further consideration is being given to the role of primary care in cancer within the context of the new GMS contract and how this might be reflected in future revisions.

## **The Draft Rehabilitation Measures**

The draft measures are based on the recommendations in the Improving Outcomes Guidance for Supportive and Palliative Care (the IOG).

The IOG uses the “4-level” model of care as an aid to service and workforce planning. At the time of writing there are no comprehensive, nationally accepted definitions for the levels of care in cancer rehabilitation or analyses of rehabilitation procedures, matching them to the levels. Therefore the draft measures allow for networks to agree their own definitions for the levels and their own classification of procedures into the levels.

The draft measures are concerned with establishing a network cancer rehabilitation lead and a network cancer rehabilitation group with specific membership, terms of reference and administrative support. The draft measures also address the functions of the network cancer rehabilitation group: agreeing criteria for the 4-level model, a survey of current service provision, agreeing cancer rehabilitation guidelines, developing a service specification, needs assessment and training and education strategy and providing a rehabilitation section for each locality’s cancer services directory.

## The Consultation Process

It is hoped that you will contribute to this consultation exercise to ensure that the published Rehabilitation Measures are both comprehensive and clear.

The purpose of this consultation is not to reopen the extensive consultation on Improving Outcomes Guidance, but rather to invite your comments on the contents of the draft measures, for example:

- Is the wording of each quality measure sufficiently clear? Are there instances where there is some ambiguity as to what is required?
- What additional, if any, supplementary guidance on the quality measures is required?
- Are there any important gaps?

To achieve the target of publishing the Rehabilitation Measures and the consultation response by the end of February 2008 the programme for considering responses and making appropriate amendments has a very short timescale. The receipt of any responses in advance of the three-month deadline would therefore be much appreciated. For the same reason it will not be possible to consider any comments that are received after the deadline, Friday 11<sup>th</sup> January 2008.

A proforma has been provided to assist you in compiling your comments on the contents of either or both of the drafts and this can also be found on the Department of Health web-site or CQuINS web-site.

Any comments on either of the drafts should be submitted by Friday 11<sup>th</sup> January 2008 to:

Tamika Chung  
Consultation Coordinator  
Cancer Peer Review  
Department of Palliative Medicine  
St Thomas' Hospital  
Lambeth Palace Road  
London  
SE1 7EH

Email: [Tamika.chung@gstt.nhs.uk](mailto:Tamika.chung@gstt.nhs.uk)

The consultation will follow the Cabinet Office Code of Practice on Consultation

[www.cabinet-office.gov.uk/regulation/consultation/code](http://www.cabinet-office.gov.uk/regulation/consultation/code).

For DH consultations, comments or complaints (but not responses to the consultation itself) should be directed to:

Consultations Coordinator  
Department of Health  
Room 2N16  
Quarry House  
Quarry Hill  
Leeds  
LS26 9BA  
Email: Mb-dh-consultations-coordinator@dh.gsi.gov.uk

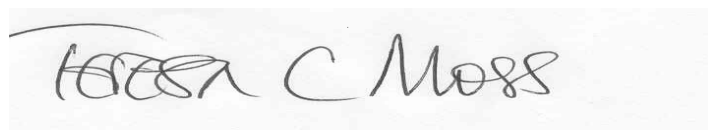
Information provided in response to this consultation, including personal information, may be published or disclosed in accordance with the access to information regimes (these are primarily the Freedom of Information Act 2000 (FOIA), the Data Protection Act 1998 (DPA) and the Environmental Information Regulations 2004).

If you want the information that you provide to be treated as confidential, please be aware that, under the FOIA, there is a statutory Code of Practice with which public authorities must comply and which deals, amongst other things, with obligations of confidence. In view of this it would be helpful if you could explain to us why you regard the information you have provided as confidential. If we receive a request for disclosure of the information we will take full account of your explanation, but we cannot give an assurance that confidentiality can be maintained in all circumstances. An automatic confidentiality disclaimer generated by your IT system will not, of itself, be regarded as binding on the Department.

The Department will process your personal data in accordance with the DPA and in most circumstances this will mean that your personal data will not be disclosed to third parties.

We look forward to receiving your comments.

Yours sincerely,

A handwritten signature in black ink that reads "TERESA C Moss". The signature is written in a cursive style with some capital letters.

Teresa Moss  
Director of Cancer Modernisation  
National Cancer Action Team

## Contents

Executive summary.....	4
Draft Cancer Rehabilitation Measures .....	9
Consultation Proforma .....	1

# Draft Cancer Rehabilitation Measures

## INTRODUCTION

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

The measures are based on the recommendations in the Improving Outcomes Guidance for Supportive and Palliative Care (the IOG). The IOG uses the “4-level” model of care as an aid to service and workforce planning. At the time of writing there are no comprehensive, nationally accepted definitions for the levels of care in cancer rehabilitation or analyses of rehabilitation procedures, matching them to the levels. Therefore the measures allow for networks to agree their own definitions for the levels and their own classification of procedures into the levels. Network may wish to co-operate with each other in this work and would be expected to adopt any national agreements as professional bodies make them available.

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

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

- (i) Establishing a network cancer rehabilitation lead and a network cancer rehabilitation group with specific membership, terms of reference and administrative support. This is the responsibility for review purposes of the chair of the network board and is reviewed under Topic 1A in the Manual for Cancer Services. Compliance counts towards the review of the network board.
- (ii) The functions of the network cancer rehabilitation group: agreeing criteria for the 4-level model, a survey of current service provision, agreeing cancer rehabilitation guidelines, developing a service

specification, needs assessment and training and education strategy and providing a rehabilitation section for each locality's cancer services directory. These functions are the responsibility for review purposes of the network cancer rehabilitation lead (who should also chair the network cancer rehabilitation group) and are reviewed under Topic 1E in the Manual for Cancer Services. Compliance counts towards the review of the network cancer rehabilitation group.

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

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## DRAFT CANCER REHABILITATION MEASURES

### TOPIC 1A - 3 – CANCER NETWORKS – CANCER REHABILITATION

#### SPECIFIC MEASURES

MEASURE DETAILS & DEMONSTRATION OF COMPLIANCE	
<b>THE NETWORK CANCER REHABILITATION LEAD</b>	
<b>1A-331</b>	<p>The network board should agree a single named lead for cancer rehabilitation for the network, who should be a qualified member of one of the following professions: physiotherapy, OT, SLT or dietetics, and a member of the network palliative care group. The network board should agree a list of responsibilities, and specified time in their timetable or job plan, for the role of network cancer rehabilitation lead.</p>
<b>1*</b>	<p>Notes:</p> <p>The cancer rehabilitation lead should also be the chair of the network cancer rehabilitation group.</p> <p>See appendix ..... for an example list of responsibilities (for illustration only).</p>
Compliance:	<p>The named lead agreed by the chair of the network board.</p> <p>The list of responsibilities and specified time agreed by the cancer rehabilitation lead and chair of the network board.</p> <p>The list of members of the network palliative care group.</p>
<b>THE NETWORK CANCER REHABILITATION GROUP</b>	
<b>1A-332</b>	<p>There should be a single group for the network having a membership which, as a minimum, is specified below:</p>
<b>1*</b>	<ul style="list-style-type: none"> <li>• The network cancer rehabilitation lead, who should be the chair of the group.</li> <li>• A representative of each of the four AHPs which are not represented by the cancer rehabilitation lead's own profession.</li> <li>• Two user representatives.</li> </ul> <p>Notes:</p> <ul style="list-style-type: none"> <li>• The group may choose additional members. For instance, it is strongly recommended that if there is a lymphoedema service in the network which is lead by and/or delivered by nurses, one of them should be a nurse member of the group.</li> <li>• It is strongly recommended that the members of the network</li> </ul>

	<p>palliative care group which represent AHPs and/or rehabilitation are drawn from members of the network cancer rehabilitation group.</p> <ul style="list-style-type: none"> <li>• If the local user group do not wish to, or are unable to nominate user representatives, but there is an agreed mechanism for obtaining user advice, then the measure will be deemed to have been complied with.</li> </ul>
Compliance:	The list of named members and what they represent, agreed by the chair of the network board.
<b>1A-333</b>	There should be terms of reference for the network cancer rehabilitation group which include:
<b>1*</b>	<ul style="list-style-type: none"> <li>• The group should be recognised as the network primary source of opinion on issues relating to cancer rehabilitation and for co-ordination and consistency across the network on such issues.</li> </ul> <p>Notes:</p> <ul style="list-style-type: none"> <li>• These are terms of reference. Detailed measures for the functions of the group are to be found in Topic 1E ...</li> <li>• The network board may agree additional terms of reference.</li> </ul>
Compliance:	The terms of reference agreed by the chair of the network board and the network cancer rehabilitation lead.
<b>1A-334</b>	There should be specified and agreed secretarial and administrative support in terms of WTEs or portions of WTEs for the work undertaken by the network cancer rehabilitation group.
<b>1*</b>	
Compliance:	The number of WTEs agreed by the chair of the network board.

## DRAFT CANCER REHABILITATION MEASURES

### TOPIC 1E - 6 – FUNCTIONS OF THE NETWORK CANCER

#### REHABILITATION GROUP

##### Introduction

These measures cover:

- Agreeing network criteria for implementing the 4 level model of care for cancer rehabilitation.
- A survey of the current provision of cancer rehabilitation in the network.
- The development of cancer site specific rehabilitation guidelines and cancer rehabilitation guidelines for specialist palliative care teams.
- The development of a service specification.
- From the service specification and the current service provision, the development of a service needs assessment.
- The development of a training and education strategy resulting from the service needs assessment.
- A rehabilitation section for each locality's cancer services directory.

The IOG describes the rehabilitation service as being divided into four “levels of care”, each level being distinguished from other levels by the minimum degree of experience and/or qualification and/or cancer-specific specialisation required by anyone wishing to practice at that level.

Two areas of work are left undefined by the IOG and need to be completed by networks as part of compliance with the measures. They may choose to co-operate with other networks or sources of advice.

- 1 It is necessary to define the precise criteria which place a given practitioner into a given level. The chosen criteria may prove to be different for the different AHPs.
- 2 Having defined the practitioner criteria, it is necessary to divide the range of individual therapeutic interventions for each AHP into the levels of care. A level of care as applied to an intervention or therapeutic procedure (say, level 3, for illustration) is defined as follows: a level 3 intervention or therapeutic procedure is one which should be carried out either by a practitioner of at least level 3 status or, if a team of practitioners are being used, the team should include a practitioner of at least level 3 status.

Practitioners may also carry out procedures at a level below their own status. It follows that procedures may also be carried out at any level above their stated level.

There are three constraints on this process. Firstly, the IOG defines “level one” care as that type of care which may be provided by any health care professional (not necessarily in one of the AHPs) or even by most able bodied carers such as family and friends.

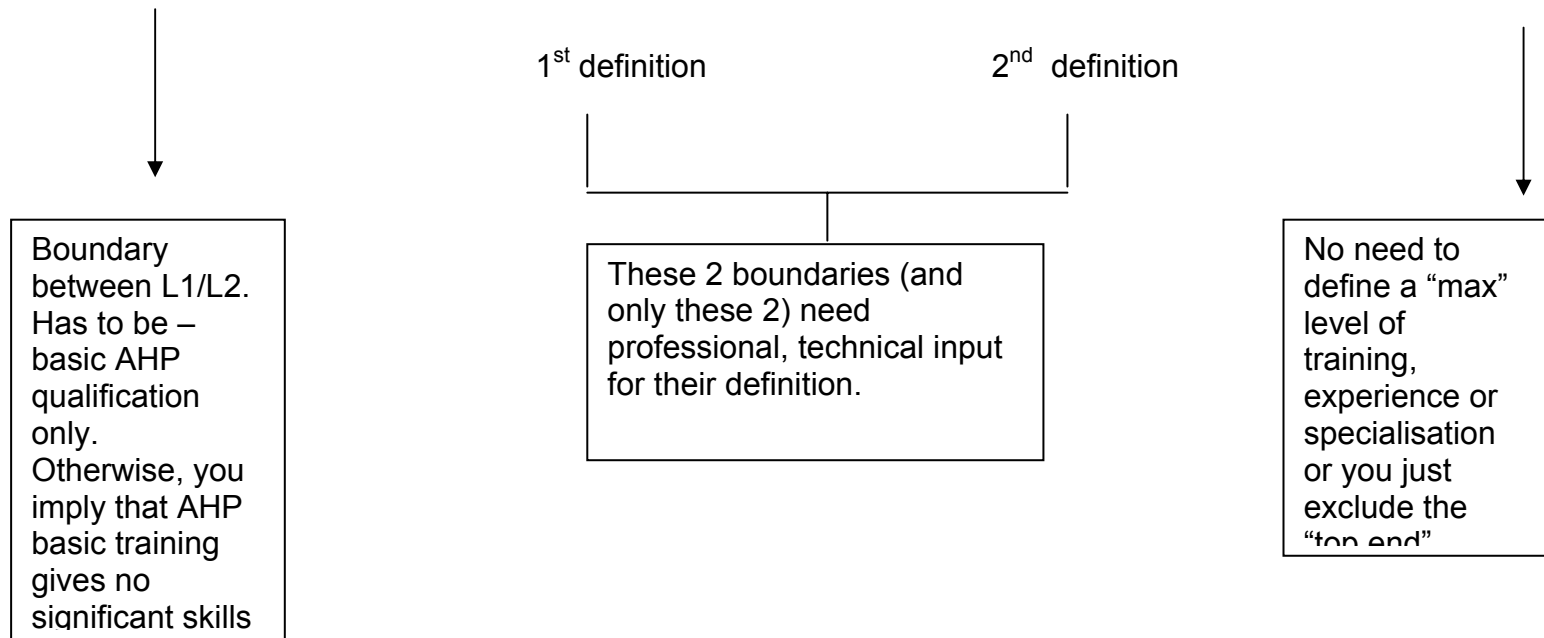
Secondly, for a system of levels to be practical and useable for service planning and commissioning, the remaining levels 2 to 4 should encompass the whole range of AHP practitioners engaged in therapy, from the most junior, least qualified, experienced or specialised, to the most senior, most qualified, experienced or specialised.

Thirdly, the criteria should make the levels mutually exclusive and there should be no “gaps” between levels, leaving some types of practitioner impossible to place in a level.

It would also be helpful for a network to use criteria for the practitioner levels, which map clearly on to the perceived training and education strategy – eg use the concept of experience and or training in cancer specific rehabilitation interventions.

**Notes on defining the boundaries between “levels” of practitioner**

Level 1	Level 2	Level 3	Level 4
Already defined in IOG as “any health professional or carer”.	Basic AHP, up to a first min defined amount of experience and/or training and/or specialisation.	AHP with first min training, experience, specialisation up to second defined amount of training, experience or specialisation.	AHP with at least second defined amount of training, experience, or specialisation.



## MEASURE DETAILS & DEMONSTRATION OF COMPLIANCE

The responsibility for review purposes for the measures in this section lies with the chair of the Network Cancer Rehabilitation Group (the network cancer rehabilitation lead).

### DEFINING LEVELS OF CARE

**1E-601**

The cancer network rehabilitation group should agree criteria to define the four levels of care as required by the IOG, in terms of practitioner status and fulfilling the features described in the introduction to these measures.

**1\***

They should be based on one or more of the following:

- Practitioners' qualifications and/or verifiable training.
- Practitioners' length of experience.
- Practitioners' proportion of time spent on cancer specific rehabilitation work.

Compliance: The criteria agreed by the network cancer rehabilitation lead.

Note:

The network may agree different criteria for each of the four AHPs.

### PLACING REHABILITATION INTERVENTIONS INTO LEVELS OF CARE

**1E-602**

The network cancer rehabilitation group should agree, for a range of interventions, which level of care is the minimum level at which that intervention should be offered, as described in the introduction to these measures.

**1\***

Compliance: A table for each of the four AHPs, placing each individual type of intervention into its respective minimum care level, agreed by the network cancer rehabilitation lead and the chair of the Network Palliative Care Group.

Note:

It is not practical to state all the interventions which should be included in this analysis, but the aim is to cover a range of cancer related interventions which can form a basis for service needs assessment, workforce planning and a training and education strategy. Compliance should not depend on details around the exhaustiveness of the analysis. The reviewers should exercise judgement in this respect. The interventions should be those identified in the cancer site specific, rehabilitation guidelines, agreed with the MDTs (see below).

## BASELINE SURVEY (SURVEY OF CURRENT SERVICE PROVISION)

1E-603

The network cancer rehabilitation group should produce a survey of the current service provision for cancer rehabilitation in the network, which fulfils the following:

1\*

- (i) It should be expressed in terms of WTEs of practitioner time, classified according to the care levels defined in measure ..... and for each of the 4 AHPs plus a separate lymphoedema service if relevant.
- (ii) It should be expressed as the service currently available to each locality in the network, to support the work of the particular MDTs and specialist palliative care teams encompassed by each locality.
- (iii) It should describe the service available for weekend cover as well as weekdays.

Note:

All care levels and all AHPs may not be relevant to each location.

Compliance: The baseline survey agreed by the network cancer rehabilitation lead. The reviewers should verify that it fulfils (i) to (iii) above.

## CANCER SITE SPECIFIC REHABILITATION GUIDELINES

### INTRODUCTION TO MEASURES ..... TO .....

The network cancer rehabilitation group should agree rehabilitation guidelines with each network site specific group for the cancer site(s) which it deals with. The guidelines should specify:

- The particular clinical indications for referral to rehabilitation services.
- The relevant intervention or procedure or therapy required.
- The contact points for referrals.

Example (for illustration only)

Breast cancer NSSG: physiotherapy for joint mobilisation following shoulder stiffness after surgical axillary clearance; contact point – the member of the extended MDT representing physiotherapy.

Notes:

- There is likely to be a number of different interventions required for each NSSG.
- The guidelines should cover those indications which are specific to that cancer site, rather than duplicating widely known general indications, such as post anaesthetic chest physiotherapy.
- One set of guidelines should be agreed with each NSSG, which cover any or all of the four AHPs as relevant. Interventions by some professions will be largely

confined to only a few cancer sites (eg SLT to head and neck, and CNS tumours).

- It is not practical to state all the interventions which should be included in these guidelines but the aim is to cover a range of cancer related interventions which can form a basis for service needs assessment workforce planning and a training and education strategy. Compliance should not depend on details around the exhaustiveness of the guidelines. The reviewers should exercise judgement in this respect.
- Where there is no NSSG in the network for a given cancer site, guidelines should be agreed with the NSSG for the network to which patients with that cancer are referred.

**Note to Reference Group and Peer Review Co-ordinating Team**

The following measures should be applied separately for each NSSG, since it is important to know which cancer sites are complying and which are not. How the list of measures is expanded as new IOGs produce measures, is a process issue. It may be best to write them at the start for all current and forthcoming cancer site specific measures (excluding children and young people, which needs a much more simple approach).

<b>1E-604</b>	The network cancer rehabilitation group should agree the rehabilitation guidelines for patients with breast cancer.
<b>1*</b>	
Compliance:	The guidelines agreed by the network cancer rehabilitation lead and the chair of the breast cancer NSSG.
<b>1E-605</b>	As above, for lung cancer and the lung cancer NSSG.
<b>1*</b>	
<b>1E-606</b>	As above, for colorectal cancer and the colorectal cancer NSSG.
<b>1*</b>	
<b>1E-607</b>	As above, for gynaecological cancer and the gynaecological NSSG.
<b>1*</b>	

<b>1E-608</b>	As above for upper GI cancer and the upper GI NSSG.
<b>1*</b>	
<b>1E-609</b>	As above for urological cancer and the urology NSSG.
<b>1*</b>	
<b>1E-610</b>	As above for haematological malignancy and the haematology NSSG.
<b>1*</b>	
<b>1E-611</b>	As above for head and neck cancer (including thyroid cancer) and the head and neck NSSG.
<b>1*</b>	
<b>1E-612</b>	As above for skin cancer and the skin cancer NSSG.
<b>1*</b>	
<b>1E-613</b>	As above for brain and CNS malignancy and the brain and CNS SSG.
<b>1*</b>	
<b>1E-614</b>	As above for sarcoma and the sarcoma SSG.
<b>1*</b>	

## **CANCER REHABILITATION GUIDELINES FOR SPECIALIST PALLIATIVE CARE**

### **Introduction**

A different approach is needed to agreeing guidelines with specialist palliative care teams to that used for cancer site specific MDTs. This is because:

- The site specific guidelines are themselves considered to be part of the palliative and supportive care recommendations in the IOG.

- Specialist palliative care teams are not cancer site specific so in theory, guidelines for them could potentially duplicate much of those agreed with the MDTs.

Therefore, for the purposes of the measures and the peer review rehabilitation guidelines agreed with specialist palliative care should be limited to contact points for the provision of equipment needed to aid the care of patients approaching the end of life, and a policy that the equipment should be made available within 24 hours.

Note:

The network may agree additional guidelines with specialist palliative care, but these are not subject to review.

**1E-615**

The network cancer rehabilitation group should agree the rehabilitation guidelines for specialist palliative care patients.

**1\***

Compliance: The guidelines, agreed by the network cancer rehabilitation lead.

## SERVICE SPECIFICATION

**1E-616**

The network cancer rehabilitation group should produce a network service specification for cancer rehabilitation, which fulfils the following:

**1\***

- (i) It should be expressed in terms of WTEs of practitioner time, at each of the care levels defined in measure ..... and each of the four AHPs, plus a separate lymphoedema service if relevant.
- (ii) It should be estimated from the required interventions described in the cancer site specific rehabilitation guidelines, and those for specialist palliative care teams.
- (iii) It should take into account the throughput of the MDTs.
- (iv) It should be expressed as the service for each locality in the network, according to the work of the particular MDTs and specialist palliative care teams encompassed by each given locality.
- (v) It should take into account a need for at least some service cover between 9.00 am and 5.00 pm, 7 days per week.

Note:

- All care levels and all AHPs may not be relevant to each cancer site, and there may be alternative options for service provision, using alternative care levels.

Compliance:	<p>The service needs specification, agreed by the network cancer rehabilitation lead.</p> <p>The reviewers should enquire as to the methods used to produce the service needs assessment and verify that it fulfils (i) to (v) above.</p>
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**SERVICE NEEDS ASSESSMENT**

<b>1E-617</b>	<p>The network cancer rehabilitation group should produce a network service needs assessment for cancer rehabilitation which fulfils the following:</p>
<b>1*</b>	<ul style="list-style-type: none"> <li>(i) It should be based on the difference between the service specification (measure ..... ) and the baseline survey (measure .....).</li> <li>(ii) It should be expressed in terms of WTEs of practitioner time at each of the care levels defined in measure ..... and each of the 4 AHPs plus a separate lymphoedema service if relevant.</li> <li>(iii) It should be expressed as the service need for each locality in the network according to the work of the particular MDTs and specialist palliative care teams encompassed by each locality.</li> </ul> <p>Note: All care levels and all AHPs may not be relevant to each cancer site, and there may be more than one option for service provision.</p>

Compliance:	<p>The service needs assessment agreed by the network cancer rehabilitation lead. The reviewers should verify that it fulfils (i) to (iii) above.</p>
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**TRAINING AND EDUCATION STRATEGY**

<b>1E-618</b>	<p>The network cancer rehabilitation group should produce a network cancer rehabilitation training and education strategy which fulfils the following:</p>
<b>1*</b>	<ul style="list-style-type: none"> <li>(i) It should be based on the gap between practitioners' qualifications, experience and competencies identified as required by the service needs assessment, and those of the existing practitioners.</li> <li>(ii) It should deal with post basic training specific to cancer practice, for basically trained AHPs.</li> <li>(iii) It should also provide for "specialist" training to create "advanced" practitioners.</li> </ul> <p>Note: Since the terms "specialist" and "advanced" are referred to in this context in the IOG, but are not further specified, this training can only be defined for the purpose of the measures as training which is further to that specified under (ii), above.</p>

- (iv) It should be set over a defined, stated number of years, with a start and end date.
- (v) It should set a pragmatic target for a given number or % of practitioners to be trained to stated levels of practice on the four level model.
- (vi) It should finally express the training and education needs in terms of numbers of places per year, on named local, regional or national courses or programmes.

Compliance: The cancer rehabilitation training and education strategy, agreed by the network cancer rehabilitation lead.

The reviewers should enquire as to how it was produced and verify that it fulfils (i) to (vi) above.

### THE REHABILITATION SECTION OF THE LOCAL CANCER DIRECTORY

**1E-619**

The network cancer rehabilitation group should produce a rehabilitation section for each locality in the network.

**1\***

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

Compliance: The rehabilitation section agreed by the network cancer rehabilitation lead, for each locality in the network and each agreed by the chair of the relevant locality group.

Annex A:

# THE MANUAL FOR CANCER SERVICES

## Consultation Proforma

### Draft Rehabilitation Measures

**Please use this proforma to make comments on the draft Rehabilitation Measures.**

Please return this document no later than the Friday 11<sup>th</sup> January 2008 to:

Tamika Chung  
Project Assistant, Cancer Peer Review  
Department of Palliative Medicine  
St Thomas' Hospital  
Lambeth Palace Road  
London  
SE1 7EH  
Email: Tamika.chung@gstt.nhs.uk

Name: \_\_\_\_\_

Organisation: \_\_\_\_\_

Position: \_\_\_\_\_

Contact Number: \_\_\_\_\_

<b>Measure Number / Section</b>	<b>Is the measure explicit? If 'no' suggest modifications.</b>	<b>What other types of information are required to demonstrate compliance?</b>	<b>Is the level assigned to the measure appropriate? If 'no' what should it be?</b>