Greater Manchester Cancer

GMCA GREATER MANCHESTER COMBINED AUTHORITY

NHS in Greater Manchester

Understanding the role of Allied Health Professionals in supporting people affected by cancer in the North West: Greater Manchester, Lancashire & South Cumbria, Cheshire & Merseyside

Survey Results and Training Needs Analysis

Purpose and Summary of Document:

The North West AHP cancer survey was devised with the purpose to have a better understanding of the role AHPs have in supporting people affected by cancer. This included understanding the offer Specialist and Generalist AHPs give this patient cohort, confidence levels and training needs.

This document presents the findings of this survey including making recommendations of how gaps in provision, confidence and competence need to be addressed, particularly through a comprehensive training package.

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1.0 Executive summary

- A North West (NW) Allied Health Professionals (AHPs) survey was conducted in January 2021 to understand how generalist and specialist AHPs are currently supporting cancer patients, and to identify training needs.
- Responses were received from 125 AHPs working within dietetics, physiotherapy, occupational therapy, speech and language therapy, radiography, podiatry, art therapy and paramedic services across the NW.
- This has been agreed to be a positive response rate considering the survey was conducted during a period of high demands and redeployment of the AHP workforce in response to the Covid-19 pandemic.
- 54.4% of respondents were from Greater Manchester, 24% were from Cheshire & Merseyside, 21.6% were from Lancashire & South Cumbria.
- 62% of respondents were generalist AHPs from across the NW.
- There is significant variation in job titles across the NW, which could highlight variation in practice, roles and responsibilities.
- AHPs have a key role to play in delivering personalised care for patients; however the survey highlighted low awareness of personalised care assessments and interventions for cancer patients which needs to be addressed at a regional level.
- There was regional variation in AHP attendance at Cancer Multidisciplinary meetings. Overall only 18.4% respondents take part in cancer Multidisciplinary meetings across the NW.
- A significant number of respondents expressed low to moderate confidence levels in relation to delivering assessments and interventions to cancer patients.
- 100% of respondents expressed a desire for accessing cancer-related training and development opportunities.
- Survey results have demonstrated the need to provide education and development opportunities to the whole AHP workforce to enhance knowledge and increase confidence when providing support for people with cancer.

2.0 Background

Allied Health professionals (AHPs) are the third largest professional workforce in the NHS with 14 disciplines. AHPs provide system-wide care to assess, treat, diagnose and discharge patients across social care, housing, education, and independent and voluntary sectors. By adopting a holistic approach to healthcare, AHPs are able to help manage patients' care from birth to palliative care.

The role of AHPs in delivering cancer services is unclear, specifically the role of generalist AHPs. They play a pivotal role in diagnosis (radiographers), and personalised treatment, being a key link between primary and secondary care, however, they remain an underutilised resource within the cancer workforce.

There are a number of case studies of AHPs delivering cancer services in the North West including advanced practitioner radiographer led clinics to address consequences of cancer treatment; prehabilitation and rehabilitation region wide services led by an AHP (Prehab4Cancer), training to perform US guided drain insertion for ascites (previously done by radiologist) to reduce waiting times; and upskilling paramedics in specialist palliative care to reduce emergency admissions. This is further demonstrated from a national perspective in the NHSE/I 2018 '*Quick guide: the role of AHPs in supporting people to live well with and beyond cancer*' and is evident from the *Macmillan AHP competence framework,* originally published in 2018 but recently refreshed in 2021.

AHPs have also played a central role in the response to COVID-19, and it has been important to capitalise on this and explore how North West (NW) cancer alliances can utilise this resource further, to support the current and predicted shortfalls in our current cancer workforce.

Regional surveys have been conducted by other cancer alliances across England including South Yorkshire, Bassetlaw and North Derbyshire, to understand the role of AHPs in supporting people affected by cancer. This paper outlines the results from a NW survey, which was developed with support from AHP networks, and targeted at both generalist AHPs and AHPs who specialise in cancer. The survey captures how AHPs perceive their role in supporting people affected by cancer; identify any gaps in knowledge, skills, and confidence to inform a targeted training programme.

3.0 Survey method

Engagement commenced in 2019 with key stakeholders about a NW survey including the GM Cancer AHP Advisory board, Regional Head AHPs at Health Education England (HEE), Greater Manchester (GM) AHP lead / AHP Faculty, Director of AHPs, Northern Care Alliance, ICS AHP at Lancs & South Cumbria, NW cancer workforce leads, Workforce planning lead and Clinical Collaboration Lead at Cheshire and Merseyside, and all have been fully supportive of the proposal. Links with the national Macmillan AHP expert advisory group has also supported the design and delivery of this survey, having had access to similar surveys completed in other regions of the UK via this forum.

The target audience for this survey was AHPs across the NW region working as generalist AHPs and in specialist cancer service roles.

To agree the survey content, a workshop was held in September 2020 with the contribution of AHP professionals across the NW region. Example surveys were shared from other regions and discussion held as to whether questions included elsewhere meet the requirements of the NW region. From this a finalised survey was created. The survey was piloted by a small working group to determine whether it was feasible and acceptable for the target audience. Slight changes were made following this and the survey was then consolidated and distributed on the HEE *Online Surveys* platform. The

survey was promoted through normal communications channels including social media, newsletters and through stakeholder networks. The survey was available between January and February 2021 and may have had reduced uptake due to it coinciding with a further wave of the COVID-19 pandemic. Enough responses were received for the following report to be created and results to be of merit to inform AHP workforce and education/training planning going forwards.

4.0 Survey Results

4.1 Demographic Breakdown

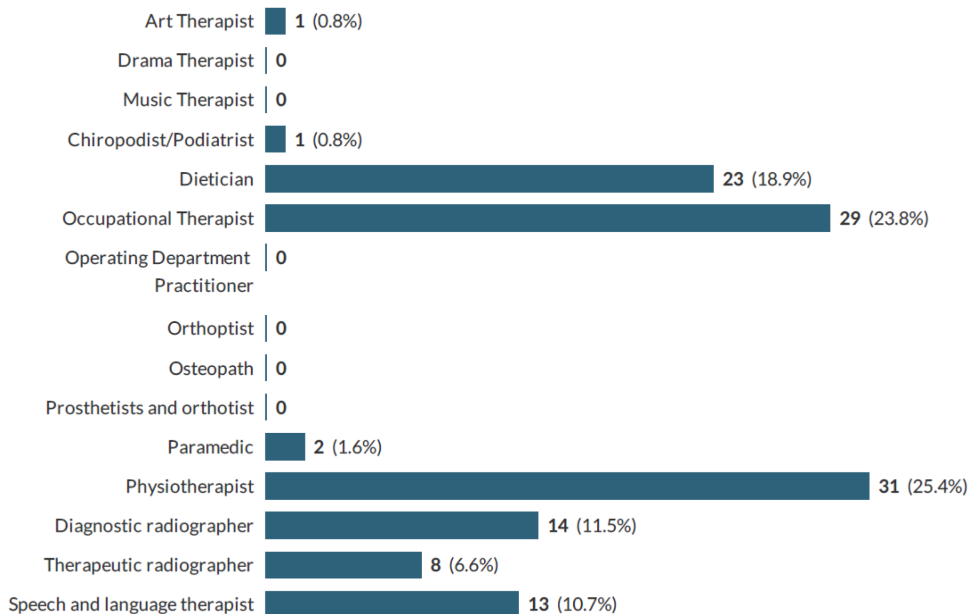
4.1.1 The survey generated a total of 125 respondents

4.1.2 Respondents broken down by locality are as follows:

54.4% of respondents were from Greater Manchester (n=68)
24% were from Cheshire & Merseyside (n=30)
21.6% were from Lancashire & South Cumbria (n=27)

A more detailed regional breakdown of respondents can be found in Appendix A

4.1.3 Respondents broken down by profession are as follows:



A full list of respondents' job titles can be found in appendix B.

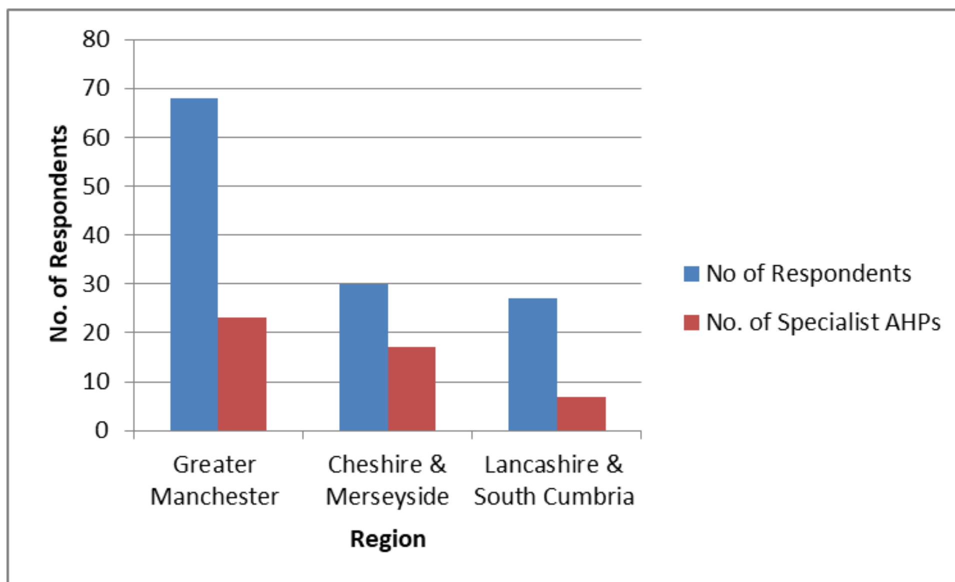
Job titles collected showed the diverse and inconsistent range of prefixes, such as 'specialist' or 'highly specialist which do not necessarily correlate with banding.

4.1.4 1.6% of respondents advised they work 40 hours+ per week (n=2)
64% of respondents advised they work 37.5 hours per week (n=80)
15.2% of respondents advised they work 30 hours per week (n=19)
19.2% of respondents advised they work less than 30 hours per week (n=24)

4.1.5 38% of respondents advised their role was a Specialist Cancer Role (n=47). Of these respondents, the most common length of time for respondents to have been working in specialist cancer services was between 1 and 4 years (n=11).

This could suggest that the shift to having specialist AHP roles is relatively new. Or it could indicate that specialist AHPs in post develop quickly and move onto other roles, making way for other AHPs to work in these roles.

Regional breakdown of AHPs in a Specialist Cancer Role:

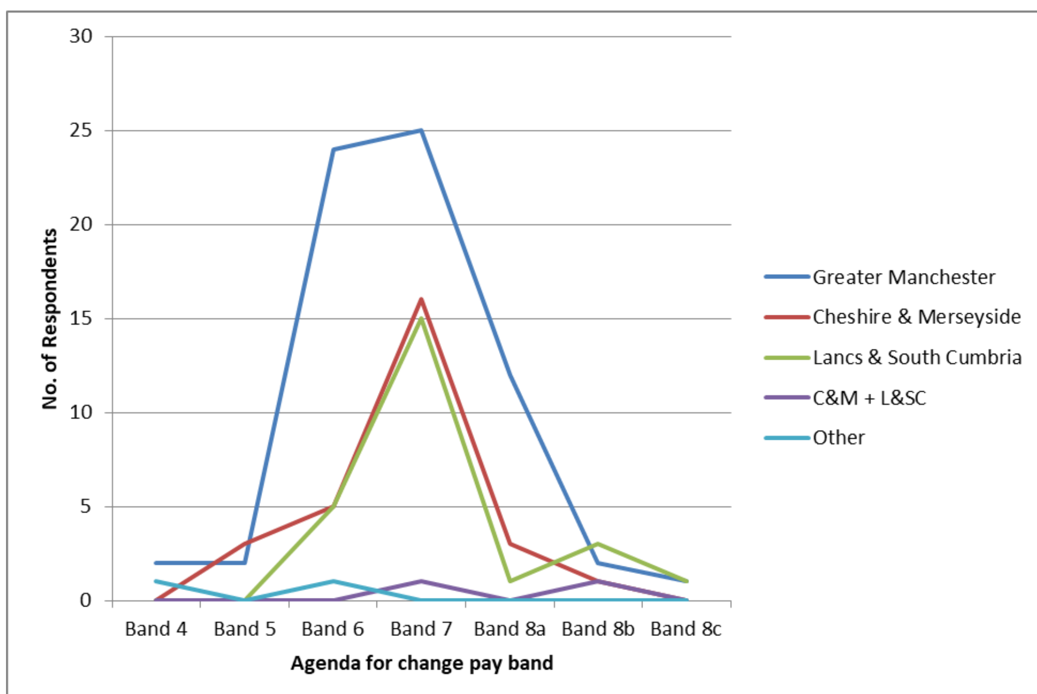


4.1.6 The most common length of time for respondents to have been working as an AHP or in AHP services was 5 – 10 years (n=29)

4.1.7 Breakdown of respondents by AHP registration

90% of respondents were registered clinical AHPs (n=113)
8% were registered AHPs, but non-patient facing (n=11)
2% were from none-registered support roles (n=3)

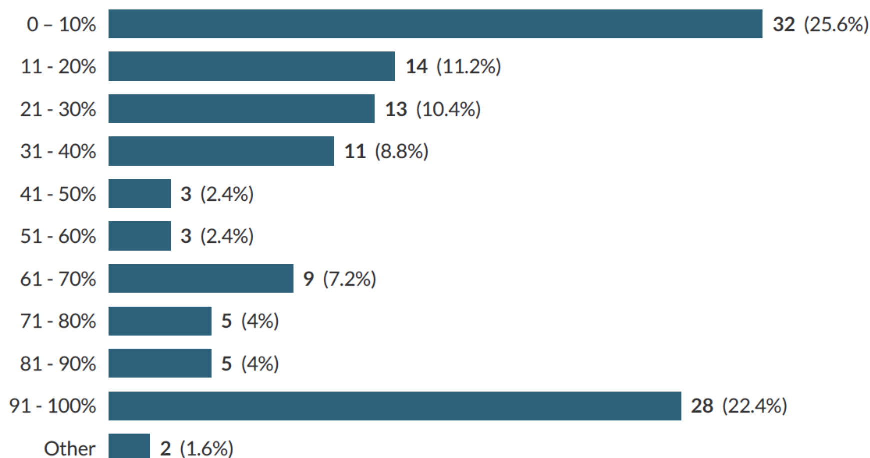
4.1.8 The most common agenda for change pay band is band 7 with 45.6% of respondents selecting this option (n=57)



Full data can be found in Appendix C

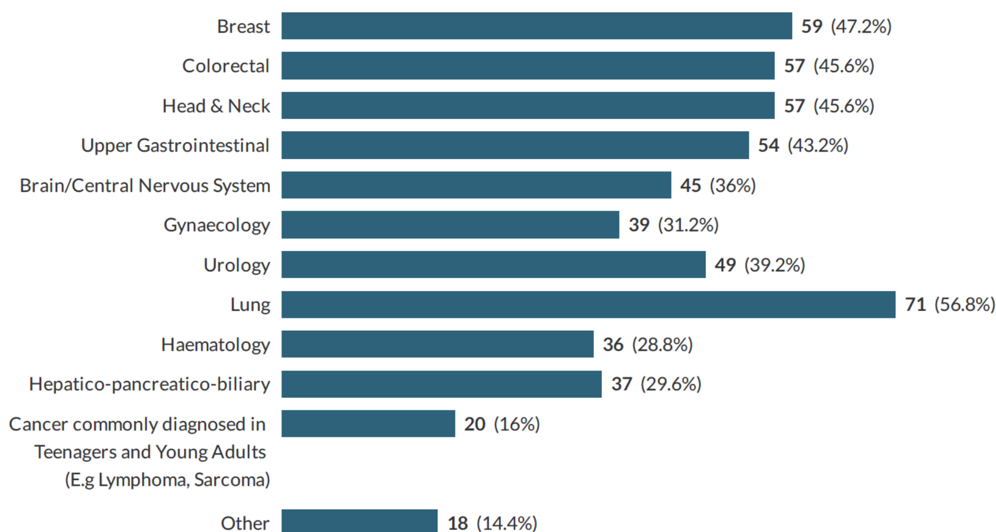
4.2 AHPs in Cancer Services

4.2.1 Breakdown of patients the respondents have contact with who have a cancer diagnosis in a typical week



Responses from respondents who selected ‘Other’ were in non-patient facing management roles. It is not clear whether respondents have answered on the basis of patients having a recent or active cancer diagnosis, or whether they have considered patients with cancer within their pre-medical history. This again may be a question to be clarified should this survey be repeated.

4.2.2 Breakdown of the cancer types regularly seen by respondents:



‘Other’ responses highlighted that additional education may be required to understand cancer types.

4.2.3 We asked respondents to think about a typical week, and estimate the percentage of patients with a cancer diagnosis seen during the below pathway stages, the average percentages are as follows.

Initial cancer diagnosis	Start of medical treatment	During medical treatment	End of medical treatment	Follow up	Diagnosis of recurrence	End of life	Unknown stage of patient pathway
18%	13%	43%	22%	29%	11%	21%	20%

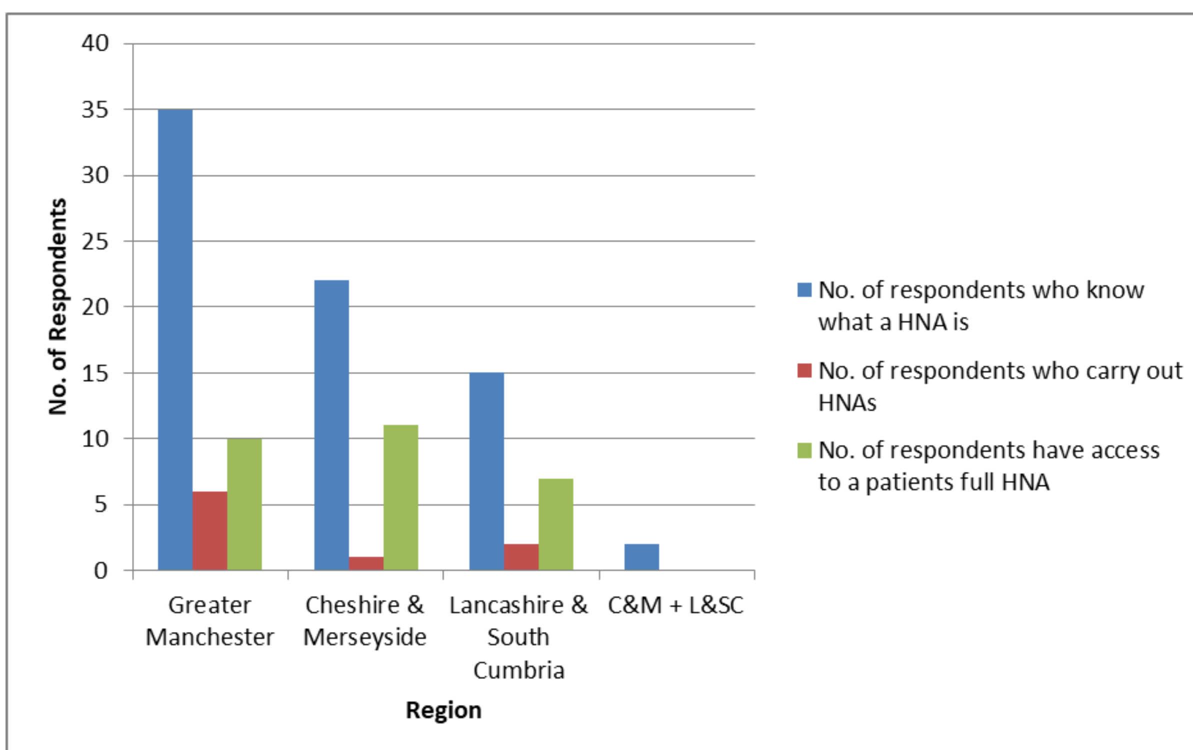
The 20% in the ‘unknown stage of patient pathway’ highlights training needs for respondents who may be working with cancer patients where they are unaware of their stage of their cancer pathway and so unable to fully provide personalised care.

4.2.4 59.2% of respondents said they knew what Holistic Needs Assessment (HNA) was (n=74). Of those that advised they did know what this was, 12.2% said they carried these out (n=9).

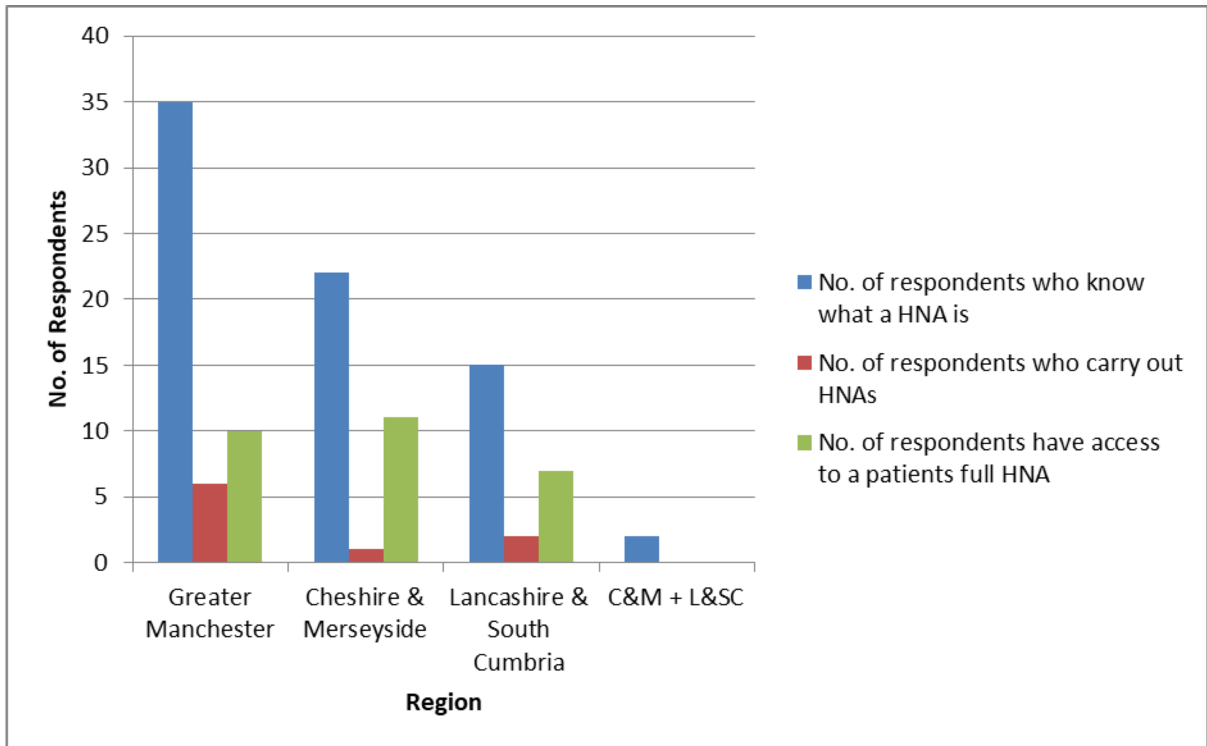
This highlights a significant training need as all cancer patients should have a HNA completed, potentially at several points in their cancer pathway. Much of the information gathered in a HNA will be pertinent to the assessment and interventions AHPs are completing (whether generalist or specialist), thus we recommend further education to be provided widely on this topic.

4.2.5 We asked if respondents have access to a patient’s full Holistic Needs Assessment (HNA), 22.4% said they do (n=28).

Holistic Needs Assessment data by Regional breakdown:



Information gathered in a HNA and summarised within a cancer patients' care plan is vital to be shared with AHPs for reasons previously described. See previous recommendation for HNA and care plan education to be incorporated into any cancer-specific training which is provided for AHPs in the NW going forwards.



4.2.6 We asked respondents if they carry out any form of a structured needs assessment, which is different to a HNA, 32% advised that they did (n=40). A list of these assessments can be found in Appendix D.

37.6% of these respondents advised that they share these assessments and subsequent care plans (n=47). Details of who these are shared with can be found in appendix E.

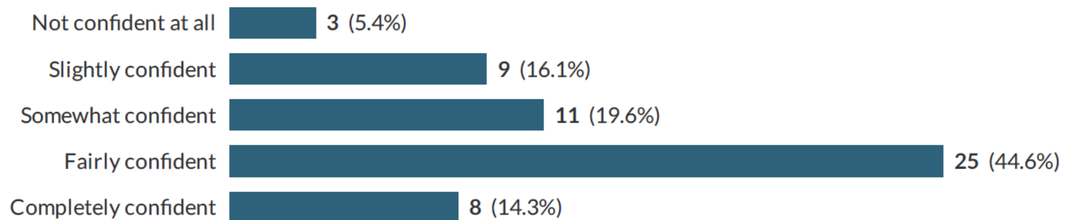
The list of symptoms included in questions 15 through to question 20 represent widely experienced cancer symptoms and side effects which are routinely reported by people affected by cancer. They impact on cancer patients' functional ability, their quality of life and potentially exacerbate previous co-morbidities or disabilities patients endure.

The results for these questions demonstrate that often these symptoms are NOT being addressed by AHPs working with cancer patients and that further training and education as well as promotion of accountability and responsibility is required. This extends to people who are more widely affected by cancer such as family members, carers and friends. A cancer patient's support network have been shown to improve outcomes and quality of life for the person they are supporting. The survey has demonstrated the need for upskilling, training and improved confidence for AHPs to provide the required input to both cancer patients and their support network.

The list provided in full in Appendix F - K provides detailed information which can support the design and provision of training as an aim/outcome of this survey report.

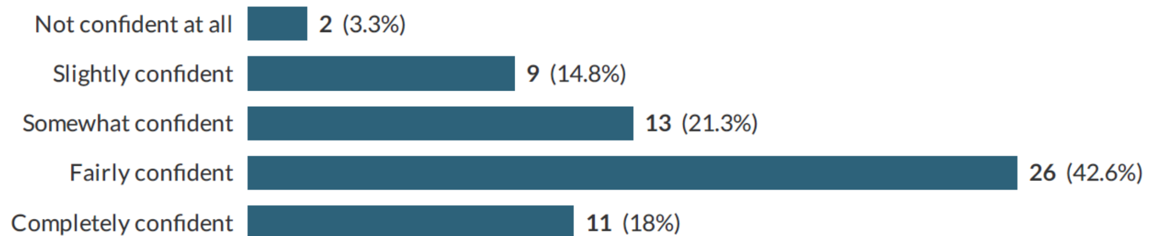
4.2.7 We asked respondents if they deliver assessments and interventions which require specialist knowledge of late effects/consequences from cancer treatment? (i.e. which could occur months, years or decades after treatment)

4.2.8 For those respondents who answered 'Yes', we asked how confident are were in their specialist knowledge in this area

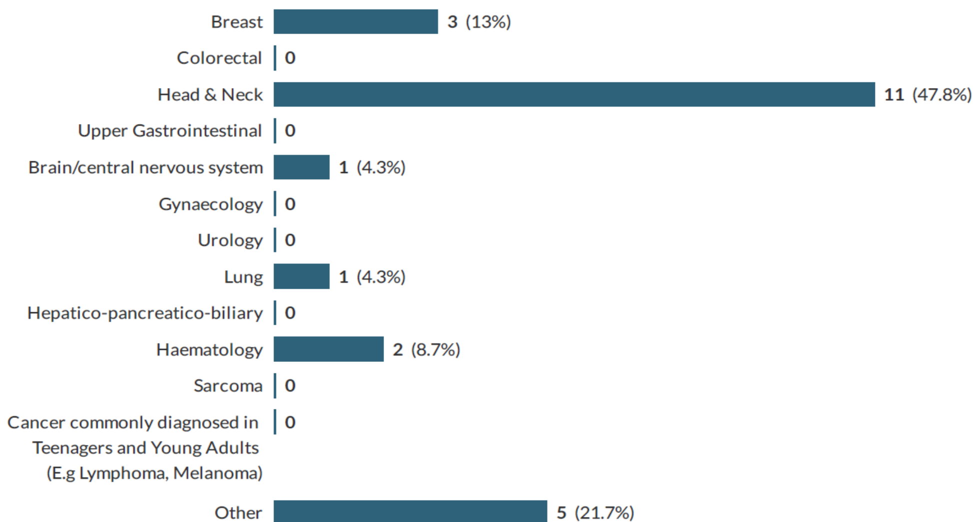


4.2.9 We asked respondents, for people with a cancer diagnosis, do they personally deliver specialist interventions for patients with advanced diseases, complex palliative and end of life care issues?

4.2.10 For those respondents who answered 'Yes', we asked how confident are were in their specialist knowledge in this area

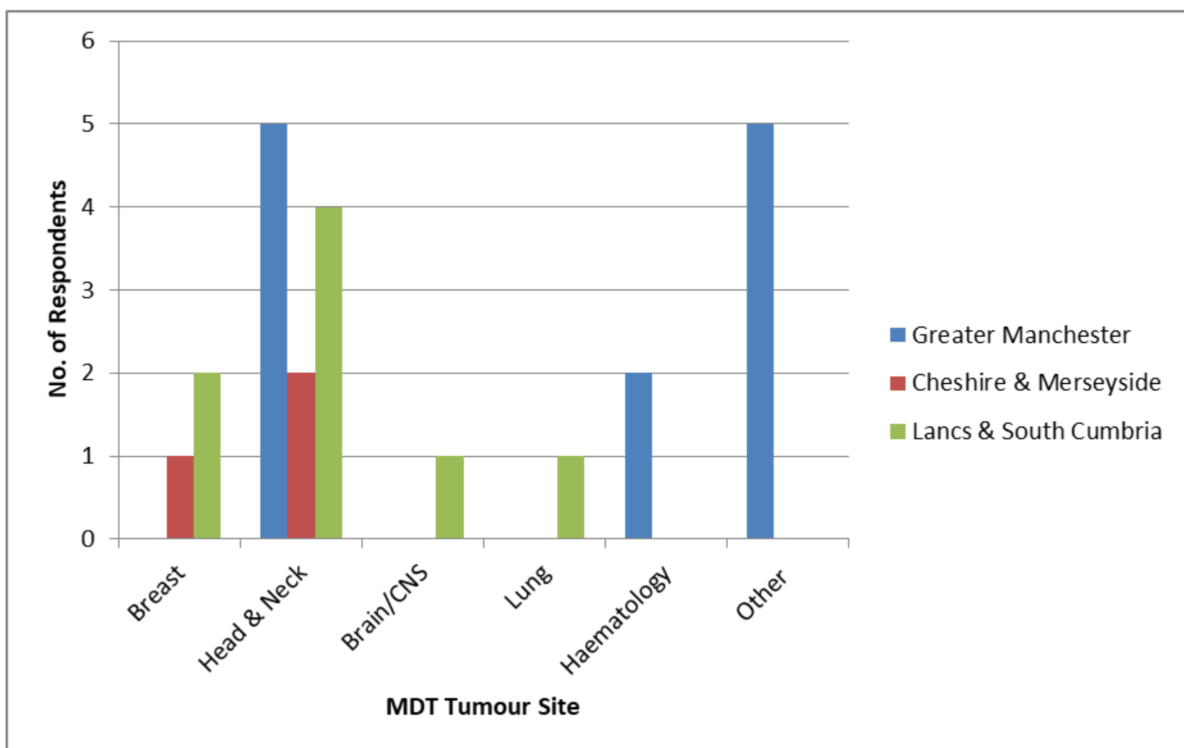


4.2.11 We asked respondents if they are an active member of a 'regular' (weekly/biweekly) Cancer MDT meeting where treatment decisions are being made linked to specific pathways, 18.4% advised they are (n=23). Of these respondents, they advised the tumour site MDT meetings which they attend:



Responses from respondents who selected 'Other' were attendees at a weekly palliative care MDT meeting.

Regional breakdown of MDT attendees:



Full data can be found in Appendix L

Breakdown of respondents by job title and which MDT meeting they are a member of:

Job Title	MDT Meeting
Occupational Therapist	Brain/central nervous system
Consultant Radiographer	Breast
Specialist Advanced practice Sonographer	Breast
Consultant Radiographer	Breast
Haematology Dietitian	Haematology
Specialist Haematology Oncology Occupational Therapist	Haematology
Macmillan speech and language Therapist	Head & Neck
Head and neck specialist dietitian	Head & Neck
head and Neck Oncology dietitian	Head & Neck
specialist speech and language therapist	Head & Neck
Senior Specialist S<	Head & Neck
Specialist Dietitian	Head & Neck
Speech and Language Therapist	Head & Neck
Clinical Lead Speech & Language Therapist	Head & Neck
Speech and Language Therapist	Head & Neck
Senior Dietitian	Head & Neck
Speech and Language therapist	Head & Neck
Dietetic team leader	Lung
Highly specialist Macmillan speech and language therapist	Other
Occupational Therapist	Other
Macmillan dietitian	Other
Specialist palliative care occupational therapist	Other
Macmillan Occupational Therapist	Other

The expectation is that there would be other MDTs attended by AHPs, such as the OG MDTs (which are known to have dietetic input) however it may be that individuals involved in these cancer pathways were not able to engage in the survey at the time it was live.

4.2.12 We asked respondents, from their experience and knowledge; what they thought are key service gaps which need to be addressed locally to better meet the needs of people affected by cancer. Below are the key themes taken from responses:

Communication between healthcare professionals (Inter-professional and inter-agency working)

- Better communication across hospital sites and between primary and secondary care
- Increased inclusion of AHPs in cancer care (both generalists providing enhanced care to meet cancer patient's needs, in a variety of clinical settings, and, an increased number of specialist cancer AHP roles)
- Supporting patients with a dual diagnosis of dementia and cancer
- Increased awareness of specific AHP teams across the region
- More advertisement of cancer support groups and carers support

Timely and increased access to specialist cancer services

- Therapeutic radiography team to provide increased holistic care, with greater utilisation of their skillset and their repeated interaction with cancer patients during their treatment pathways
- A more standardised prehabilitation service across the region
- Increased specialist psychological and bereavement support
- Rehab for people following completion of treatment, living with long term effects, particularly psychosocial issues and lifestyle support
- Financial support for patients
- More dietetic outpatient and follow up services - hospital or community based
- More counselling and complimentary therapies for post-operative long stay inpatients
- More accessible specialist services to address inconsistencies
- Increased provision of specialist palliative care OT input
- Increased provision for spiritual support/interventions such as art therapies
- Earlier referral of patients to AHP support to enable interventions prior to crisis point
- Improved early intervention and advanced EOL planning
- Improved network wide neuro-oncology therapy services

Social Care

- Supporting older carers
- Obtaining the appropriate specialist equipment for patients with complex needs e.g. MSCC or GBM to enable more timely care packages
- Increased provision for social care

Continued Professional Development

- Increased knowledge of the whole patient pathway
- Better access to training and education opportunities
- Peer support groups between professionals to share best practice
- Supervision sessions for AHPs similar to what CNS' receive to help workforce to effectively support patients

Release Clinical Capacity

- Current workload requires a larger workforce
- Time for AHPs to meet the patient when they're not overloaded with information and MDT discussion outcomes
- Increased administration support

Service Development, better processes and reducing variation in service provision

- Better screening to pick up issues at diagnosis and repeated at regular intervals throughout pathway to promote greater consistency of care across treatments and regions
- Bridge between palliative and ‘generalist’ services
- Standardised provision of services in the community and monitoring of patients is needed
- Better process required for patients who are acutely unwell in an outpatient setting and require a review and potential admission
- Improved understanding of rehab needs of people with a palliative diagnosis. More active rehab in community settings rather than just assess / provide equipment.
- Early and regular screening for malnutrition and first-line treatment for malnutrition/ muscle wastage which could be implemented by any member of MDT

Patient and carer/family education (Health literacy)

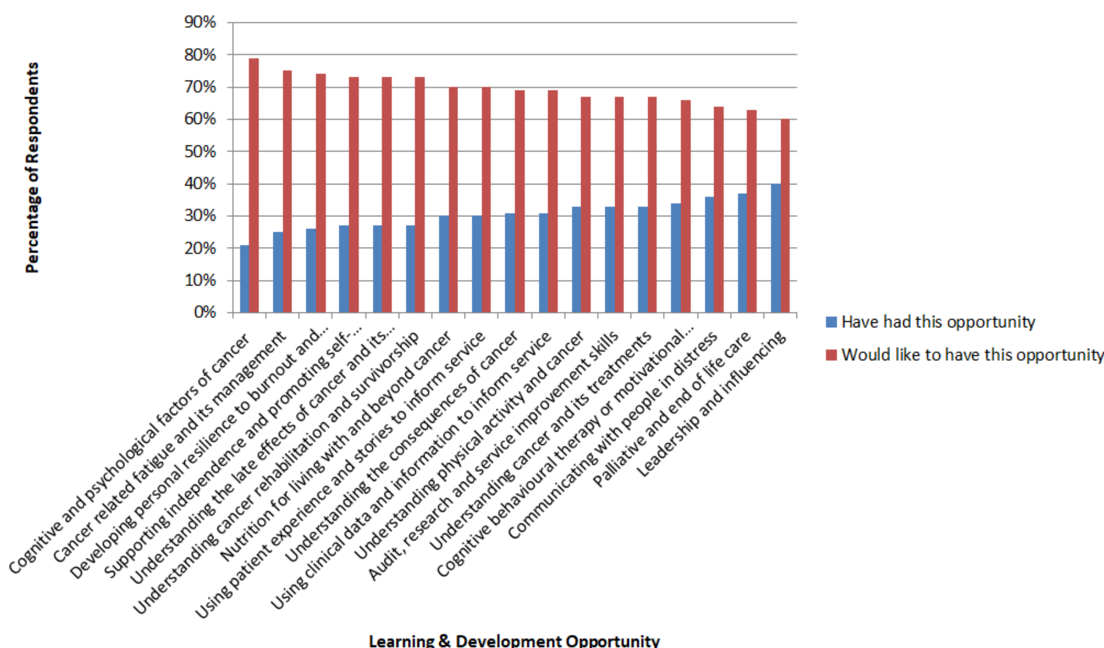
- Increased awareness for people to raise health concerns as early as possible to improve outcomes
- Improved patient education regarding specific side effects of cancer diagnosis and treatment

4.3 Learning and Development Needs

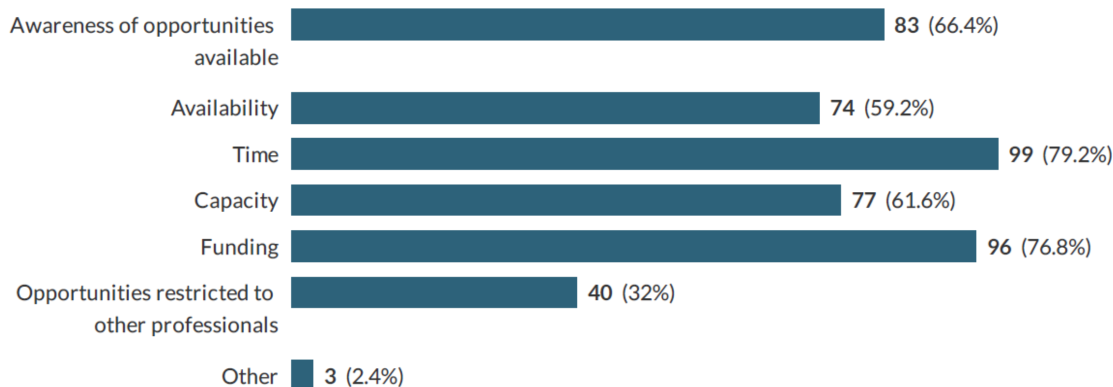
4.3.1 We asked respondents what learning and development opportunities they would like to access to enhance the support they give to people with cancer 100% of respondents advised they would like to access learning and development opportunities.

Respondents' additional learning and development comments can be found in Appendix M.

Learning and development opportunity	Have had this opportunity	Would like to have this opportunity
Cognitive and psychological factors of cancer	21%	79%
Cancer related fatigue and its management	25%	75%
Developing personal resilience to burnout and emotional wellbeing	26%	74%
Supporting independence and promoting self-management	27%	73%
Understanding the late effects of cancer and its treatment	27%	73%
Understanding cancer rehabilitation and survivorship	27%	73%
Nutrition for living with and beyond cancer	30%	70%
Using patient experience and stories to inform service	30%	70%
Understanding the consequences of cancer	31%	69%
Using clinical data and information to inform service	31%	69%
Understanding physical activity and cancer	33%	67%
Audit, research and service improvement skills	33%	67%
Understanding cancer and its treatments	33%	67%
Cognitive behavioural therapy or motivational interviewing	34%	66%
Communicating with people in distress	36%	64%
Palliative and end of life care	37%	63%
Leadership and influencing	40%	60%



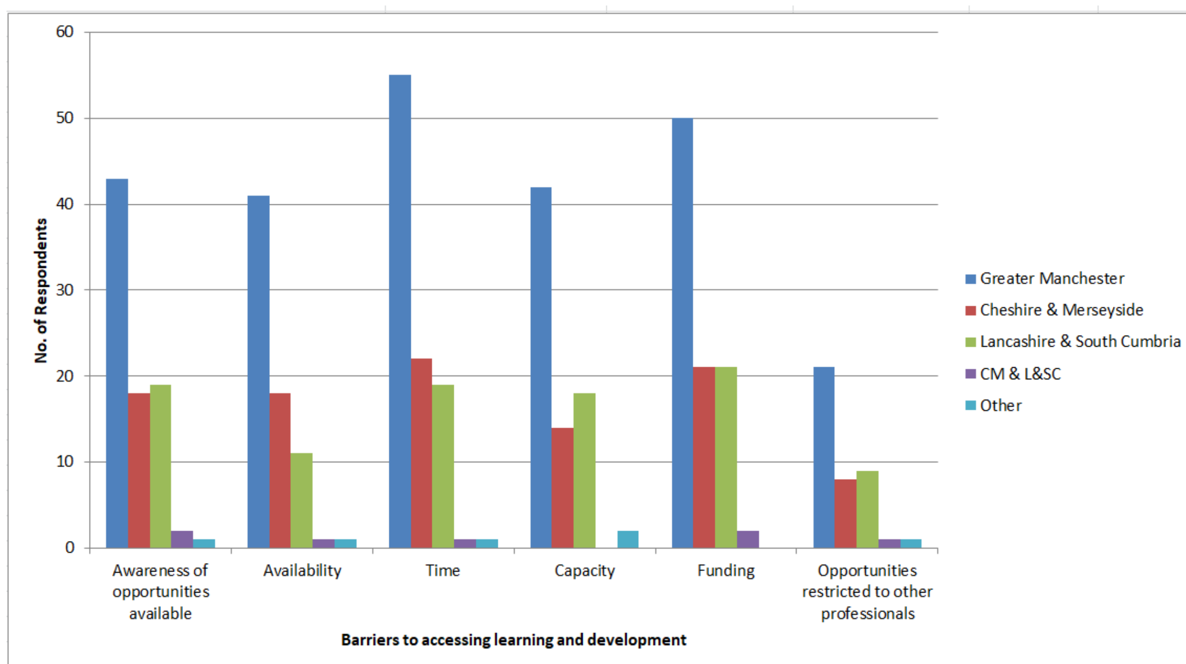
4.3.2 We asked respondents what they consider to be potential barriers to accessing learning and development:



Responses from respondents who selected 'Other':

Diagnostic Radiographers often have a single, brief but intense interaction with cancer patients, making ongoing support impossible.
It not being considered a major part of my job/client group
COVID - less opportunity to network

Regional breakdown of potential barriers to accessing learning and development:



4.3.3 We asked respondents if they have an opportunity at appraisals to raise cancer specific training needs, 86.4% said they do (n=108). For those that said they do not, advised the below:

Could bring it up if we wanted to but not a specific part of our appraisal
For me personally, it isn't part of my role. My contact with cancer patients as clinical tutor and reporting radiographer is limited. But, generally, for diagnostic radiographers working within the various modalities, I believe some of the above training would be of value.
I currently work as a locum occupational therapist so do not have appraisals
I haven't ever raised this at an appraisal but am sure I could. As we see children and adults with any long-term medical condition affecting their function, we need to be aware of lots of medical conditions of which cancer is part of but not specifically specialist to our service. I would liaise with other specialist professionals involved with the client as and when needed, though it would be beneficial for me to attend training courses which would give me a better understanding of cancer types, symptoms, effects etc.
I work in a mental health setting and patients with cancer diagnoses are limited so would not necessarily be seen as a priority by my line manager
It is such a small part of our caseload it does not get raised.
Varied job role not just for cancer patients so training needs are varied

4.3.4 Below is a breakdown which respondents advised would be their preference for the format in which training is delivered:

4.3.5 97.6% of respondents advised they have access to the resources required to attend virtual training? E.g. A laptop (n=122)

5.0 Discussion

The NW survey was developed with support from AHP networks, building on previous surveys conducted by other cancer alliances across the region. Responses were received from 125 AHPs working within dietetics, physiotherapy, occupational therapy, speech and language therapy, radiography, podiatry, art therapy and paramedic services, which was considered a positive response rate given it was conducted during a period of high demand and redeployment of the AHP workforce in response to the Covid-19 pandemic. Interestingly 62% of respondents were generalist AHPs, which enabled greater insight into current practice, and gaps in knowledge and skills.

The survey yielded some interesting results providing good insight into the current AHP training and educational needs. The first section focused on the demographic breakdown of respondents which highlighted significant variance in job titles across the region. This indicates variation in job descriptions, roles and responsibilities across the region and could be confusing for patients, carers, family members and other healthcare professionals accessing and/or working with AHPs. Promoting standardised job titles could encourage standardisation of service provision and enhance competency and career frameworks, which in turn may contribute to an improvement in recruitment and retention of the AHP workforce.

The second section focussed on gaining a greater understanding for how generalist and specialist AHPs are currently supporting cancer patients, with specific questions on delivering personalised care interventions. This revealed gaps in knowledge and understanding with only 59.2% of respondents stating that they knew what a Holistic Needs Assessment (HNA) was and as few as 12.2% conduct these assessments. Furthermore when asked about structured needs assessment only 32% stated that they conducted these. This response rate could be due to interpretation and the language used e.g. AHPs referring to their assessments under a different heading however, HNAs or personalised care and support plans are imperative to delivering personalised care to cancer patients. They should be completed for all, potentially at several points in their cancer pathway. Much of the information gathered in a HNA will be pertinent to the assessment and interventions AHPs are completing (whether generalist or specialist) and so it is imperative that all AHPs are aware and proficient at either conducting or interpreting such plans. This highlights a clear training need for consideration.

Linked to the above is the low percentage of AHPs that have access to these plans (22.4%) and / or also share their structured needs assessment (37.6%). This is an area to be addressed as a number of concerns raised by cancer patients in the care plans could be 'treated' by both generalist and specialist AHPs to improve quality of life.

Survey results displayed a low level of AHP presence in cancer services including reduced involvement of AHPs in cancer MDTs and in improving cancer service delivery. Given the important service gaps identified by respondents, there is an opportunity to ensure AHPs have a voice and can influence service provision and improvement for cancer patients.

Responses highlighted a significant number of AHPs with low to medium levels of confidence in supporting cancer patients. 40% of respondents ranged between not at all confident to somewhat confident when it comes to delivering assessments and interventions for patients with palliative care / end of life needs or interventions requiring specialist knowledge of late effects / consequences of treatment. Confidence supporting cancer patients is critical taking into account the prevalence of cancer in the population, with 1 in 2 people expected to receive a diagnosis of cancer in their lifetime. The growth in the cancer workforce has not kept pace with the growing demand for cancer services and so the need to upskill generalist AHPs to feel more confident to utilise their skills to benefit cancer patients has never been more important. Generalist AHPs also need confidence to apply for specialist cancer AHP roles, with some level of competence already consolidated for succession planning.

There is always risk of misinterpretation of survey questions however the need for cancer training and education for both generalist and specialist AHPs is overwhelming. 100% of respondents expressed a desire for cancer related learning and development opportunities. For each cancer topic suggested, between 60-80% of respondents agreed they would like the opportunity to further their learning however, time and funding could be a barrier to accessing training offered.

6.0 Recommendations

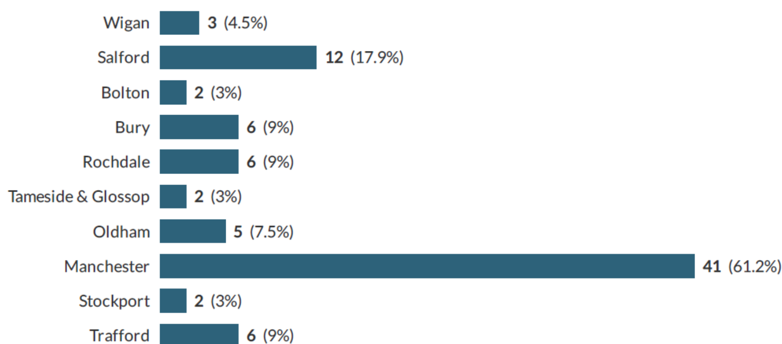
To address the findings within this report the following recommendations have been identified:

1. Develop a NW cancer training and education programme for all AHPs and for this to include the following as a minimum: • Cognitive and psychological factors of cancer • Cancer related fatigue and its management • Developing personal resilience to burnout and emotional wellbeing • Supporting independence and promoting self-management • Understanding the late effects of cancer and its treatment • Understanding cancer rehabilitation and survivorship • Nutrition for living with and beyond cancer • Using patient experience and stories to inform service • Understanding the consequences of cancer • Using clinical data and information to inform service • Understanding physical activity and cancer • Audit, research and service improvement skills • Understanding cancer and its treatments • Cognitive behavioural therapy or motivational interviewing • Communicating with people in distress • Palliative and end of life care • Leadership and influencing There is potential to utilise existing training packages under development such as PRosPER (Macmillan/HEE).
2. Look at mechanisms for raising awareness of regional and national training and development opportunities for AHPs
3. Consider the role of appraisals in improving confidence to support cancer patients and identifying cancer related training needs
4. Ensure protected time within AHP job plans and access to funding to support learning and development
5. Establish a small working group to explore further the responses to the questions regarding HNAs / structured needs assessments to identify next steps and to understand the role of AHPs in delivering personalised care interventions for cancer
6. Explore standardising AHP job role and titles
7. Work with cancer pathway boards to increase the involvement of AHPs within cancer MDTs
8. Look at ways to increase AHP involvement in improving cancer service delivery.
9. Work with the AHP Faculty and NW higher education institutions to ensure cancer specific training is a component of undergraduate AHP education and practice placements.
10. Use **mentors** from more experienced, senior specialist cancer clinical staff (AHPs and Medics/Nurses) to empower AHPs to have greater confidence, ensure they are present within the right forums (such as MDT meetings and tumour specific pathway boards), they feel able to promote all AHP professions, not just their own discipline and they are able to clearly articulate the value AHPs add to cancer pathways and healthcare provision.

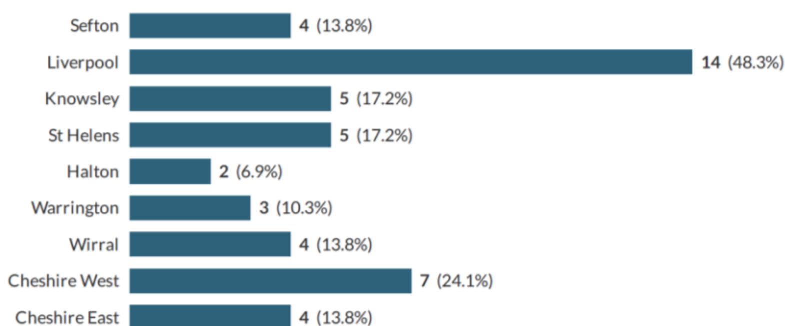
7.0 Appendices

Appendix A

Greater Manchester

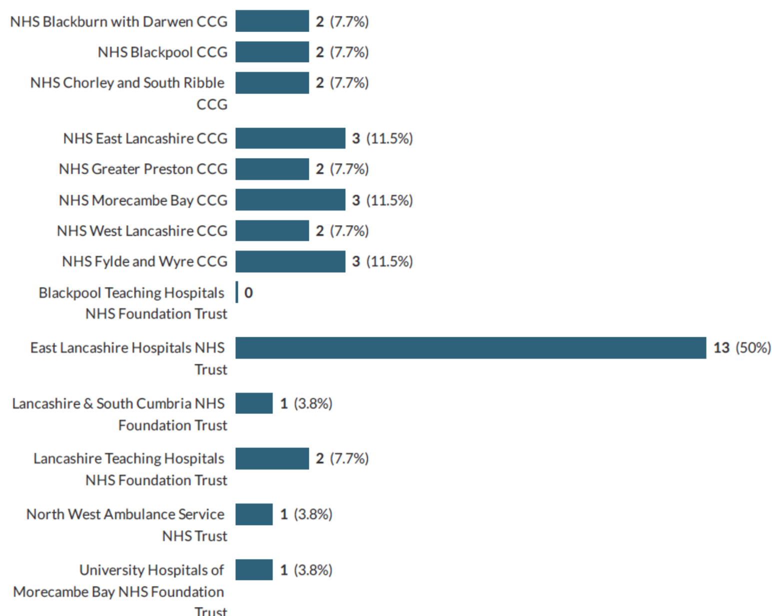


Cheshire & Merseyside



Lancashire & South Cumbria

Please note, breakdown of region by CCG was advised as most meaningful data capture by Cancer Alliance



Appendix B

Respondents job titles	
Community Trainee Advanced Clinical Practitioner AHP	1
Advanced Clinical Practitioner	1
Advanced Clinical Practitioner Physiotherapist	1
Advanced Clinical Specialist	1
Advanced MSK Practitioner	1
Advanced paramedic practitioner	1
Advanced Physiotherapist	1
Advanced Practice Reporting Radiographer	1
Advanced Practitioner Occupational Therapist	1
Advanced Therapy Technical Instructor	1
AHP Lead	1
All Age Community Dietitian	1
Band 5 Dietitian	1
Band 7 Clinical Team Lead Wards	1
Breast & Pelvic Health Physiotherapist	1
Cancer rehab specialist physiotherapist	1
Children's Occupational Therapist	1
Clinical Lead Physiotherapist in Supportive and Palliative Care	1
Clinical Lead Speech & Language Therapist	1
Clinical Specialist Dietitian	1
Clinical Specialist Occupational Therapist	1
Clinical Specialist Physiotherapist	1
Clinical specialist Podiatrist	1
clinical specialist physiotherapist	1
Clinical Trials Radiographer	1
Clinical Trials Research Radiographer	1
Clinical Tutor and Advanced Practice Reporting Radiographer	1
Com OT Major adapts & Equipment	1
Community Advanced Practitioner	1
Community Mental Health Occupational therapist	1
community occupational therapist	1
Community Physiotherapist	1
Consultant Paramedic	1
Consultant Physio/ Service Lead	1
Consultant Physiotherapist	1
Consultant Radiographer	3
Diabetes Specialist Dietitian	1
Dietetic team leader	1
Dietitian	5
Haematology Dietitian	1
head and Neck Oncology dietitian	1

Head and neck specialist dietitian	1
Head Art Psychotherapist	1
Highly specialist Macmillan speech and language therapist	1
Highly specialist physio / advanced practitioner	1
Home enteral feeding dietitian	1
In Hospital Theapy Lead and Neuro Physio	1
Lead MRI Radiographer	1
Macmillan dietitian	1
Macmillan occupational therapist	3
Macmillan Palliative Care Physiotherapist	1
Macmillan Physiotherapist	1
Macmillan Senior Specialist HPB Dietitian	1
Macmillan Service Manager	1
Macmillan Specialist Physiotherapist - Breast Care	1
Macmillan Speech and Language Therapist	2
Occupational Therapist	13
Occupational Therapy Team Leader	1
Physiotherapist	5
Physiotherapy surgery	1
Physiotherapy team leader acute medicine	1
Prehabilitation Lead	1
Principal Therapeutic Radiographer	1
Professional lead Dietitian	1
Professional Lead for Dietetics and Therapy Operational Manager	1
Project Manager	1
Radiographer	2
Radiotherapy Advanced Practitioner	1
Reporting Radiographer	2
Rotational dietitian	1
Senior Dietitian	1
Senior Occupational Therapist	1
Senior Radiographer	2
Senior Specialist S<	1
Senior Therapy Radiographer	1
Service manager	1
Specialist Advanced practice Sonographer	1
Specialist Dietitian	1
Specialist Gastroenterology Dietitian	1
Specialist Haematology Oncology Occupational Therapist	1
Specialist Head and Neck Oncology Physiotherapist	1
Specialist Palliative Care Occupational Therapist	2
specialist speech and language therapist	3
Speech and Language Therapist	4
Speech and Language Therapist Inpatient Team Lead	1

Team Lead Dietitian	1
Team Lead Physiotherapist	1
Technical instructor	1
Therapeutic Radiographer	2
Therapy assistant	1

Appendix C

	Greater Manchester	Cheshire & Merseyside	Lancashire & South Cumbria	C&M + L&SC	Other
Band 4	2	0	0	0	1
Band 5	2	3	0	0	0
Band 6	24	5	5	0	1
Band 7	25	16	15	1	0
Band 8a	12	3	1	0	0
Band 8b	2	1	3	1	0
Band 8c	1	0	1	0	0

Appendix D

List of Structured Needs Assessments
Mfsi
COPM in OT clinic settings
OT assessment
PSGAG
PSAG
Nutritional specific assessment tools
Check Vascular supply via Doppler assessment
our own physiotherapy assessment
Locally developed holistic assessment
Full holistic initiative assessment
Swallowing questionnaires MDADI - self rating
My art psychotherapy assessment includes assessment of psychological and social needs in particular, but also touches on physical and spiritual needs
Physio assessment
service provided holistic needs assessment
Use Holistic but Proportionate assessment
Full OT ax, MOHO interest checklist, HADS, CAM, ACE 3
Our standard initial OT assessment which is needs based
IPOS
Our initial Macmillan Ax covers all holistic needs
EORTC
clinical subjective and objective assessment

PG-SGA Advance Care plans
A,B,C,D,E dietetic assessment
Occupational Therapy initial interview. Occupational Therapy Functional assessment. Cognitive assessments if indicated (e.g. MOCA) Equipment assessment if indicated.
Tailored holistic crisis response assessment
Just as part of our individualistic socio-clinic-therapeutic assessment pathway.
Assessment
Physiotherapy and Fall Axs.
pre-treatment assessment, post-treatment assessment, dysphagia swallowing assessment
Physiotherapy assessment and Transfer of care stating needs when transferring to Wards-community
My own
We do carry out a comprehensive assessment which is holistic in nature. We look into medical, ADLs, Social elements and manage patient accordingly.
CORE assessment
Health & Social Needs Assessment as part of mental health Care Programme Approach
Initial OT assessments e.g. CMOP, OCAIRS
Dietetic assessment
Environmental assessments to assess for assistive equipment needs
Macmillan assessment
HNA Health and Social Care

Appendix E

List of who assessments and subsequent care plans are shared with
MDT
Cancer MDT, relevant community services, GP if necessary.
OT in my team
Electronically on EMIS
Nursing and medical team as appropriate.
treating team, GP and Patient
Community team and specialist acute team if appropriate
DN team, Vascular team, MDT and Diabetology
Not shared directly but they are available as shared records to other staff that use the same electronic system as us.
I carry out language assessments and share these with parents, teachers and wider MDT members.
complete assessment of needs and share with the MDT team / local authority / education partner agencies
They are on EMIS as a shared record for all community and primary care services to access as needed
They are accessible to anyone using the electro notes system involved in that patients care
Oncology team

Where appropriate information is shared with the client's social worker/community nurse and/or care team/support workers
Surgical teams as appropriate
anyone the clients consents to
Carefirst - open to all health & social professionals
patient, caregivers, MDT
Social services are able to access them as we are on the same system. Some Health care staff with access to the system can also view them. Client consent for sharing records is always established at the initial assessment.
Shared electronically on system record - anyone else involved with the patients care with access to this system can view if patient has consented to this. This includes Hospice, consultants in palliative care, district nurses, other AHP teams with in the organisation
GP, DNs
Documentation available to all ESR users
Other professions via patient notes e.g. clinician
Our HNAs will contact and refer our patients on to relevant people who can address the need/ concerns of the patient be it GPs, dieticians, holistic practitioners, Macmillan advice for finance for example
AHPs; Nursing, Medics etc.
MDT and onto electronic systems Other professionals if referring on
Nurses, speech and language therapists, palliative care team
Doctors (written and verbal), Nursing staff (written and verbal), Social Services (verbally, no formal written report).
Head and neck colleagues as appropriate
Macmillan GPs DNs Therapists Depends on who patient needs to see. We are short term up to 72 make safe and stabilise then hand back/over to community Primary care and specialist services we work with
Sometimes with the MacMillan team, the acute hospital teams, the Christies team, patient's GP, NWAS team and any other relevant teams, as deemed necessary for patient's care and safe management at home.
Via emis
With all professional who have access to EMIS
MDT
MDT, Onward Therapy and MDT, Hospice, Integrated neighbourhood team
The team, as they go onto SCR
In electronic patient record (emis) so that all community services involved with patient and GP will be able to access the records
The assessment is held on an electronic record that can be viewed by all community professionals and GPs involved with patient care and with their consent.
Patient and carer (if appropriate) Other health & social care providers (consent gained by patient/carer) NWAS Police as and when necessary
offered to service users / family members and with MDT colleagues
on EMIS where SLT can also access

EMIS notes - teams open to the patient and GP
Assessment is kept in patient's case notes and if needed sent ICAT and any other teams that may require the information
Macmillan multi-disciplinary team. Other staff as required.
Patient, carer, GP, any other health professional involved in care

Appendix F

Breakdown of respondents by any further training requirements to provide support to address any of the following concerns to people with a cancer:

	Do you support this person		Do you feel confident to support this person?		Do you require further training to support this person?		If you don't provide support, do you know who to signpost them to?	
	Yes	No	Yes	No	Yes	No	Yes	No
Physical appearance	43%	57%	40%	60%	63%	37%	65%	35%
Sleep Problems	40%	60%	32%	68%	57%	43%	75%	25%
Sex, intimacy or fertility	20%	80%	15%	85%	55%	45%	66%	34%
Swelling	45%	55%	36%	64%	54%	46%	88%	12%
Tingling in hands/feet	34%	66%	30%	70%	53%	47%	82%	18%
Hot flushes/sweating	24%	76%	21%	80%	52%	48%	80%	20%
Memory or concentration	47%	53%	43%	57%	52%	48%	90%	10%
Wound care after surgery	24%	76%	21%	79%	51%	49%	92%	8%
Other medical conditions	50%	50%	43%	57%	50%	50%	86%	14%
Pain or discomfort	71%	29%	67%	33%	50%	50%	94%	6%
Dry, itchy or sore skin	25%	75%	28%	72%	49%	51%	87%	13%
Nausea or vomiting	53%	47%	55%	45%	49%	51%	95%	5%
Sight/hearing	29%	71%	28%	72%	49%	51%	79%	21%
Tiredness, exhaustion or fatigue	71%	29%	72%	28%	47%	53%	88%	12%
Indigestion	41%	59%	44%	56%	46%	54%	89%	11%

Sore or dry mouth or ulcers	50%	50%	58%	42%	44%	56%	86%	14%
Swallowing	47%	53%	46%	54%	43%	57%	92%	8%
Diarrhoea	50%	50%	50%	50%	43%	57%	93%	7%
Breathing difficulties	58%	42%	60%	40%	43%	57%	87%	13%
Passing urine	40%	60%	44%	56%	42%	58%	94%	6%
High temperature or fever	35%	65%	40%	60%	40%	60%	93%	7%
Constipation	55%	45%	57%	43%	38%	62%	90%	10%
Changes in weight	60%	40%	63%	37%	37%	63%	95%	5%
Eating or appetite	65%	35%	69%	31%	37%	63%	93%	7%
Moving around (walking)	67%	33%	71%	29%	34%	66%	88%	12%

Appendix G

Breakdown of respondents by any further training requirements to provide support to address any of the following practical concerns to people with a cancer:

	Do you support this person		Do you feel confident to support this person?		Do you require further training to support this person?		If you don't provide support, do you know who to signpost them to?	
	Yes	No	Yes	No	Yes	No	Yes	No
Problems with alcohol or drugs	46%	54%	28%	72%	58%	42%	82%	18%
Medication	52%	48%	43%	57%	54%	46%	86%	14%
Money or finance	26%	74%	21%	79%	51%	49%	79%	21%
Work or education	40%	60%	39%	61%	48%	52%	73%	27%
Housing	33%	66%	32%	68%	46%	54%	78%	22%
Travel	26%	74%	26%	74%	45%	55%	70%	30%
Difficulty making plans	66%	34%	42%	58%	43%	57%	71%	29%

Taking care of others	51%	49%	58%	42%	42%	58%	82%	18%
Talking or being understood	58%	42%	67%	33%	39%	61%	80%	20%
Taking care of pets	36%	64%	38%	62%	39%	61%	65%	35%
Smoking cessation	47%	53%	48%	52%	38%	62%	86%	14%
Transport or parking	37%	63%	38%	62%	34%	66%	72%	28%
Grocery shopping	60%	40%	75%	25%	32%	68%	81%	19%
Laundry or housework	44%	56%	54%	46%	30%	70%	77%	23%
Washing/Dressing	53%	47%	60%	40%	29%	71%	85%	15%
Preparing meals/drinks	75%	27%	84%	16%	27%	73%	89%	11%

Appendix H

Breakdown of respondents by further training requirements to provide support to any of the following people in the patients' support network:

	Do you support this person		Do you feel confident to support this person?		Do you require further training to support this person?		If you don't provide support, do you know who to signpost them to?	
	Yes	No	Yes	No	Yes	No	Yes	No
Children	71%	29%	71%	29%	62%	38%	82%	18%
The person they care for	31%	69%	31%	69%	57%	43%	72%	28%
Their carer	44%	56%	55%	45%	54%	46%	73%	27%
Partners	66%	34%	71%	29%	53%	47%	78%	22%
Other relatives/friends	42%	58%	49%	51%	53%	47%	72%	38%

Appendix I

Breakdown of respondents by further training requirements to provide support to address any of the following psychological concerns to people with a cancer diagnosis:

	Do you support this person		Do you feel confident to support this person?		Do you require further training to support this person?		If you don't provide support, do you know who to signpost them to?	
	Yes	No	Yes	No	Yes	No	Yes	No
Guilt	42%	58%	28%	72%	75%	25%	67%	33%
Regret about the past	36%	64%	26%	74%	72%	28%	64%	36%
Hopelessness	45%	55%	36%	64%	70%	30%	71%	29%
Unable to express feelings	45%	55%	41%	59%	68%	32%	70%	30%
Anger or frustration	54%	46%	40%	60%	67%	33%	72%	28%
Uncertainty	52%	48%	40%	60%	63%	37%	77%	23%
Thinking about the future	52%	48%	44%	56%	63%	37%	69%	31%
Worry, anxiety or fear	68%	32%	50%	50%	62%	38%	78%	22%
Loneliness or isolation	59%	41%	52%	48%	62%	38%	74%	26%
Loss of interest in activities	55%	45%	56%	44%	61%	39%	74%	26%
Sadness or depression	61%	39%	49%	51%	61%	39%	79%	21%
Loss of role	50%	50%	44%	56%	59%	41%	66%	34%
Independence	64%	36%	60%	40%	56%	44%	72%	28%

Appendix J

Breakdown of respondents by further training requirements to provide support to address any of the following lifestyle or information needs of people with a cancer diagnosis:

	Do you support this person		Do you feel confident to support this person?		Do you require further training to support this person?		If you don't provide support, do you know who to signpost them to?	
	Yes	No	Yes	No	Yes	No	Yes	No
Alcohol and drugs	39%	61%	31%	69%	58%	42%	77%	23%
Managing symptoms	64%	36%	66%	34%	54%	46%	87%	13%
Planning for future priorities	34%	66%	38%	62%	54%	46%	63%	37%
Smoking	43%	57%	46%	54%	54%	46%	82%	17%
Complimentary therapies	31%	69%	38%	63%	52%	48%	69%	31%
Patient and carers support groups	51%	49%	53%	47%	51%	49%	76%	24%
Making a will	13%	87%	11%	89%	49%	51%	61%	39%
Sun protection	24%	76%	36%	64%	44%	56%	62%	38%
Exercise and activity	66%	34%	71%	29%	43%	57%	84%	16%
Diet and nutrition	62%	37%	70%	30%	40%	60%	89%	11%

Appendix K

Breakdown of respondents by further training to requirements to provide support to address any of the following spiritual or religious concerns of people with a cancer diagnosis:

	Do you support this person		Do you feel confident to support this person?		Do you require further training to support this person?		If you don't provide support, do you know who to signpost them to?	
	Yes	No	Yes	No	Yes	No	Yes	No
Feeling at odds with culture, belief or values	29%	71%	16%	84%	71%	29%	50%	50%
Meaning or purpose of life	27%	73%	20%	80%	69%	31%	51%	49%
Faith or spirituality	26%	74%	17%	83%	67%	33%	58%	42%

Appendix L

Regional breakdown of respondents who advised they are an active member of a 'regular' (weekly/biweekly) Cancer MDT meeting:

	Greater Manchester	Cheshire & Merseyside	Lancashire & South Cumbria
Breast	0	1	2
Head & Neck	5	2	4
Brain/CNS	0	0	1
Lung	0	0	1
Haematology	2	0	0
Other	5	0	0

Appendix M

Respondents additional learning and development comments
Attended a cancer study last year which was brilliant and really improved my knowledge around cancer! Would love to have one focussing more around the psychological/social aspects and what services are available for me to signpost patients to with regards to this.
Clinical breast examination is a key skill which I have. Advanced communications skills training are also essential. As radiographers working within the breast MDT this should be mandatory but many colleagues at other trusts have not had this.
Exercise and rehabilitation in palliative and recovering oncology
have lots of access as Macmillan role
I am involved in Patient public & practitioner partnership training
I am not sure if this applies to my job
I believe that collaboration with our cancer patients is the key to developing our services and ensuring that our patients' experiences are at the heart of the decisions that we make. We should always involve our patients , therefor methodologies to achieve this should be encouraged and supported e.g. Always Events
Managing ongoing/late effects of treatment and how to talk to patients about this when they were not adequately warned about long lasting effects of treatment
Nutrition following cancer treatments Palliative and end of life care and nutrition
Psychological support around body image
Research, audit
Some of the topic above I have engaged with in day to day work with colleagues from different specialities/areas however I would find it beneficial to have some formal training on all the subjects. Those that I know something about, there is always room to expand knowledge
the sage and thyme training is beneficial in addition to motivational interviewing
Training specific to AHPs in rehab for pts with MSCC and brain tumours (inc upper limb)
Understanding issues related to structural racism within services, eg BAME people being diagnosed later and being discriminated against at every stage of their health journey
Would be very useful to have learning opportunities for complementary therapies.
Writing and developing business cases