

ALLIED HEALTH PROFESSIONALS

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CANCER SUPPORT

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Introduction

Allied health professionals (AHPs) are an integral part of multidisciplinary teams, supporting people with cancer from diagnosis, during treatment, through recovery and at end of life.

AHPs can use their valuable skillset to help keep people living with and recovering from cancer out of hospital, support them to be as healthy as they can before and after treatment and maximise their health and wellbeing at every stage of the care pathway.

Earlier this year, Macmillan launched the first competence framework for UK allied health professionals working with people affected by cancer, and on page iii you can read about how this is now being used to enhance patients' experience of cancer care.

The framework has taken considerable time and expertise to develop, and we are grateful to everyone who has supported the project. However, it will only be effective if we embed these standards right across cancer services.

As Macmillan's Chief of Nursing and Allied Health Professionals, a role I took on in May this year, I will be supporting the continued use of this framework at this critical time when we need to focus on being adaptable, innovative and flexible.

I have previously worked as a nurse consultant and community palliative care nurse, and am also a trained cognitive behavioural therapist. Now, I will be working to ensure that AHPs have a voice within Macmillan as an organisation, as well as within NHS frontline services.

This includes helping to shape our policies around workforce and the implementation

of the Recovery Package as part of the cancer strategy.

AHPs are very much a hidden workforce, and they don't always have a seat at the top table. I want to hear from AHP colleagues to get their views on developing cancer services and where the gaps are, so that I can lobby for further resources and a more sustainable role for AHPs moving forward.

A key part of that is continuing to build the evidence base to demonstrate the added value that AHPs provide for people living with cancer, and the practice examples in this edition of *Sharing Good Practice* all help to illustrate that value, both in outcomes for patients and cost savings for services.

This will help us to influence commissioners as to where they should be putting money and resources – and you can read more about the new commissioning guidance that is highlighting the vital role that rehabilitation plays on page viii.

Lastly, we also need to think about how we can better help people living with and beyond cancer in the community, as this population continues to grow. Many are living with chronic and enduring consequences of treatment, and yet AHPs are often least accessible and visible to this group. The North Manchester Macmillan Palliative Care Support Service (NMMPCSS) – featured on page xii – is a great example of how we can provide high-quality, holistic care to people, when and where they need it.



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How I use the Macmillan AHP Competence Framework

My current role as a Macmillan clinical AHP educator focuses on education for all allied health professional (AHP) and nursing staff at Hertfordshire Community Trust, with an emphasis on palliative and end of life care and palliative rehabilitation for people with any life limiting condition, including cancer.

The Trust employs around 1,200 clinical staff, of whom 633 are registered AHPs, as well as a further 120 un-registered healthcare rehabilitation staff.

AHP staff are based across all healthcare settings, including community integrated teams, community hospital bed-bases and within specialist services, and are employed by the community trust to work within acute hospital services (including the East and North Hertfordshire Trust Mount Vernon Cancer Centre). Many AHP staff work alongside people with a cancer diagnosis at all points in the cancer pathway.

Introducing the framework

I have promoted the Competence Framework to all AHP staff groups through the Trust's AHP Forum (chaired quarterly by Jill Callander, Lead Allied Health Professional), through our 48 clinical end of life champions, 50% of whom are AHP staff, and by referring to the document during all relevant training events.

I believe the framework gives clinicians an opportunity to clearly identify the level at which they are working and set specific targets to raise their level of competency in whichever domains are applicable to their role. This is especially helpful for non-specialist staff working in the community, or newly qualified staff on rotation through specialist services, who are aiming to identify and achieve a

'competent' level within a limited time.

As a Macmillan clinical educator, I have personally identified two framework competencies as being most relevant to my current role: support and development of healthcare professionals (5c) and research, audit, data and service evaluation (5a).

I have been able to use the framework to inform learning objectives for the clinical training programmes that I develop and deliver with Macmillan colleagues, for example, using the sections on clinical practice – symptom management (1e) and care co-ordination – personalising the care pathway (2).

I have also been able to use the framework to raise the profile and identify the role of AHPs working in cancer care within Hertfordshire Community Trust when at operational or quality meetings.

Challenges, benefits and outcomes

I have experienced some difficulties with inputting text into the framework PDF table – as the electronic format created problems with font size and how much text I could fit in.

However, the benefits of being able to complete an electronic record of my specifically-identified competencies has meant this can be easily and quickly aligned to my Trust's appraisal objectives and linked electronically to my online AT-Performance and appraisal records as clear evidence.

The framework enables me to clearly demonstrate my varying levels of competency within relevant areas of work, identify learning objectives for the development of training programmes and promote the role of AHPs working within cancer care.



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Collaborative working in Wales

In 2008, Macmillan and the South East Wales and South West Wales Cancer Networks developed AHP lead roles. These roles were created to raise the profile of cancer rehabilitation, to develop cancer rehabilitation pathways that embedded Macmillan's Recovery Package and to ensure that the eight domains of care, as described by NICE¹, were inherent in all specialist cancer therapy services.

The Cancer Network AHP leads developed training for cancer key workers to formalise the relationships between cancer-specialist therapy teams and third sector, social and community partners providing support services for people affected by cancer and their multi-disciplinary teams (MDTs). This recognises that the cancer key worker role is not only for specialist cancer nurses, especially for the increasing cancer survivorship population.

In 2010, they were responsible for developing the National Cancer Standards for Adults with Cancer, published by the Welsh Government. They also drew together AHP leaders and champions across health boards and trusts in South Wales into a Network Cancer Rehabilitation Advisory Group (NCRAG), fostering a culture that supported service improvement and research.

Between 2008 and 2016, the Cancer Networks in Wales underwent significant restructure, and in October 2016 a single Wales Cancer Network was formed. Within this new structure, my full-time role as Macmillan Network Lead AHP was developed. This role works to inform and implement the Cancer Delivery Plan and is a core member of the person-centred care sub group, delivering against the priorities identified by the Cancer Implementation Group (CIG). The NCRAG has linked with the Wales Therapy Advisory Committee (WTAC) since January 2017, which has opened a constructive dialogue between

cancer and non-cancer AHPs at a strategic level.

I am working with health boards and Macmillan to promote the benefits of developing AHP leadership roles within cancer centres and health boards, and since April 2017, the NCRAG has comprised dedicated cancer AHP lead roles and nominal representatives from health boards across Wales.

I also work very closely with the Wales Cancer Network Macmillan Lead Cancer Nurse to support more collaborative working between nurses and AHPs. We recognise that there is a robust community of cancer specialist nurses, but the increasingly-explicit reliance on non-cancer specialist teams to support people affected by cancer demonstrates the need for foundation education for AHPs.

The NCRAG is currently undertaking a systematic approach to reviewing the National Cancer Standards for Adults with Cancer (2010). This will inform a proposed strategy for transforming AHP services for people affected by cancer in Wales, which includes a governance framework to ensure the high quality of this work programme. The proposed strategy will include the development of a cancer rehabilitation dataset as part of the National Cancer Performance Framework. This data will inform accurate monitoring of quality and effectiveness of AHP services in cancer, and support AHP involvement in the national peer review programme of cancer MDTs.

Our aim is to embed AHPs within cancer MDTs by demonstrating the impact that these services have on the outcomes and experiences of people affected by cancer. As the strategic landscape of cancer care evolves, a key priority for the NCRAG is to foster partnership working and bridge the gap between the needs of people affected by cancer and the services currently available to them.



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Adopting enhanced recovery principles with cancer treatments

In his insightful book, *Being Mortal: Illness, Medicine and What Matters in the End*, Atul Gawande says, 'We think our job is to ensure health and survival. But really it is larger than that. It is to enable wellbeing. And wellbeing is about the reasons one wishes to be alive.'

Occupational therapists support people to achieve health, well-being and life satisfaction through participation in occupation.

'Occupation' means all activities that are meaningful to a person, that they undertake, enjoy and value².

As an occupational therapist with more than 20 years' experience caring for people with cancer in hospital, I have been delivering an occupational therapy service to oncology and haematology out-patient clinics in Lincolnshire for the past five years.

In 2016, I won the United Lincolnshire Hospitals 2016 Staff Innovation Award for developing the service, which was initially funded by Macmillan Cancer Support for three years and has helped empower people living with cancer and improve quality of care.

The wider impact of treatment

Having previously worked as a team lead occupational therapist in oncology and surgery, I wanted to replicate the benefits of enhanced recovery for surgery for people preparing for other cancer treatments, namely radiotherapy, chemotherapy and hormone therapy.

This proactive approach has already been proven, pre-operatively and post-operatively, to improve clinical outcomes

and reduce length of hospital stays and risk of admissions³.

Prior to developing our occupational therapy service, I asked every person who came into the oncology ward what their two main concerns were on admission. Over a period of one month, more than 50% of concerns were related to the impact of cancer and cancer treatment on individuals' physical and mental health, and that of their families. Many of these concerns could have been addressed earlier during people's cancer journeys, through understanding that we can predict and prevent, if not minimise, certain side effects of cancer and its treatment.

Cancer treatments, numerous

appointments and other comorbidities can turn everyday activities into challenges and turn people into 'patients'. They impact on things that matter most to people, such as mobility, work, relationships, sexual

matters and social life. In turn, this can affect people's tolerance of or compliance with treatment and increase the risks of developing future health and social care needs.

I receive e-referrals from consultants, nurse specialists, radiographers and other health care professionals, and can meet with people at the oncology department, chemotherapy suite or at home.

Using a rehabilitation model, which may be preventative, restorative, supportive or palliative, the service includes interventions such as fatigue management, health promotion and active lifestyle, psychoeducation, self-management, aspects

'It is not just the medical care and treatment that matters. It is people's emotional, social and spiritual wellbeing.'

of CBT and motivational interviewing, and empowers people to be in control of their own lives.

The service has been well evaluated, with 80% of professionals referring people reporting that the Macmillan Occupational Therapy service is 'very beneficial' to their own service delivery and 90% reporting it as 'very beneficial' to patients and their families.

More than 90% of people and families using the service described their overall experience as 'excellent', while 85% reported the service as 'very beneficial'.

Optimising outcomes

During the service development, I addressed affordability, sustainability and efficient use of resources. This led me to propose an enhanced recovery group session for individuals preparing for radiotherapy and their families, which I developed and deliver with Jane Hall, Macmillan Specialist Radiographer.

We use a telephone booking system, and gathering information about each group, such as diagnoses, age and treatment aims, means we can adapt the session content accordingly.

The session agenda includes self-management⁴, radiotherapy, minimising side effects, exercise, work, emotional wellbeing and available support. We offer one-to-one consultations at the end of the session and invite self-referrals for occupational therapy.

More than 80% of people attending said they are 'extremely likely' to recommend the session to others. In addition, health care professionals have reported less time needed for 'pre-treatment chats' and improved compliance from individuals concerning treatment preparation and advice.

Working in the NHS for 28 years, I have had the privilege of meeting thousands of people living with cancer and their families who have shared their stories, their hopes,



Helen leads an enhanced recovery group session.

their fears and their secrets. It is not just the medical care and treatment that matters. It is people's emotional, social and spiritual wellbeing. It is their fear, anxiety and uncertainty. Without doubt, these are the things that can prevent people going home from hospital, staying at home, staying in relationships, socialising, returning to work, feeling 'normal', feeling valued and feeling well.

Nationally, a focus on recovery at the end of cancer treatment has prevailed. This evidence supports the growing need for recovery to begin with prehabilitation, delivering rehabilitation before treatment including surgery, radiotherapy and chemotherapy.



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Commissioning guidance to improve cancer rehabilitation services

NHS England commissioning guidance for rehabilitation has highlighted the vital role that rehabilitation plays in delivering better outcomes for patients⁵.

Cancer rehabilitation is an integral part of care for people living with and beyond cancer⁶, and it is likely that demand for services will grow as our population ages, and more people survive cancer and live with the consequences of cancer treatment.

Whether that is loss of physical function, psychological issues or a need for continuing education about side effects, patients and carers should have access to a holistic system that enables them to maximise their quality of life and functioning and work towards their goals. Cancer rehabilitation spans the entire treatment pathway, contributing to a range of positive outcomes:

- Preventative – reducing the impact of expected disabilities and improving coping strategies, e.g. prehabilitation before major surgery
- Restorative – returning a person to the levels of function they had before treatment, e.g. vocational rehabilitation
- Supportive – limiting functional loss and providing support in the presence of persistent disease and need for treatment, e.g. physical activity interventions during chemotherapy
- Palliative – preventing further loss of function, eliminating or reducing complications and providing symptom management⁷, e.g. fatigue management groups.

It is now well recognised that improving the care of people living with and beyond cancer is of vital importance, but we have some way to go to ensure that everyone living with and beyond cancer has timely access to rehabilitation services.

In the UK, there is work underway by NHS England and Macmillan Cancer Support to improve rehabilitation services for patients and deliver better health outcomes across the entire system.

'We have some way to go to ensure that everyone living with and beyond cancer has timely access to rehabilitation services.'

The strategy for England published by the independent Cancer Taskforce in 2015 includes a clear recommendation to review the cancer rehabilitation workforce and promote the role of allied health professionals (AHPs) within multidisciplinary teams.

Rehabilitation in cancer care is also gaining increasing recognition through a dedicated national work programme led by Macmillan. An important step forward in that work has been the development of an AHP competency framework, which is now available and has been piloted across the UK.

However, to ensure the sustainability of AHP roles and joined-up cancer rehabilitation services, we must do more to demonstrate their added value to commissioners at the

local and national level.

The development of a sound economic argument for rehabilitation services that clearly shows the cost benefits of good rehabilitation and how it can impact on key metrics such as length of hospital stay, admissions to hospital, healthcare utilisation and return to work is key.

There is also an urgent need for commissioning guidance that is accessible and easy to use, develops a shared understanding of what good rehabilitation looks like and how it should be commissioned, provides a convincing economic case for investment, advises on data and metrics to improve evaluation of services, and provides relevant local data to inform decision making.

This was clearly demonstrated by a project undertaken last year by the Transforming Cancer Services Team (TCST) for London to better understand the scope of cancer rehabilitation services in London and to inform the development of future commissioning guidance for cancer rehabilitation⁸.

Our cancer rehabilitation stakeholder engagement event, followed by more targeted focus groups with local commissioners, found that there are significant gaps in cancer rehabilitation services and the rehabilitation workforce across London, and there is evidence that this impacts on patient care.

Key challenges for improving the commissioning of cancer rehabilitation services include poor understanding of the economic benefits of good rehabilitation, a lack of good data on cancer rehabilitation services, education and training needs of the wider workforce and system leadership.

Our focus groups with commissioners have generated important and useful data for the future development of TCST commissioning guidance for cancer rehabilitation. It was agreed that future guidance should include:

- A format that is accessible and uses visuals and words.
- Language which gets everyone 'on the same page' with respect to what we mean by cancer rehabilitation, its breadth, scope and interconnections with current strategic directives, e.g. the Recovery Package.
- A clear economic argument for why rehabilitation is important and should be better commissioned.
- A clear outline of 'what good looks like' and how it should be commissioned, ideally using a service specification and examples of best practice.
- A focus on data and metrics to improve evaluation. Implementation of the guidance will be complex and challenging but will be supported by linking the guidance to national directives and local priorities, having a good communications strategy and seeking local champions across the system and at every level.

The Macmillan Rehabilitation Clinical Lead position has now been funded by Macmillan until December 2018, which will enable us to develop this comprehensive guidance for commissioners on cancer rehabilitation and consequences of treatment.

We hope to publish the guidance in 2018, building on the findings from these stakeholder engagement activities, alongside a suite of tools to support commissioning of rehabilitation services.

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Leadership and innovation in cancer rehabilitation

This year, Macmillan sponsored the Advancing Healthcare Award for leadership and innovation in cancer rehabilitation. Here, the winning team and two runners-up talk about their award-winning work.

For more information about the awards visit www.ahpandhsawards.co.uk



Award winner

Investigating treatable symptoms caused by chemotherapy

Cancer is increasingly common, and we need to do more to ensure a meaningful quality of life for the rising numbers of people living with and beyond cancer.

One of the frequently ignored causes of a lower quality of life are the troublesome gastrointestinal (GI) symptoms arising from cancer treatments.

Research into the chronic GI side effects of radiotherapy has demonstrated that these symptoms can be investigated and effectively treated following an algorithm. However, no study has investigated if troublesome GI symptoms arising during chemotherapy can be managed in the same way.

Chemotherapy can cause a multitude of troublesome GI side effects, which can lead to dose reductions, treatment breaks, cessation of treatment and impaired quality of life. People are often told these symptoms are inevitable and the underlying causes of the symptoms are not systematically investigated.

In specialist late effects clinics,

specialist nurses can be trained to utilise an algorithm to meet service demand. However, the number of patients living with and beyond cancer is growing at a rate likely to exceed current service provision in specialist gastroenterology clinics. There is an urgent need to innovate and embed cost-effective management of treatment side effects into standard care. There is also a growing recognition of the potential to expand the scope of practice of allied health professionals (AHPs).

This study sought to prospectively assess and investigate troublesome and treatable GI symptoms during chemotherapy using an algorithm. The study also sought to investigate if non-specialist nurses or AHPs, in this case a dietitian, could investigate symptoms using this algorithm.

Patients with GI cancer undergoing chemotherapy for the first time were eligible. The research dietitian or nurse independently and systematically assessed participants with questionnaires prior to starting chemotherapy



L-R: June Davis, Macmillan National Cancer Rehabilitation Lead, Ann Muls, Nurse Consultant, Carolyn Adams, Clinical Research Nurse, Laura Caley, Dietitian, Victoria Pittordou, Research Nurse and Alison Strode, Former Therapy Advisor for Wales.

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and then every month for a year. If new troublesome GI symptoms arose, the nurse or dietitian were trained to recommend and order investigations in accordance with an investigational algorithm, developed with a gastroenterologist with expertise in cancer GI side effects.

Investigations included blood tests, stool tests, urinalysis, endoscopic procedures, testing for bile acid malabsorption and breath tests looking for the development of small intestinal bacterial overgrowth or carbohydrate malabsorption. The nurse or dietitian would inform the oncology team of any abnormal results to review and treat as appropriate. Treatment protocols were provided to the oncology team by the dietitian or nurse when required.

Preliminary analysis of the data shows that, for those who had investigations, many of their GI symptoms that are widely believed to be inevitable and untreatable have simple causes. Additionally, non-specialist nurses and AHPs can be taught to use this algorithm with minimal support from the gastroenterology team.

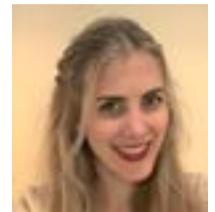
There were challenges to implementation, such as many participants declining additional investigations suggested by the algorithm. Reasons for this included that the investigations required extra hospital visits and were not recommended directly by their

managing team. Teaching was provided to the oncology team to ensure they understood the importance of additional investigations. We tried to minimise visits for additional tests where possible. However, this highlights an area for further research to try and embed simple gastroenterological management of GI side effects into standard care.

Another challenge to implementation was handing over investigation results to the oncology team as they were unfamiliar with how to manage these diagnoses. As a result, we developed treatment protocols in conjunction with the gastroenterologist, to ensure a clear treatment plan was available for the oncology team managing the patient.

Preliminary findings indicate that bothersome GI symptoms are common. Simple questionnaires can be helpful in enabling systematic assessment of symptoms requiring investigation. Tests selected using an easy-to-use algorithm can help identify causes of GI symptoms. Non-specialist nurses and AHPs can order these accurately and safely.

With further refinement, this model has the potential to transform the management of troublesome GI symptoms. This could improve patient outcomes by reducing chemotherapy treatment breaks and dose reductions and improving quality of life. We are now undertaking final data analysis.



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Runner-up

Redesigning an integrated model of community care

The North Manchester Macmillan Palliative Care Support Service is a multidisciplinary service that integrates AHP and clinical nurse specialist interventions in the community for complex cancer and palliative care patients.

The Macmillan Cancer Improvement Partnership initially funded this project to expand the current service provision and enable better access to holistic care. The service includes a palliative care consultant, clinical nurse specialist, occupational therapist, physiotherapist, dietitian and speech and language therapist, as well as an assistant practitioner and volunteer coordinator. The team has strengthened relationships with outreach complimentary therapy and lymphoedema services.

The team works with wider services to deliver cancer rehabilitation and end of life care in a person's preferred place of care and death. The service operates from 8am to 8pm, seven days a week, with a dedicated triage clinician who can respond to patients' needs in a timely manner.

A daily multidisciplinary team (MDT) meeting is led by the triage clinician to discuss updates and new referrals. This regular and consistent communication method enables early identification of symptoms that may require treatment or rehabilitation. This has increased care and support for people with cancer and their carers, relieving pressure and optimising patients' physical and psychological functioning.

This flexible and dynamic approach avoids duplication, streamlines patient care and avoids hospital admission.

The service has been designed to respond to the needs of a complex cancer population

in the community. All team members have a different and specialist skillset, however the triage role is undertaken by everyone. This requires an enhanced understanding of the different roles and interventions offered by each team member.

The traditional AHP role has been expanded, meaning we can deal with social crisis or acopia, and enable people to remain at home if this is their preferred place of care or death. There is a greater understanding of symptom control and we can advise people on their medication or signpost patients to the most appropriate health professional, so they feel supported.

Evaluation and expansion

Ongoing evaluation of the project has shown improvement on all national palliative care data sets, including meeting people's preferred place of care and death and leading to significant cost savings. This was reflected in a Care Quality Commission report which identified the significant service improvement and awarded an 'Outstanding' rating for compassionate care in March 2016.

There are now plans to adopt a seven-day model across the City of Manchester. The NMMPCSS now has the ability to influence the development of a city-wide service and promote the importance of a designated triage role.

With thanks also to Karen Walsh, Macmillan Speech and Language Therapist and Macmillan Dietitians Catherine Ferguson and Liz McCreery.

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Providing pre- and rehabilitation for prostate cancer patients



Runner-up

One of the most common side effects of treatment for prostate cancer is urinary incontinence. A local Transforming Cancer Follow-Up (TCFU) prostate audit demonstrated that only 33% of men felt they were supported to make lifestyle changes to maximise their health and wellbeing. This does not reflect the NICE Prostate guideline (2014), the Macmillan Consequences of Cancer Treatment document (2013) or the current health and social care board TCFU model.

Specialised continence physiotherapy is well recognised as a conservative approach to managing bladder, bowel and pelvic dysfunction. In Northern Ireland, this service is commissioned for women, but not for men, creating a basic health inequality.

An 18-month pilot was established in January 2015 with funding from Prostate Cancer UK to develop a referral pathway, a prehabilitation screening and education service and an intensive therapy clinic for patients undergoing radical prostatectomy. The project directly addresses this health inequality and ensures that wider issues, such as erectile dysfunction and cancer-related fatigue, are also considered.

Prior to the pilot, standard care was verbal advice on pelvic floor muscle exercises. Post-operative patients attended consultant reviews and were referred to community services for pads. There was no physiotherapy intervention for radiotherapy patients with bladder or bowel problems.

We wanted to increase opportunities for people to have a more active and healthy lifestyle, and enable more patients to return to employment, as well as improving social and emotional well-being.

After implementation, we have audited and analysed the results.

Analysis has shown that 81% of men referred agreed to a digital rectal examination, and of these, 59% needed instruction to improve their pelvic floor muscle technique.

The prehabilitation group had a lower incontinence score post-operatively, plus a better quality of life score after the physiotherapy intervention compared with those not seen. Men living with ongoing continence issues well beyond treatment showed the best improvement in leakage, which can only be attributed to physiotherapy intervention.

Challenges included a lack of knowledge of the benefits of effective and efficient physiotherapy, but strengthening communication links has ensured the full support and collaborative working of the multidisciplinary team.

This evidence-based project is easily transferrable to other urology oncology teams throughout the UK as physiotherapy skilled staff are already available who could replicate the service.

The pilot, which focused mainly on the surgical pathway, could be widened to support people using oncology services and patients with bladder or bowel dysfunction as a consequence of pelvic radiation or surgery for other tumour sites. However, funding remains a barrier to all new developments, and a creative approach to exploring different sources is required.

We have developed an innovative idea into a pilot and bid successfully for permanent funding through Macmillan. This could not have been achieved without support from the wider physiotherapy team, the surgical and oncology multidisciplinary teams, the cancer commissioners and the patient voice.

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Cancer training for allied health professional students

People living with and beyond cancer often experience late effects from the disease and associated treatment⁹.

Nurses and AHPs have a key role to play and it has been acknowledged that some may feel less confident and competent with various aspects of cancer care delivery¹⁰. Considering this and recognising the important role that AHPs play in caring for people living with and beyond cancer, a five-day Macmillan cancer course was piloted at Queen Margaret University in Edinburgh in May 2017.

The course, titled *The Individual with Cancer in Scotland*, was made available to AHP students with an interest in this area, and was delivered at the end of a semester with students participating in their own time. Four students applied, three studying occupational therapy and the other training in physiotherapy.

The course aimed to enhance students' knowledge of the wide variety of support experiences related to cancer diagnosis and treatment available for people in Scotland. Course content included:

- Exploration of common cancers and treatments
- Financial implications of a cancer diagnosis
- Communication skills
- Prehabilitation and rehabilitation
- Supported self-management
- Attending support services in the community e.g. Macmillan Move More
- The philosophy of palliative care

To ensure that we met the learning and development needs of the students we mapped the course content to the Macmillan AHP Competency Framework. The week-long programme consisted of modified

lectures, discussions and visits to Macmillan services in the community. The course was facilitated by the Macmillan Learning team and expert guest speakers.

Macmillan's patient and professional resources supplemented each session and the students were signposted to our learning and development resources.

Evaluation

The students completed pre- and post-course questionnaires, as well as separate evaluations at the end of each day. The results demonstrated that confidence levels and knowledge had increased and suggested that the new learning would be of great benefit for future placements. Three students said they would now consider a career caring for people affected by cancer.

One student said, 'Thank you for giving me a better insight into the different services Macmillan Cancer Support offers. It was such a positive learning experience! I feel a lot more equipped to talk to and signpost patients/families that I will come across on my clinical placement and in professional practice.'

We aim to deliver this course again next year, and would like to thank Professor Fiona Coutts, Dean of The School of Health Science and Joanna Beveridge, Lecturer in Occupational Therapy at Queen Margaret University, for their support.

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Award-winning AHP students

This summer, Macmillan provided four learning and development awards for final year AHP students at the University of the West of England in Bristol. The students' work was judged by Dr Mary Cramp, Associate Head of Department for Allied Health Professions (Research, Innovation and Knowledge Exchange), Andrea Maggs

from the Radiology and Oncology Team and Dr Anne Johnson from the Occupational Therapy Programme. The four winners came from a variety of professional backgrounds including occupational therapy, radiology and oncology and diagnostic imaging. The winners were:

Name of student	Degree programme	Title of research work
Mary-Jane Sweeting	BSc (Hons) Occupational Therapy	Exploring current practice in cancer rehabilitation: How do occupational therapists consider they are addressing the occupational needs of adults undergoing active cancer treatment?
Amy Walkman	BSc (Hons) Radiotherapy and Oncology	Standardisation of bowel and bladder preparation for prostate radiotherapy.
Grace Clarke	BSc (Hons) Diagnostic Imaging	An Evaluation of the Role of Molecular Imaging in the Detection of Breast Cancer for Women with Dense Breast Tissue.
Amelia Clark	BSc (Hons) Radiotherapy and Oncology	Communication Skills in Cancer and Palliative Care Module: A Qualitative Study Exploring Student Therapeutic Radiographer Perspectives.



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Resources

Further information

You can access the Macmillan Allied Health Professions Competence Framework and accompanying table at <https://www.macmillan.org.uk/about-us/health-professionals/resources/practical-tools-for-professionals.html>

The document also signposts to references and further reading.

Learnzone resources

Macmillan offers several e-learning courses for professionals supporting people with the consequences of cancer and its treatment. These include:

- Recovery Package toolkit
- Working with cancer
- Sexual relationships and cancer

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References:

¹ NICE (2004). Improving Supportive and Palliative Care for Adults with Cancer. Available at: <https://www.nice.org.uk/guidance/csg4> [Accessed 07/11/17].

² World Federation of Occupational Therapists (2012). Definition of Occupational Therapy. Available at: <http://www.wfot.org/AboutUs/AboutOccupationalTherapy/DefinitionofOccupationalTherapy.aspx> [Accessed 07/11/17].

³ Department of Health (2011). Enhanced Recovery Partnership Programme Report. Available at: <https://www.gov.uk/government/publications/enhanced-recovery-partnership-programme> [Accessed 07/11/17].

⁴ The Health Foundation (2015). A practical guide to self-management support: Key components for successful implementation.

Available at: <http://www.health.org.uk/publication/practical-guide-self-management-support> [Accessed 07/11/17].

⁵ NHS England. Commissioning Guidance for Rehabilitation (2016). Available at: <https://www.england.nhs.uk/publication/commissioning-guidance-for-rehabilitation/> [Accessed 07/11/17].

⁶ NCAT (2013). Cancer Rehabilitation: making excellent cancer care possible. Available at: http://webarchive.nationalarchives.gov.uk/20130612144748/http://ncat.nhs.uk/sites/default/files/work-docs/Cancer_rehab-making_excellent_cancer_care_possible.2013.pdf [Accessed 07/11/17].

⁷ Dietz, J.H (1980). Adaptive rehabilitation in cancer. *Postgraduate Medicine*. 68 (1): 145-153.

⁸ Healthy London Partnership and Macmillan Cancer Support (2017). Cancer rehabilitation: a scoping report for London. Available at <https://www.healthy london.org/resource/cancer-rehabilitation-scoping-report-london/> [Accessed 07/11/2017].

⁹ Macmillan Cancer Support (2013). Throwing Light on the Consequences of Cancer and its Treatment. Available at: <https://be.macmillan.org.uk/be/p-22572-throwing-light-on-the-consequences-of-cancer-and-its-treatment.aspx> [Accessed 07/11/17].

¹⁰ Faithful, S., Samuel, C., Lemanska, A., Warnock, C., Greenfield, D (2016). Self-reported competence in long term care provision for adult cancer survivors: A cross sectional survey of nursing and allied health care professionals. *International Journal of Nursing Studies*. 53, 85-94.