



The British  
Psychological Society



Division of  
Clinical Psychology

# Demonstrating Quality and Outcomes in Psycho-oncology

March 2015

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## Executive summary

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This report outlines a rigorous, multidimensional framework for evaluating quality and outcomes in psycho-oncology services, which can be flexibly adapted to local needs and priorities.

It aims to challenge psycho-oncology services to develop and standardise procedures that address the clinical and operational aspects of quality, while maintaining a firm focus on the experiential.

The proposed framework focuses on six key domains of service quality:

- Is this service *safe*?
- Is this service *equitable*, while also focused on those most in need?
- Is this service timely and *responsive*?
- Is this service respectful, collaborative and *patient-centred*?
- Is this service offering *effective* interventions?
- Is this service contributing to *efficient* multidisciplinary care?

To address these domains, psycho-oncology services need to draw on multiple, convergent sources of data, including key performance indicators, activity levels, patient self-report measures, feedback from professional colleagues, etc.

## Scope of this document

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The full detail of this guidance may be of most use to clinical services, while cancer managers and specialist commissioners may find the tailored summary (p.15) and checklist in Appendix II (p.21) useful.

This guidance covers psycho-oncology services for adults, including the teenager and young adult age range of 16–24. It includes consideration of cancer end-of-life care, but not the full range of palliative care services for other health conditions.

## Endorsements

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This guidance has been endorsed by the following organisations:

### The Faculty of Oncology & Palliative Care



The Faculty of Oncology & Palliative Care (SIGOPAC) is special group for clinical and counselling psychologists in cancer and palliative care within the British Psychological Society's Division of Clinical Psychology.

[www.bps.org.uk/sigopac](http://www.bps.org.uk/sigopac)

### British Psychosocial Oncology Society



The British Psychosocial Oncology Society is the national professional society dedicated to advancing education and research in psychosocial aspects of cancer.

[www.bpos.org](http://www.bpos.org)

### London Cancer



London Cancer is the integrated cancer system serving north east and central London and west Essex.

[www.londoncancer.org](http://www.londoncancer.org)

## Psycho-oncology services

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Psycho-oncology refers to the specialist field of psychological and mental health care for people affected by cancer. Psycho-oncology clinical services are offered by clinical and counselling psychologists as well as counsellors, liaison psychiatrists, psychotherapists and social workers. In the UK, psycho-oncology services are most frequently embedded within specialist cancer centres, general hospitals and hospices, working closely with oncologists, surgeons, cancer nurse specialists and palliative care teams, and spanning diagnosis to long-term survivorship and end-of-life care.

The scope of these services includes direct clinical care for patients, partners, carers and families, to address distress, risk, coping and adjustment, as well as input to cancer professionals through consultation, training, supervision and staff-focused care, as outlined in the NICE (2004) guidance on *Improving Supportive and Palliative Care for Adults with Cancer*, and the 2012 *National Cancer Peer Review Guidance for Psychological Support*.

## What do we mean by quality and outcomes?

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Quality in healthcare is recognised as a multidimensional concept. Effectiveness, patient experience and safety are the three core facets enshrined in the UK Health and Social Care Act 2012. These mirror the clinical, operational and experiential aspects of value as outlined in the academic healthcare quality literature (Young & McClean, 2008).

NHS services are being challenged to look beyond clinical and operational outcomes to the experiential elements. Specifically in cancer care, the recent Department of Health survey on *Quality of Life of Cancer Survivors in England* (Department of Health, 2012) sets a clear policy direction to address Domain 2 of the NHS Outcomes Framework: *Enhancing Quality of Life for People with Long-Term Conditions*. The use of quality of life surveys for cancer survivors is likely to be used to compare outcomes at different hospitals.

Following the Francis report (2013) the UK Government appointed Professor Don Berwick to carry out an independent review into patient safety (Department of Health, 2013). In previous work, Professor Don Berwick had proposed six distinct dimensions of quality care: *safe, effective, patient-centred, timely, efficient and equitable* (Committee on Quality of Health Care in America, 2001). These six dimensions are echoed in the plans for quality improvement in cancer services espoused by the Scottish Government's policy document *Better Cancer Care, An Action Plan* (NHS Scotland, 2008).

In England and Wales, the Care Quality Commission have introduced a new inspection model in 2014 (Quality Care Commission, 2014) that '...will look at the quality and safety of the care provided based on the things that matter to people. We will look at whether the service is: safe, effective, caring, responsive to people's needs, and well-led. Through this approach, we will have a richer and broader understanding of the quality provided.'

NHS Scotland's Cancer Taskforce has recently set out Quality Performance Indicators (QPIs) for every cancer specialty, as well as for patient experience overall (NHS Scotland,

2013). These cover communication, information provision and shared decision-making, with each domain being measurable through a detailed patient questionnaire.

Psycho-oncology services have a strong ethos of valuing patient experience. A recent internal survey of clinical psychologists from 48 cancer centres across the UK indicated that the large majority of services regularly gather and report patient satisfaction and experience data.

A key challenge for psycho-oncology services, therefore, will be to develop and standardise procedures that address the clinical and operational aspects of quality, while maintaining a firm focus on the experiential.

Outcomes, in turn, typically refer to measurements of the impact of an intervention. Typically, in the broader field of psychological therapies, this is achieved through a comparison of pre- and post-intervention scores on a specific set of measures, often patient-reported questionnaires (PROMs). For instance, IAPT services for common mental health problems have a predefined core dataset of symptom-focused measures such as the Patient Health Questionnaire (PHQ-9) and Generalised Anxiety Disorder Questionnaire (GAD-7) that are completed by the patient at every session. Equally, research trials in psychological interventions need to rigorously define very specific endpoint measures for their statistical conclusions to be considered valid.

Default adoption of such approaches may, however, be overly narrow and insufficiently patient-centred in the context of a much broader remit across the cancer diagnosis, treatment, survivorship and end-of-life care pathways.

Thus, beyond symptomatic relief, a broader range of outcomes may be of value to people with cancer and their families and carers at different stages; for example, an increased sense of control or hope, more open family discussions, improved relationships with staff, reduced illness intrusiveness, or even the space and containment to reflect, in itself, may be the person's most valued outcome.

Psycho-oncology services therefore need to consider the challenge of combining rigorous and valid measurement with capturing the outcomes that patients value and prioritise.

## A framework for quality and outcomes in psycho-oncology

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We suggest that the following six domains are considered when evaluating quality and outcomes in a psycho-oncology service:

- Is this service *safe*?
- Is this service *equitable*, while also focused on those most in need?
- Is this service timely and *responsive*?
- Is this service respectful, collaborative and *patient-centred*?
- Is this service offering *effective* interventions?
- Is this service contributing to *efficient* multidisciplinary care?

To address these domains, psycho-oncology services are encouraged to gather and consider multiple, convergent sources of data, including:

- Key performance indicators.
- Activity levels.
- Staff qualifications, accreditation and registration.
- Quantitative patient self-report measures.
- Qualitative patient feedback.
- Feedback from professional colleagues.
- Additional data sources.

This document will start by discussing the types and sources of data that can be routinely gathered in clinical practice. We will then put forward some suggestions for how to pull these sources together to address the above six domains.

## Data sources

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### (i) Key performance indicators

Key performance indicators (KPIs) are those discrete, meaningful and necessary steps in a process that can be observed and measured. These offer a robust way of tracking and measuring whether a complex process is occurring in a safe, consistent and reliable way.

In psycho-oncology services, relevant KPIs may include some of the following:

- Every new non-urgent referral is discussed at a weekly team meeting.
- The client (patient, carer, couple, etc.) is offered an appointment within the agreed timescale.
- The client is given a choice of appointment times.
- The appointment letter includes a patient information leaflet, etc.
- The person is seen within 10 minutes of their appointment time.
- The client completes a measure of well-being prior to the appointment.
- Risk (to self, others, children) is considered and documented.
- A plan is agreed with the person at the appointment and documented in the clinical notes.
- The client completes a session rating scale and/or patient experience form.
- The assessment/formulation is presented to the team meeting.
- Client and/or session data is entered into a database system.
- Feedback, including the agreed plan, is sent to the referrer (if outpatient) or discussed with the nurse or doctor on the ward.
- The person is sent a copy of written reports (unless opted out).
- Referrers are notified when a case is closed.

When a service or practitioner operates mostly within an explicit framework (e.g. prescribing medication, cognitive analytic therapy (CAT), cognitive behavioural therapy (CBT), psychosexual counselling), additional KPIs may be possible to define. For example:

- CBT: A clear session agenda is set in each session.
- CAT: The person is presented with a reformulation letter within 4–6 sessions.
- Prescribing: The person is presented with information on likely side-effects.

However, it is unlikely to be helpful to define KPIs too narrowly for therapeutic activity within a session, as these will risk making clinical practice rigid and diverting the practitioner from being primarily person-centred, collaborative and flexible.

KPIs that address the domains of quality as described above can be defined locally after a careful consideration of the clinical process and the specific local context. For example, relevant KPIs in community palliative care will differ from KPIs in acute oncology services, and KPIs for a service run by a sole practitioner at a district general hospital will be different to those of a multi-professional team at a tertiary cancer centre.

The process of reviewing KPIs can be registered as an audit and measured either continuously, through routinely entering the relevant data within a clinical activity database, or at specific intervals (e.g. a one-month sample of data every six or twelve months).

## **(ii) Activity levels**

The quality of a psycho-oncology service will be related to its workload, and it is important that this be maintained at a balanced level to ensure a sustainable, good quality service that attracts and retains the highest calibre staff.

Comparison of activity data from services across the UK yielded an average of around 120 new cases per year for a Level 3/4 professional with a full-time clinical focus.

There is expected to be broad variation around this figure, depending on role, therapeutic orientation, local priorities and service structures. For example a psychotherapist may have fewer but highly complex cases; a Band 7 psychologist offering in-patient solution-focused consultations may see considerably more, and a consultant psychologist responsible for a team's service development and governance would have fewer clinical days and fewer new cases.

The level of activity needs to allow for psycho-oncology professionals to provide the full range of input suggested by the NICE (2004) guidance, including seeing in-patients, outpatients, carers and families for assessment and direct therapeutic work, recording notes and writing reports, offering consultation, participating in some multidisciplinary meetings, offering formal training and supervision to Level 2 colleagues, running patient and staff support groups, contributing to multidisciplinary health and well-being programmes, engaging in service development activity and receiving adequate clinical supervision for their own caseload.

Specialist, national or tertiary services will also likely have different needs and constraints. For example, a professional working only within a national neuro-oncology surgery centre may see few patients but provide intense and time-consuming input, while one working in a regional team for teenagers and young adults may see all the young people on regular schedule of reviews.

Sustainable activity levels are integral to organisational efficiency as well as patient outcomes, service quality and staff well-being. Howard et al. (2010) and Moore et al. (2007) found that the costs of psychological therapies were offset by resulting savings to the NHS on physical care, while a recent report by Arving et al. (2014) demonstrated that during the first two years of adjuvant treatment for breast cancer in Sweden, individual psychological support showed lower care costs and improved quality-adjusted life years compared to standard care alone, while accounting for only three per cent of total healthcare costs. These efficiencies, demonstrated in a research setting, are only likely to be achieved in clinical setting when there is sufficient resource to implement them coherently.

Survey data from across the UK also suggested that patients, on average, were seen for 4–8 appointments, with a subset receiving considerably longer (e.g. 16+ sessions). It is important to acknowledge that such variation is expected and indeed required in order to provide for the full range of patient needs, from a single consultation with a carer discussing how to cope with a sudden hospitalisation, to a structured psychotherapeutic intervention with an individual with past trauma and ongoing social adversity receiving palliative treatment.

In addition, many services identify waiting times and rates of non-attendance as related metrics. National data suggests that services typically aim to offer appointments within 30 days (four weeks) for routine outpatients, and within 2–7 days for in-patients. Individual clinicians also reported rates of 10–25 per cent of appointments missed or cancelled, with this variance reflecting multiple differences in data recording as well as service setups (e.g. whether referrals have been triaged, whether initial appointments are set up by phone or letter).

### **(iii) Staff qualifications, registration/accreditation and supervision**

All psycho-oncology services should be able to demonstrate full compliance with National Cancer Peer Review (2012) requirements, which specify that all Level 3/4 practitioners hold specified professional qualifications and full current registration (e.g. HCPC, GMC) or accreditation with the relevant professional body (e.g. BACP, UKCP).

The relevant professional bodies will also have specific requirements for clinical supervision, continuous professional development, fitness to practice, professional codes of conduct, etc. For clinical and counselling psychologists, these requirements are set by the Health and Care Professions Council and the British Psychological Society, for instance the DCP Policy on Supervision (2014) for clinical psychologists.

### **(iv) Quantitative patient self-report measures**

Patient self-report measures used by psycho-oncology services in the UK can broadly be clustered into three groups:

(i) Psychometric questionnaires in validated formats with standardised norms focusing on symptomatology, and aspects of adjustment or quality of life that are used clinically, such as the Hospital Anxiety and Depression Scale (HADS), General Health Questionnaire (GHQ), CORE Outcome Measure (CORE-EM), Profile of Mood States (POMS), Beck Depression Inventory (BDI-II), Generalised Anxiety Disorder Assessment (GAD-7), Patient Health Questionnaire (PHQ-9), Impact of Event Scale (IES), Mental Adjustment to Cancer (MAC), Functional Assessment of Chronic Illness Therapy (FACIT), Functional Assessment of Cancer Therapy – General (FACT-G), Warwick-Edinburgh Mental Wellbeing Scale (WEMWBS) or EORTC-QLQ.

(ii) Those which focus on the therapeutic process and the patient's experience of the relationship (e.g. the Miller SRS or CORE's ARM-5). Such measures offer the key advantage of focusing on the common factors of therapy, thus being acceptable and applicable to a broad mix of professional backgrounds and therapeutic orientations.

(iii) Idiographic measures which ask the patient to rate their progress towards an individualised set of therapy aims (goal-attainment scaling) (e.g. PSYCHLOPS (Ashworth et al, 2012) or the CORE Goal Attainment Form).

Each of these measures has its use cases, advantages and limitations, and it is outside the scope of this document to list them all. Helpful guidance can be found in a review paper by Luckett et al. (2009); a literature review by the New South Wales Cancer Institute (2008); the CORE Information Management Systems website (CORE IMS, n.d.); and publications from the PROMIS Group (e.g. Garcia et al., 2007), a project by the US National Institute of Health to develop valid, responsive and low-burden patient-reported measures for clinical trials in oncology.

We do not feel that at present a specific set of measures can be definitively recommended for national use in psycho-oncology. We would instead suggest that, where possible, network-level collaborative groups can provide guidance to local services that can best fit local needs and priorities.

We would encourage services to consider a combination of these measures, to yield complementary data on different aspects of clinical outcomes. It is important to establish that any measures selected have established reliability and validity, use normative data from UK cancer populations (published or locally sourced), do not place an undue burden on patients, and are practical to score and record in routine practice. In addition, services are advised to ensure they comply with all copyright/licensing restrictions for the selected measures.

## **(v) Qualitative patient feedback**

On the whole, psycho-oncology services have a strong patient-centred ethos and frequently gather patient feedback using customised local surveys, covering aspects such: as facilities and resources; access and waiting times; timing and frequency of sessions; and the professionalism, warmth and skill of the practitioner.

Strong consideration should be given to co-developing surveys with the active involvement of patients, carers and families, and clinical colleagues. Equally, it is worth noting the potential for using standardised NHS Patient Experience Surveys. These may not be directly tailored for psycho-oncology services, and thus may be overlooked by clinicians, but can offer useful benchmarking with other services within an organisation as well as nationally. The online NHS Surveys service (see [www.nhssurveys.org/surveys/479](http://www.nhssurveys.org/surveys/479)) offers questionnaire creation tools so that any organisation can carry out customised local patient surveys using the same questions and approach as are employed in the NHS patient survey programme.

To be fully valid as evidence of quality, all surveys have to comply with local audit guidelines and be drawn from an adequately broad sample of the client group.

## **(vi) Feedback from professional colleagues**

A key part of the mission of psycho-oncology services is offering specialist advice and consultation, supervision, skills training and personal development to all healthcare professionals in cancer care, including junior and senior medical, nursing and allied health staff.

Delivering Level 2 training programmes and ongoing supervision to Level 2 keyworkers are core elements of National Cancer Peer Review. Services may additionally be involved in Level 1 staff training (e.g. Sage & Thyme training), reflective practice groups with teams,

multidisciplinary patient support & education groups, joint clinics, and staff-support activities such as Schwartz Rounds (King's Fund, 2011).

All these activities offer excellent opportunities to systematically gather information from professional colleagues on the impact, quality and utility of psycho-oncology services when contributing to an individual's knowledge, skills and practice, as well as the overall clinical team and its functioning.

Such feedback from colleagues may be elicited through established instruments (e.g. the Manchester Clinical Supervision Scale; Winstanley & White, 2011), the standardised course evaluation questionnaires in a Level 2 training package (e.g. Jenkins & North, 2008), or the Miller Session Rating Scale (SRS) used by staff in a supervision session.

When looking at input to the organisational and teams level, data from NHS staff surveys (www.nhsstaffsurveys.com), which are widely performed by Trusts, may be relevant.

Additionally, feedback may be gathered through measures devised locally and tailored to a specific context. For instance, at Guy's and St Thomas' Hospitals, London, a monthly supervision group for occupational therapists and physiotherapists in oncology, facilitated by a clinical psychologist in training, collaboratively developed their own evaluation measure, addressing process, content and confidence in key skills (see Appendix I).

## **(vii) Additional data sources**

### **Audit Portfolio**

A portfolio that presents the audit track record of a psycho-oncology service can usefully contribute to a report on outcomes and quality. Past audits may not be directly linked to the KPIs listed above, however they can demonstrate a commitment to transparency and clinical governance.

### **Case studies**

A portfolio of clinical case studies, which illustrate the clinical challenges and complexities that the psycho-oncology service has addressed, can be a useful chapter in a report on outcomes and quality.

Cases studies can vividly demonstrate the value of psychological care to the individual and organisation, and highlight issues of risk, multidisciplinary working, multi-modal intervention, cost savings and patient experience that may be otherwise hard to quantify.

### **Clinical research collaborations**

Teams which are involved in clinical research (e.g. contributing to a research steering group within an Academic Health Sciences Centre or facilitating the research recruitment for a psychologist in clinical training) can usefully add these activities in a report on outcomes and quality, as a demonstration of commitment to advancing evidence-based psychological care.

### **Compliments and complaints**

A portfolio of the compliments and complaints (and how these were addressed) can be another aspect of a report on outcomes and quality, as a demonstration of responsiveness to patient feedback.

# Addressing outcomes and quality

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The following section will outline how the data sources outlined above can address the six core domains of outcomes and quality.

## **(i) Is this service safe?**

The following KPIs can be relevant in addressing safety, either via directly addressing patient risk or through providing oversight of individual clinicians:

- referrals discussed at a weekly team meeting;
- risk (to self, others, children) is considered and documented;
- a plan is agreed with the person at the appointment and documented in the clinical notes;
- the assessment/formulation is presented to the team meeting; and
- referrers are notified when a case is closed.

Data on safety should also include information on clinician workloads (including consideration of referral trends), their registration status with regulatory and professional bodies (e.g. BACP, HCPC), their access to CPD, and their attendance at clinical supervision (as set out in professional guidance).

The use of evidence-based interventions should be considered in this section. Though there is a body of evidence in psycho-oncology that can direct clinicians towards using certain therapeutic modalities and procedures, it is not at this stage definitive enough to warrant firm recommendations. There can therefore be considerable latitude between clinicians, and this variability can indeed be welcome by patients who may feel some approaches suit them better than others.

Nevertheless, consideration should be given to ensuring that interventions remain within recognised safe practices. Supervision, peer observation and joint clinics can be useful in this regard, and can be reported in this domain.

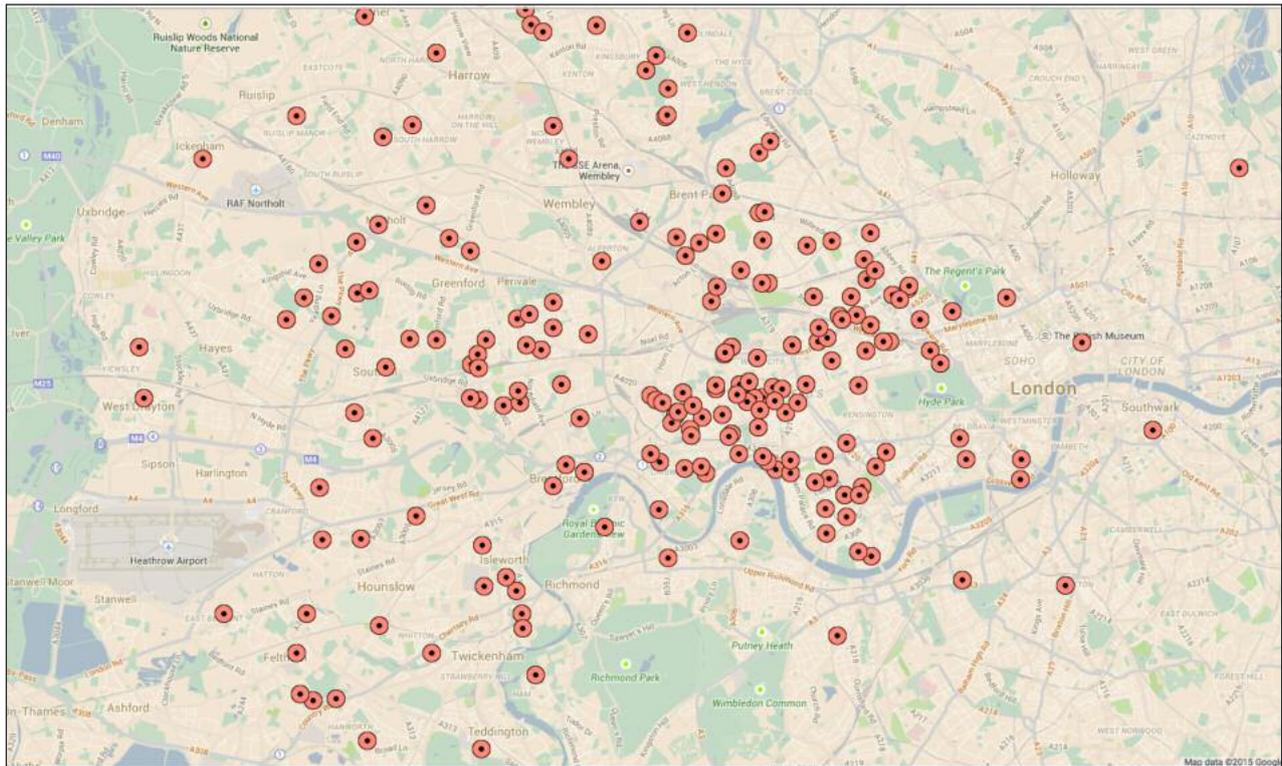
Finally, the service audit portfolio, and a listing of any critical incident reports or 'near misses' will also be relevant.

## **(ii) Is this service equitable, while also focused on those most in need?**

National Cancer Peer Review guidance suggests that between 10 and 15 per cent of people with cancer will need specialist Level 4 and Level 3 intervention (respectively) in their first year after diagnosis. As well as these broad parameters, it may be possible to outline particular subgroups with documented local or national evidence of higher rates of vulnerability to distress (for example, patients with young children) or risk (for example, older men with head and neck cancer who live alone).

Data on age, sex, marital status, cancer stage, past history of mental health difficulties and/or treatments, drug/alcohol dependence, poorly controlled pain, chronic comorbid illness burden, and quantitative self-report measures of distress (e.g. HADS) from the patients seen in the service can be compared to local cancer centre data to indicate whether the profile of referrals to the service is indeed that of the most in need.

Figure 1: An example of referrals mapping for a service in west London



As well as focusing on the most vulnerable, the broader domain of equity needs to be addressed by considering whether services are also offered equitably to all patients with cancer, and their families and carers.

Data on age, sex, ethnicity, tumour type, disease stage, employment, referral source, distance from clinic, etc. can also be compared to local cancer and palliative care registers to ensure that any systematic divergence is identified and considered.

The postcode information of patient referrals can also be easily mapped using online tools (e.g. batchgeo.com) to provide a visual representation of accessibility – see Figure 1.

Finally, evidence of collaboration in clinical research on psychological aspects of cancer, and how findings were introduced to clinical practice can also be useful to address this domain.

### **(iii) Is this service timely and responsive?**

Data on actual versus target waiting times, and whether or not patients and families/carers are able to self-refer, can address this domain. Rates of re-referrals can also be considered an indicator of a responsive service, to which patients will return to at times of need.

Offering patients choices over appointment times and frequency of sessions may also be positive indicators, while unduly high rates of cancellations and nonattendance may indicate a real or perceived lack of responsiveness.

### **(iv) Is this service respectful, collaborative and patient-centred?**

This domain can be addressed through qualitative patient experience data:

- at the level of the service (for instance, procedures in booking or cancelling appointments, adequacy of facilities, clinics running on time, etc.) – this may best be done through standardised local and national patient experience surveys; and
- at the level of the individual clinician, through measures such as the SRS or ARM-5 which focus on the therapeutic relationship and process; also, the clinical use of patient-defined goal-setting tools can in itself also be a positive indicator of collaborative care.

Additionally, evidence of involvement of service users in the evaluation of the service, for instance through a patient focus group to identify valued outcomes to be monitored, would be highly relevant in this domain.

### **(v) Is this service offering effective interventions?**

Quantitative patient self-report measures may best address this domain, though the distinct context of cancer care must be taken into account when interpreting this data.

In contrast to psychological therapy ‘packages’ (e.g. cognitive-behavioural therapy for obsessive-compulsive disorder) that are more typical in community mental health services, many fewer people seen in a psycho-oncology service will require or be able to attend a pre-defined ‘package’ of regular psychological therapy sessions, and may instead access the service at irregular intervals, with issues that will vary in relation to their cancer pathway.

For the subset of patients who do take up a formal individual or group therapy contract for a set number of sessions, services often gather pre-post data which can be analysed and presented as directly relevant to this domain. For the subset of patients who may be seen for one-off consultations or at irregular intervals, measures such as the SRS and the ARM-5 Therapeutic Alliance measure gather data on the quality of the therapeutic relationship and how well the therapist has achieved consensus on goals, method and approach, within the single session. The Birmingham and Solihull Clinical Health Psychology service routinely collect both SRS (Duncan et al, 2003) and ORS (Outcome Rating Scale; Miller et al, 2007) data at first and last outpatient sessions, and have shown that both improve significantly within this timescale (Pereira et al, 2014).

### **(vi) Is this service contributing to efficient multidisciplinary care?**

Attending to the psychological care of patients and the broader patient experience within an organisation will contribute to more efficient care and reduced costs associate with poor mental health in patients and stress in staff.

Psycho-oncology services are attentive to these organisational needs and address them in a variety of ways; for instance, through advising on care pathways being designed around psychological needs (e.g. attachment relationships), improving staff skills in identifying and responding to distress (e.g. Sage and Thyme training), supporting staff teams dealing with a complex death on a ward, etc.

Thus, as well as feedback from professional colleagues, data on the proportion of time engaged in Level 1/2 teaching, training, supervision and consultation will be directly relevant to this domain.

Additionally, the following general KPIs may be relevant:

- feedback, including the agreed plan, is sent to the referrer; and
- referrers are notified when a case is closed.

More specific KPIs can be added in specific clinical areas – for instance, a cancer genetics tertiary clinic can set a KPI that all BRCA+ patients will have a session with a Level 4 professional after diagnosis.

Case reports can give a much richer account of how psycho-oncology specialists help their clinical colleagues understand and respond to patient’s psychological needs, and can be very useful to include in this domain. Project reports from team activities to improve operations within the wider organisation will also apply.

## Summary

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Quality in healthcare is recognised as a multidimensional concept, with clinical, operational and experiential aspects. In parallel, outcomes need to look beyond the narrow confines of symptom reduction to consider the full breadth of what is of most value to service users and cancer professionals.

Psycho-oncology services have a strong ethos of gathering patient experience and satisfaction data, and are increasingly focusing on designing and standardising procedures that will address the clinical and operational domains.

To facilitate psycho-oncology services, cancer managers and specialist commissioners seeking to evaluate quality and outcomes in psycho-oncology services, this report outlines a robust, multidimensional framework that can flexibly be adapted to local needs and priorities.

The proposed framework focuses on six key domains of service quality:

- Is this service *safe*?
- Is this service *equitable*, while also focused on those most in need?
- Is this service timely and *responsive*?
- Is this service respectful, collaborative and *patient-centred*?
- Is this service offering *effective* interventions?
- Is this service contributing to *efficient* multidisciplinary care?

To address these domains, psycho-oncology services need to draw on multiple, convergent sources of data, including key performance indicators, activity levels, patient self-report measures, feedback from professional colleagues, and so on. Some examples and practical suggestions are set out, while also fully recognising that local contexts and practices vary too widely to allow for firm national recommendations on specific self-report measures, activity levels, etc.

## Summary for cancer managers and commissioners

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Psycho-oncology professionals work closely alongside cancer teams within medical settings to address the broad range of psychological support and mental health needs of patients with cancer, their partners, families and carers; and offering consultation, training, supervision and staff-focused care, as set out in the NICE (2004) guidance on *Improving Supportive and Palliative Care for Adults with Cancer*, and the 2012 *National Cancer Peer Review Guidance for Psychological Support*.

Psycho-oncology services are staffed by clinical and counselling psychologists as well as counsellors, liaison psychiatrists, psychotherapists and social workers. Clinicians often share a strong holistic and patient-centred ethos, with assessment and intervention adapted to each person and their cancer pathway, rather than delivered as a pre-defined, structured package. As well as addressing distress, psychological care in cancer can lower care costs and improve quality-adjusted life years (QALYs) (Arving et al., 2014).

This report outlines a broad, multidimensional yet rigorous framework for evaluating quality and outcomes in psycho-oncology services. We encourage all psycho-oncology services to draw on this framework, adapting it to their specific local setting, workforce, priorities and practices, to develop a thorough and transparent local report about their service.

A report should address the following core domains of quality and outcomes:

- Is this service *safe*?
- Is this service *equitable*, while also focused on those most in need?
- Is this service timely and *responsive*?
- Is this service respectful, collaborative and *patient-centred*?
- Is this service offering *effective* interventions?
- Is this service contributing to *efficient* multidisciplinary care?

Psycho-oncology services need to draw on multiple, convergent sources of data to address these domains, including process KPIs, activity levels, response times, patient reported outcome measures (PROMs), training and supervision outcomes.

In this document we explicitly do not set out firm recommendations on aspects of service specification and standards, such as workforce levels, waiting times, activity levels, etc. However, these parameters clearly have a direct bearing on outcomes and quality, and thus we do give some broad guidance, based on evidence drawn from our survey of practitioner psychologists and expert consensus from within our national special interest group.

To support cancer managers and specialist commissioners in agreeing and reviewing quality and outcome standards for psycho-oncology services, we offer a checklist as a broad starting point (see Appendix II).

## Report authors

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This report has been written by Dr Alex King, with major contributions from the British Psychological Society's Faculty for Oncology and Palliative Care (SIGOPAC) committee, and especially Dr Jonnie Raynes, Dr Nadine Hobro, Dr Robin Paijmans and Dr Inigo Tolosa, and input from the expert reference group at the SIGOPAC York workshop in November 2012.

The content was further refined with feedback from SIGOPAC membership consultation (October–December 2013), a workshop at the British Psychosocial Oncology Society Annual Conference (February 2014) and feedback from Dr Catherine Dooley, Chair of the BPS DCP Professional Standards Unit (June 2014).

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## References

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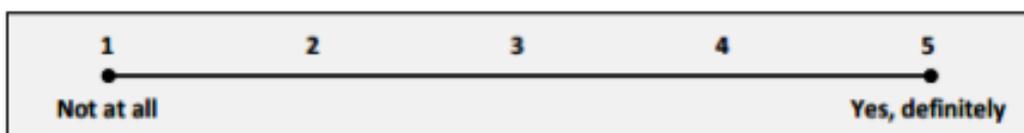
- Arving, C., Brandberg, Y., Feldman, I., Johansson, B. & Glimelius, B. (2014). Cost–utility analysis of individual psychosocial support interventions for breast cancer patients in a randomized controlled study. *Psycho-Oncology*, 23, 251–258.
- Ashworth, M., Kordowicz M. & Schofield, S. (2012). ‘PSYCHLOPS’ (Psychological Outcome Profiles): An outcome measure. *Integrating Science and Practice*, 2, 36–39.
- Cancer Institute New South Wales (2008). *Using Patient-Reported Outcomes in a Health Setting*. Factsheet 31. Retrieved from [www.cancerinstitute.org.au/media/144048/2011-1-31\\_factsheet\\_using-patient-reported-outcome-measures-in-cancer-setting.pdf](http://www.cancerinstitute.org.au/media/144048/2011-1-31_factsheet_using-patient-reported-outcome-measures-in-cancer-setting.pdf)
- Care Quality Commission (2014). *Our New Inspection Model*. Newcastle upon Tyne: Author. Retrieved from [www.cqc.org.uk/content/our-new-inspection-model](http://www.cqc.org.uk/content/our-new-inspection-model)
- Committee on Quality of Health Care in America (2001). *Crossing the Quality Chasm: A new health system for the 21st century*. Washington, DC: Institute of Medicine. Retrieved from [www.nap.edu/catalog/10027/crossing-the-quality-chasm-a-new-health-system-for-the](http://www.nap.edu/catalog/10027/crossing-the-quality-chasm-a-new-health-system-for-the)
- CORE IMS (n.d.). *Measurement and Assessment Tools*. Rugby: Author. Retrieved from [www.coreims.co.uk/About\\_Measurement\\_Tools.html](http://www.coreims.co.uk/About_Measurement_Tools.html)
- Department of Health (2012). *Quality of Life of Cancer Survivors in England Report on a pilot survey using patient reported outcome measures (PROMS)*. London: Author. Retrieved from [www.gov.uk/government/publications/cancer-survivors-give-their-views-in-pilot-survey](http://www.gov.uk/government/publications/cancer-survivors-give-their-views-in-pilot-survey)
- Department of Health (2013). *A promise to learn – a commitment to act: Improving the safety of patients in England*. London: Author. Retrieved from [www.gov.uk/government/publications/berwick-review-into-patient-safety](http://www.gov.uk/government/publications/berwick-review-into-patient-safety)
- Department of Health (2013, 25 May). *Expansion of groundbreaking scheme to support NHS staff* [Press release]. Available from [www.gov.uk/government/news/expansion-of-groundbreaking-scheme-to-support-nhs-staff](http://www.gov.uk/government/news/expansion-of-groundbreaking-scheme-to-support-nhs-staff)
- Duncan, B.L., Miller, S.D., Sparks, J.A., Claud, D.A., Reynolds, L.R., Brown, J. & Johnson, L.D. (2003). The Session Rating Scale: Preliminary psychometric properties of a ‘working’ alliance measure. *Journal of Brief Therapy*, 3(1), 3–12.
- Francis (Chair) (2013). *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry*. London: The Stationery Office. Retrieved from [www.midstaffspublicinquiry.com](http://www.midstaffspublicinquiry.com)
- Garcia, S.F., Cella, D., Clauser, B.S., Flynn, K.E., Lad, T., Lai, J-S., Reeve, B.B., Wilder-Smith, A. Stone, A.A. & Weinfurt, K. (2007). Standardizing patient-reported outcomes assessment in cancer clinical trials: A patient-reported outcomes measurement information system initiative. *Journal of Clinical Oncology*, 25(32), 5106–5112.
- Howard, C., Dupont, S., Haselden, B., Lynch, J., Wills, P. (2010). The effectiveness of a group cognitive-behavioural breathlessness intervention on health status, mood and hospital admissions in elderly patients with chronic obstructive pulmonary disease. *Psychology, Health and Medicine*, 15(4), 371–385.

- Jenkins, K. & North, N. (2008). *Psychological Assessment Skills: A training course for all health care professionals and social care staff working in cancer services*. Salisbury: Salisbury NHS Foundation Trust.
- Kingsfund (2011). *Schwartz Center Rounds: Evaluation of the UK pilots*. London: Author. Retrieved from [www.kingsfund.org.uk/publications/schwartz-center-rounds-pilot-evaluation](http://www.kingsfund.org.uk/publications/schwartz-center-rounds-pilot-evaluation)
- Luckett, T., Butow, P. & King, M. (2009). Improving patient outcomes through the routine use of patient-reported data in cancer clinics: future directions. *Psycho-Oncology*, *18*, 1129–1138.
- Miller, S.D., Duncan, B. L., Sorrell, R. & Brown, G.S. (2005). The partners for change outcome management system. *Journal of Clinical Psychology*, *61*(2), 199–208.
- Moore, R.K., Groves, D.G., Bridson, J.D., Grayson, A.D., Wong, H., Leach, A., Lewin, R.J. & Chester, M.R. (2007). A brief cognitive-behavioural intervention reduces admission in refractory angina patients. *Journal of Pain Symptom Management*, *33*(3), 310–316.
- NHS Scotland (2008). *Better Cancer Care, an Action Plan*. Edinburgh: Scottish Government. Retrieved from [www.scotland.gov.uk/Publications/2008/10/24140351/16](http://www.scotland.gov.uk/Publications/2008/10/24140351/16)
- NHS Scotland (2013). *Cancer Quality Performance Indicators (QPIs): Cancer patient experience quality performance indicators*. Edinburgh: Healthcare Improve Scotland. Retrieved from [www.healthcareimprovementscotland.org/our\\_work/cancer\\_care\\_improvement/programme\\_resources/cancer\\_qpis.aspx](http://www.healthcareimprovementscotland.org/our_work/cancer_care_improvement/programme_resources/cancer_qpis.aspx)
- NICE (2004). *Improving Supportive and Palliative Care Services for Adults*. London: Author. Retrieved from [www.nice.org.uk/guidance/csgsp](http://www.nice.org.uk/guidance/csgsp)
- Pereira, B., Brookes, S., Court, D., Phull, M. & Tolosa, I. (2014). Using patient-directed and outcome-informed outcome measures with psycho-oncology patients in a clinical health psychology setting. Poster presentation at the 2014 British Psycho-Oncology Society Annual Conference. *Psycho-Oncology*, *23* (Supp 2), 12. DOI: 10.1111/pon.3495
- Winstanley, J. & White, E. (2011). The MCSS26: Revision of the Manchester Clinical Supervision Scale using the Rasch Measurement Model. *Journal of Nursing Measurement*, *19*(3), 160–178.
- Young, T. & McClean, S. (2008). A critical look at Lean Thinking in Healthcare. *Quality and Safety in Health Care*, *17*, 382–386.

# Appendix I: A co-designed evaluation of a reflective practice/supervision group

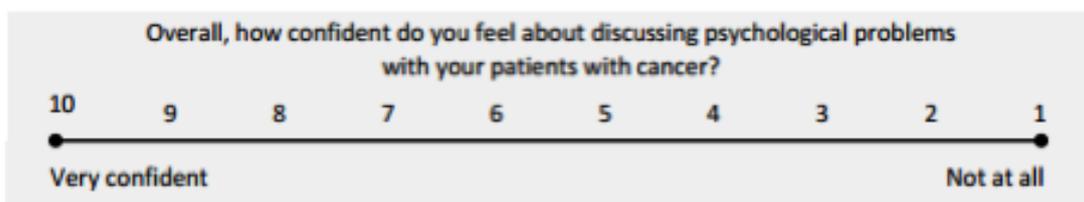
## Level 2 Group – Feedback Form

Please consider your experience of the group **today** and rate each question using the scale below:



Today I felt..	Rating
1 ..that this group is a safe space to reflect, ask questions, share my ideas and experiences	_____
2 ..supported by other people in the group	_____
3 ..that when I shared something with the group I felt heard by other group members	_____
4 ..other group members treat my contribution with respect when I shared something with the group	_____
5 ..reassured that what I am doing as a professional to support cancer patients is good enough	_____
6 ..that the way cases are discussed in this group is helpful for me	_____

Today I..	Rating
7 ..thought about how to look after myself	_____
8 ..shared or addressed an issue relevant to working with cancer patients	_____
9 .. come away from the group understanding a bit more about the experience and needs of a person with cancer	_____
11 ..come away from the group understanding a bit more about responding to patient distress	_____
12 ..come away from the group having learnt something useful about how to deal with challenging situations with my patients and their families	_____



At Guy's and St Thomas' Hospitals, London, the clinical psychologist in training offers a well-established monthly supervision group for ward-based occupational therapists and physiotherapists in oncology. The group worked collaboratively to develop their own evaluation measure that addresses process, content and confidence, and has been using this at regular intervals.

An adapted version for a wider range of clinical nurse specialists and Allied Health Professionals groups was developed with input from Dr Anna Janssen, Dr Joanne McVey, Dr Kirsty Kennedy and Dr Alex King.

This version is presented below under a Creative Commons Attribution-NonCommercial-ShareAlike 4.0 International License (see [creativecommons.org/licenses/by-nc-sa/4.0/](https://creativecommons.org/licenses/by-nc-sa/4.0/)).

For more information and the latest version, contact Dr Anna Janssen ([anna.janssen@gstt.nhs.uk](mailto:anna.janssen@gstt.nhs.uk)).

# Appendix II: Service quality and outcomes checklist

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## Safe

- All clinical staff appropriately registered/accredited.
- All clinical staff receive regular clinical supervision in line with professional guidance.
- All clinical staff undertake CPD in line with professional guidance.
- Clear procedures for governance of risk.
- Service performs audit relating to safety or risk.
- Clinical activity levels are within locally agreed range.
- Demonstration of commitment to evidence-based practice.

## Equitable

- Data on age, sex, ethnicity, cancer type and stage, level of distress, case complexity, etc. is captured on each referral.
- Data is analysed and reported regularly.
- Data from referrals is compared to data from the cancer service, local cancer registry and local population.
- Unequal take-up or unmet need is identified and considered.

## Responsive

- Service meeting in-patient response targets.
- Service meeting out-patient response targets.
- Service monitors did not attend (DNA) rates.

## Patient-centred

- Regular patient experience survey, with plans to address any issues raised.
- Patients offered a flexible choice of appointment times.
- Service accepts self-referrals.
- Use of therapeutic relationship patient-reported questionnaires (PROMs).

## Effective

- Locally agreed PROMs.
- Service collects and reports PROMs.
- Illustrates effective impact with case studies of direct and indirect work.

## Efficient

- Service always provides feedback to cancer clinicians and GPs.
- Service gathers and reports outcomes of Level 2 training.
- Service gathers and reports outcomes of Level 2 supervision.
- Illustrates efficient working with case studies of direct and indirect work.

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