

**“Stepping off a cliff and hoping the
parachute will open.”
The challenge of developing regional
psychosocial cancer services**

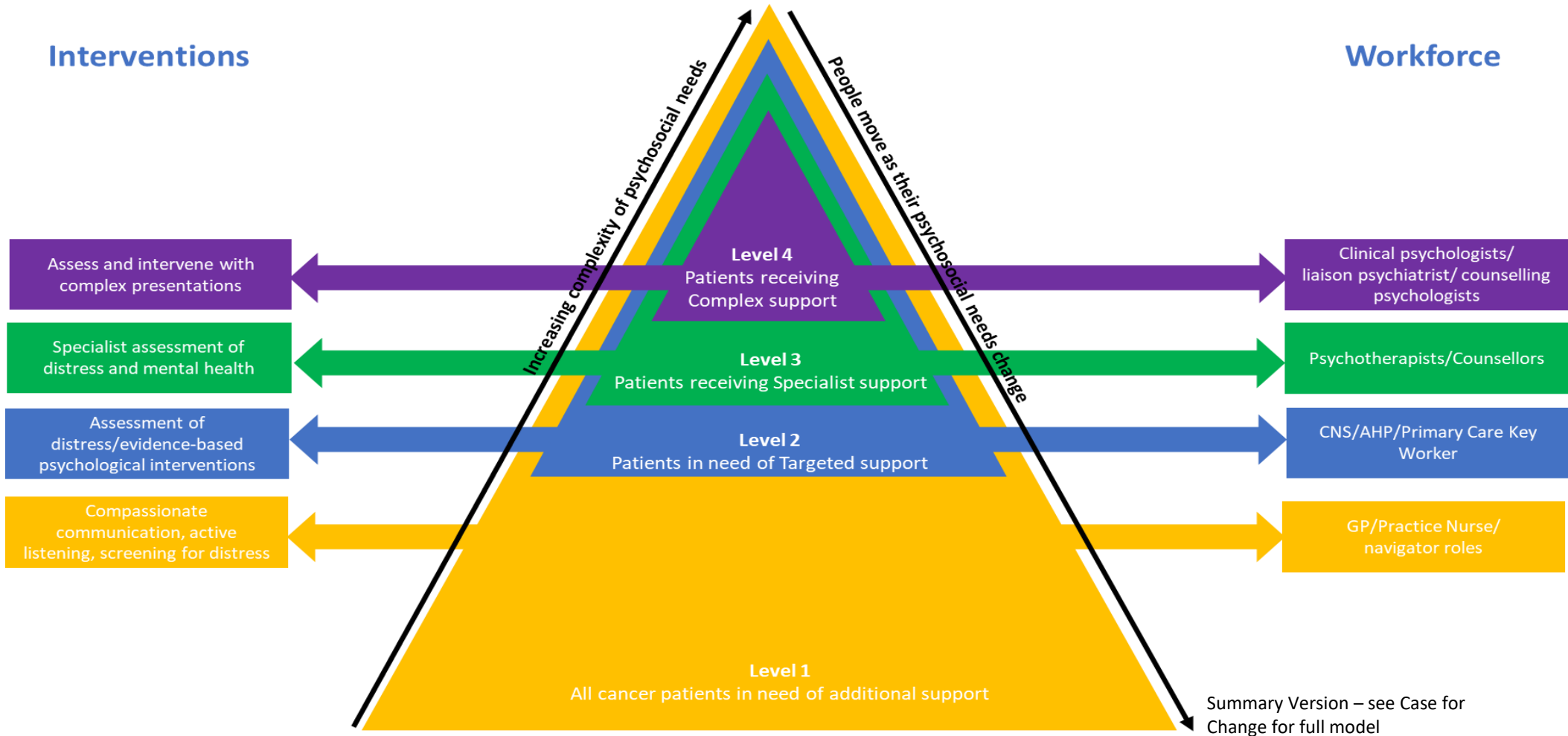
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Evidence of need

- In the year following diagnosis, around 10% of patients will experience symptoms of anxiety and depression severe enough to warrant intervention by specialist psychological/psychiatric services.
- For patients who experience recurrence of disease, the prevalence of anxiety and depression rises to 50%. Such difficulties can also be seen in 10-15% of patients with advanced disease
- 58% of people diagnosed feel their emotional needs are not looked after as much as their physical needs
- Cancer patients have a 55% higher risk of suicide than those without cancer
- Even 10 years after treatment, 54% of cancer survivors still suffer from at least one significant psychological issue
- 67% of carers experience anxiety and 42% experience depression. Of these, over three quarters do not receive any support

EMCA Psychosocial Care Model



The underpinning principles of the **EMCA Psychosocial Care Model** are preventing distress & promoting adjustment through:

- Shared decision making
- Personalised care and support planning
- Patient activation/(supported) self-management
- Social prescribing
- Population: people affected by cancer

Based on the **NICE 4-Level Psychological Assessment Framework**

(ref: *Improving supportive and palliative care for adults with cancer*, 2004)

Recommendations

- 1. All ICSs adopt and localise the end to end pathway model to ensure that the psychosocial needs of those affected by cancer are met.**
- 2. Psychosocial support for people affected by cancer will be available for the whole cancer pathway from diagnosis to end of life.**
- 3. People affected by cancer will have access to a range of emotional and psychosocial support according to need (NICE care levels 1-4).**
- 4. All 4 levels of psychosocial care will be available to people affected by cancer whether accessing cancer care through primary, secondary or tertiary services.**
- 5. People affected by cancer will be actively informed of the availability of psychosocial support to meet their needs.**
- 6. Health and social care staff, involved in cancer care, are trained and supported to identify psychosocial problems and provide support at the appropriate level.**
- 7. All ICSs establish an IAPT cancer pathway for people affected by cancer**
- 8. Commissioners engage with community and voluntary providers to optimise psychosocial support services available to people affected by cancer**
- 9. ICSs commission ongoing psycho-oncology teams (informed by the EMCA workforce model) and allocate sufficient resources to support the implementation of the EMCA Psychosocial Care Model.**

Benefits of psychosocial support

For people affected by cancer	<ul style="list-style-type: none">❖ Improved quality of care, patient experience, choice & preference❖ improved patient experience and quality of life❖ Reduced strain on carers/families❖ Improved clinical outcomes
For Primary Care	<ul style="list-style-type: none">❖ Reduced GP attendances if patient has mental health needs better met.❖ Increased confidence of GPs to manage psychosocial difficulties associated with cancer❖ Skills development through stronger links with psycho-oncology teams, training and consultation❖ Clearer pathway and knowledge of when to refer to IAPT services /psycho-oncology teams
For Providers	<ul style="list-style-type: none">❖ Psychological specialists embedded within cancer settings❖ Skills development/training for medical colleagues❖ Enhanced multi-disciplinary team working-using psychological approaches❖ Impact on wider healthcare utilisation e.g. fewer GP appts, emergency admissions etc
For System Leaders/Commissioners	<ul style="list-style-type: none">❖ An effective integrated model - psycho-oncology teams share expertise, training and skills❖ Improved quality of cancer psychosocial care for local population❖ Reduced variation/inequality❖ Potential cost savings (reduced healthcare utilisation) & improvements in QoL

TCST* Workforce algorithm

Recommended workforce algorithm for estimating minimum service requirement at Level 3 and 4 (Psycho-oncology teams)

	Example number
New cancer diagnoses per annum	1000
15 % require level 3 support	$15/100 \times 1000 = 150$
10 % require level 4 support	$10/100 \times 1000 = 100$
Number of patients with advanced active disease (AAD)	750
15% of AAD require level 3 or 4 support	$15/100 \times 750 = 113$
Total patients requiring direct input (excluding families/carers)	$113 + 150 + 100 = 363$
20 % Minimum number of carers/family requiring input (conservative estimate)	$20/100 \times 363 = 72$
120 new cases per year per 1.0 wte (NB variation between banding) ⁵⁶	$363 + 72 = 435 / 120 = 3.6$ (wte)
Add additional minimum of 20 % extra capacity required for 'indirect' work e.g level 2 supervision (e.g Clinical Nurse specialists), teaching /training /consultation with multi-disciplinary colleagues, cancer teaching for IAPT workers, liaison/partnership working with primary care staff	3.6 (wte) + 20% = 4.3 (wte)
Staff cost	£ Xxxxx (depending on service configuration)
Assumed health gain (based on mid-point QALY calculation)	363 (number of patients supported excluding carers/families) x 0.5 (proportion of people assumed to benefit) x 0.07 (QALY gain) x £25,000 (QALY value) = £317,625



The Little Red Hen



One day the Little Red Hen found some grains of wheat on the ground. "Who will help me plant these grains of wheat?" the Little Red Hen asked.



"Yes, I will," said the Little Red Hen. So the Little Red Hen planted the grains of wheat.



When the wheat had grown, the Little Red Hen asked her friends, "Who will help me cut the wheat?"



"Yes, I will," said the Little Red Hen. So the Little Red Hen took the wheat to the mill, ground the wheat into flour and carried it back to the farm all by herself.



"Yes, I will," said the Little Red Hen. So the Little Red Hen ate the bread all by herself.





Bronze – silver – gold?



Facilitators

- EMCA infrastructure
- Macmillan support
- Funded role for development & implementation
- COVID

Successes

- Engagement of all systems
- Endorsement of the model in principle
- Commitment to do something

Challenges

- Funding
- ICS transition
- Workforce

Takeaways

- Allies, champions, relationships
- Learn about the system
- Create a simple vision
- Voice of service users at centre

“...we wouldn’t give people chemotherapy without anti-sickness drugs, so why would we treat someone with a disease which clearly has significant psychological impact, without offering psychological support.”

Dr Matthew Williams, Consultant Clinical Oncologist,
Imperial College Healthcare, NHS Trust