NHS
Health Education England

Career Pathway, Core Cancer Capabilities and Education Framework for the Supportive, Assistive, Nursing and Allied Health Professions Workforce

User implementation guide including self-assessment and audit tools and supporting resources

This user implementation guide is part of the Aspirant Cancer Career and Education Development (ACCEND) programme.

ACCEND is a multi year funded programme (2022 – 2025) including all four UK nations.
Providing end-to-end transformational reform in the education, training and career pathways for cancer support workers, nurses and allied health professional's supporting people affected by cancer both now and in the future.

Funded and delivered by:

Contents

Introduction

Cancer care across all ages extends beyond care at diagnosis and during treatment to include care related to prevention, screening, prehabilitation, rehabilitation, recovery, late effects, living with and beyond cancer, palliative and end of life care.

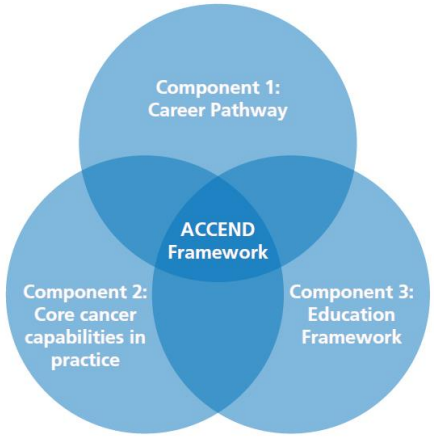
This guide should be read in conjunction with the **ACCEND Career Pathway, Core Cancer Capabilities and Education Framework for the Supportive, Assistive, Nursing and Allied Health Professions Workforce (the 'Framework).** It is provided to help further practitioners, employers, commissioners and funders understanding of the utility of the Framework, as well as to highlight the opportunities for its use for roles and services providing general and specialist cancer care across primary, secondary, tertiary and community settings, and in supra-regional centres providing quaternary (highly specialised) care for people with rarer cancers.

Structure

The Framework is structured using 3 components:

1. Career pathway component
2. Core cancer-specific capabilities in practice (CiPs) component
3. Education framework component

Combined, these components support practitioners at all levels of the career pathway to develop the core knowledge, skills and behaviours to care for people affected by cancer.



Component 1: The career pathway component identifies career levels for the workforce providing general and specialist cancer care as supportive, assistive, pre-registration, registration, enhanced, advanced and consultant levels. These levels of practice are used instead of role or job title.

The career pathway component focuses on a clinical career pathway and illustrates how it may be possible to progress along each level in cancer care, however, the pathway is not suggesting that there is a single role at each level of practice. Whilst the career pathway indicates the levels as opportunities for progression, practicing at a particular level is a legitimate endpoint. Practitioners may prefer to practice at a particular level and their expertise, knowledge and skills recognised and valued. Practitioners may also develop their practice in cancer care in clinical research, clinical academic or clinical education roles each with particular knowledge and capabilities requirements which are out of the scope of this Framework. Information and signposting about other specialist areas/roles will be available on the ACCEND Hub.

The Framework provides insight into which characteristics are required to work at each career pathway level and guidance for the knowledge, behaviours and skills needed to be working at each level of practice. These levels have been used to inform and identify:

- **the core cancer-specific capabilities in practice (CiPs) component** using the 4 pillars of professional practice for each level of practice
- **the level of preparation and learning outcomes for the minimum knowledge and understanding recommended for the different levels of practice in the education framework component.** For ease, these learning outcomes have been aligned to higher education qualifications across the UK nations to reflect the expectation that professionals working at registration level are normally graduates and/or are operating at graduate level and beyond. At advanced and consultant levels, Masters level descriptors (FHEQ 7; CQFW 7; SCQF 11) have been adopted

The career pathway component can help support the sustainability and growth of the workforce providing cancer care in general and specialist services and roles, facilitate the movement of staff to work across services as well as providing a career structure for the workforce.

Component 2: Core Capabilities in Practice (CiPs)

For the purposes of this framework, we are using the following definition of capabilities:

Capabilities are the attributes (skills, knowledge, and behaviours) which individuals bring to the workplace. This includes the ability to be competent, and to:

- manage change
- be flexible
- deal with situations which may be complex or unpredictable and,
- continue to improve performance

In practice, the terms ‘capability’ and ‘competence’ are both widely used in educational and workforce development literature, and they have often been used interchangeably, with little clear distinction between the two.

Both capability and competence:

- are about ‘what people can do’
- describe knowledge, skills, and behaviours
- can be the outcome of education, training, or experience

However, for the purposes of this framework we are using the term ‘capabilities’ as this describes the ability to be competent and to work effectively in situations which may require flexibility and creativity.

The Framework sets out the core cancer capabilities in practice (CiPs) and cancer specific knowledge recommended for the workforce providing care to people affected by cancer. **Component 2, the core cancer CiPs** identifies the underpinning theoretical and clinical knowledge, skills and behaviours for practitioners at each of the different levels of practice to develop and demonstrate their capability:

- to safely and effectively assess, plan and manage personalised care, and beyond this
- to influence, lead and manage change to improve cancer care and services

Using the four pillars of professional practice, high level core cancer CiPs across 8 domains are identified to enable practitioners and employers to contextualise the capabilities for the environment of care in which the service operates and the job/roles adopted for each level of practice.
it is recognised that, in the workplace due to the variation in role/job description and scope of practice, it is possible that the level of knowledge and/or core cancer CiPs relevant to a practitioner’s role could cross over more than one of the identified levels of practice, with a combination of the levels required.

Practitioners and employers may find there is not complete alignment to their existing role and the levels of practice within this Framework. A role may require a blend/mix of some capabilities in different levels to meet service needs. For example: a role may include some registration and some enhanced level core cancer CiPs. Alternatively, a practitioner may begin to build on capabilities to develop some level 7 academic knowledge or advanced level capabilities in a particular pillar of practice relevant to their role.

Please note: In England, this role would not meet the threshold of working at the advanced practice level as set out in the HEE (2017) Multiprofessional Framework for Advanced Clinical Practice as that defines advanced level practice as level 7 capabilities across all 4 pillars of professional practice (see Box in Framework: Qualifications and Recognition).

The core cancer CiPs can be interpreted and applied in the context of individual practitioners’ level and scope of practice, role, practice environment and the patient group(s) with whom they work. In addition, this enables employers with their employees to confirm the scope of practice and a job/role description.

Component 3: Education framework

The education framework component framework provides high level learning outcomes, syllabus and suggested assessment strategies for each level of the career pathway and to support the knowledge requirements of the core cancer CiPs.
The education framework includes:

- core knowledge for supportive, assistive and pre-registration levels identified in a 'module' format called Foundations of Cancer Care' (Framework Table 7)
- core knowledge for registration, enhanced, advanced and consultant level practice identified in a 'module' format called Fundamentals of cancer care (Framework Table 8)
- high level learning outcomes for Postgraduate Certificate, Diploma and Master's awards which incorporate and develop the core knowledge identified the Fundamentals of cancer care 'module' and across the 4 pillars of practice (Framework Table 9)

The core learning outcomes identified for the 'Foundations of Cancer Care' module and the 'Fundamentals of cancer care ' module **represent the minimum level of knowledge and understanding recommended for practitioners providing care to people affected by cancer in generalist and specialist services/roles at these levels of practice.** The level of knowledge and understanding can be developed and deepened with additional role specific continuing professional development and learning, including academic awards at postgraduate levels. Example high level learning outcomes for Postgraduate Certificate, Diploma and Master's awards which incorporate and develop the core knowledge identified the Fundamentals of cancer care 'module' and across the 4 pillars of practice are also suggested in the education framework.

Please note: Whilst presented in a 'module' and academic programme format, the learning outcomes identified can be used, achieved and evidenced through a range of learning and development opportunities. The learning outcomes, syllabi and the core cancer CiPs for each level of practice can be used for academic credit and non- credit bearing CPD or to guide workplace-based learning and assessment.

Practitioners may develop and demonstrate their knowledge, skills and capability through a range of opportunities including:

- workplace-based learning and reflection
- continuing professional development (CPD)
- eLearning/online learning resources
- university accredited modules and programmes

The learning outcomes may be helpful to Higher Education Institutions (HEIs), education and training providers, practitioners and employers when developing and reviewing a range of learning opportunities, curricula, modules or programmes for each level of practice. Commissioners and funders of education and continuing professional development opportunities may also use the education framework and core cancer CiPs for reviewing and commissioning education requirements to meet workforce needs.

Using the Framework

The Framework enables service commissioners to gain an insight into capability-based workforce development approaches so that they can use this Framework to help describe service models and assurance activities which underpin the delivery of effective services.

The Framework will enable commissioners to specify minimum standards for employment/placement and to set out clear expectations about practice by those providing care to people affected by cancer in generalist and specialist services and roles.

The Framework can be used to support the development and planning of the workforce to meet local/national population needs and to support a common understanding and expectation of operating within this field of practice, in order to facilitate the development and mobility of the workforce.

Service providers

The Framework will:

- enable employers to demonstrate that the supportive, assistive, and registered nursing and allied professional workforce at all levels meet the recommended level of knowledge and understanding identified in the education framework and the associated levels of core cancer CiPs
- demonstrate there are development plans in place to ensure that they are proactively working to achieve those learning outcomes and core cancer CiPs
- ensure Learning and Development can be targeted and focussed on the needs of the service and the workforce

The Career Pathway, Core Cancer Capabilities in Practice and Education Framework underpins the continuing professional development of staff at all levels of the career pathway to ensure their practice remains up-to-date, safe and effective and it supports the process of quality assurance to ensure the safety and effectiveness of their role.

The Framework enables employers to consider objectively how their current workforce's performance aligns to the learning outcomes and capabilities and ensure any workforce development is based on service need/outcomes.

Employers would need to undertake the following for each of their existing jobs in their setting:

- Identify which level of the career pathway the role sits on (it is possible some roles may sit across more than one level).
- For each core cancer capability there is a suggested level, based on each level of practice in the career pathway; review this and satisfy yourself that this is appropriate for the role.
- Use the core cancer capabilities as the basis for individual performance management. For example, supervision / review / appraisals.
- Use any knowledge, understanding and core cancer capability 'gaps' as the basis for Continuing Professional Development.

- Use the evidence gathered in performance reviews/appraisals as the basis for a Training/Learning Needs Analysis to inform the allocation of training resources.

A further aspiration in providing this Framework is to support service transformation. This is, that organisations use the Framework to review their current arrangements for practice and use the Framework to develop roles and teams.

This Framework also provides potential benchmarking of service provision at an organisational level and for employers to identify appropriate/further development.

Education and training providers

The Framework will:

- inform the design and delivery of curricula including learning outcomes, syllabus and assessment strategies
- promote development of a minimum level of knowledge and understanding and support capability in cancer care across the levels of practice
- promote the opportunity to identify shared learning outcomes and core cancer capabilities in practice and include interprofessional education and training in their delivery

Education and training providers and commissioners can use this Framework to support the development of knowledge, understanding and capability-based curriculum development activities.

This Framework can help those who commission, design and deliver training and development opportunities to focus on the key knowledge, understanding and capabilities that learners need to demonstrate, which in turn will guide the content to be included and the use of appropriate learning and teaching strategies and assessment.

Education providers can use this Framework to inform the design of their curricula and the delivery of education, training and development programmes, including how they articulate their intended learning outcomes. This will ensure that their learning and development provision contributes to people acquiring and demonstrating the full range of knowledge to support the capabilities required for practice in this clinical area.

Use of this Framework will also support organisational and system wide effectiveness and efficiencies by encouraging the delivery of education and training that is focused on developing these capabilities and optimise opportunities for inter-professional learning. In so doing, it should help to

increase consistency in knowledge and skills development, prevent unnecessary duplication in education and training delivery and strengthen skill mix and teamworking.

The Framework will inform those who design and deliver training and development opportunities to focus on the key knowledge and core cancer capabilities in practice that learners need to achieve and maintain. This in turn, will guide the content to be included and the use of appropriate learning and teaching strategies. In so doing, it aims to increase consistency in knowledge and skills development, prevent unnecessary duplication in education and training delivery and strengthen skill mix and teamworking.

Staff – people and teams

The Framework will support staff, people and teams by:

- promoting cancer care as a career option
- setting out clear expectations at each level of practice
- supporting appraisal
- supporting staff to identify CPD needs
- supporting the development of teams

The Framework promotes cancer care as a career option for a wide range of individuals as well as giving a clear sense of the ways in which to progress.

The Framework sets out clear expectations for the workforce at all levels about the requirements for effective and safe practice. It provides clarity about knowledge, understanding and requirements at each level of practice.

The Framework can be used by staff to better understand the development needs of themselves as individuals and the wider workforce. It can help them understand how to maximise the contribution of the existing workforce, identify opportunities for new ways of working and where appropriate, identify the need for new roles. The Framework can be used to review and recognise how existing capabilities are individually and collectively being utilised across a team and/or area of care.

The Framework can be used as the basis to conduct formal or informal appraisal and training needs analysis, comparing current capabilities with those identified in the framework.

This Framework can also be used to support career progression and development in a challenging environment and engagement in continuing professional development.

Staff using this Framework need to work with their employers to:

- identify where their existing role sits on the career pathway
- review their level of knowledge and understanding and which capabilities are applicable to their role
- as part of the performance review/appraisal process identify and evidence their level of knowledge and capability
- identify gaps in capability
- agree a programme of development to address any ‘gaps’ and/or to identify career development opportunities

The Framework will assist staff in the development of a portfolio of evidence and, where required, can be used to support revalidation requirements with the appropriate regulatory bodies.

Using this Framework: Examples

This guide illustrates three practical ways in which the Framework can be used by commissioners, providers and staff to support workforce planning and development to deliver effective care to people affected by cancer in general and specialist services which will meet population needs.

The following approaches to using the Framework are discussed here:

- Role design.
- Education and training design.
- Learning/training needs analysis.

Role design

Identify and describe level of knowledge and capabilities for a new team/service.
The Framework can be used to describe the level of knowledge and core cancer capabilities in practice required to deliver care offered by a new and/or existing team or service. Stakeholders will be able to develop a view to enable them to shape a description of what the service might look like in their locality. For example, in deciding the number of people required at each level of practice to deliver particular activities when working as a part of a team delivering cancer care.

Produce capability-based job descriptions for new and different roles based on service need.
The core cancer capabilities in practice can be used to complete a description of a role. In addition, job description linked to the role can be used to produce a person specification and full job description for a role including level of knowledge expected. This includes values and behaviours linked to the levels of practice in the career pathway, which can be supplemented with organisation specific values and the wider principles and values. Recruitment processes can be aligned to the recommended knowledge and capabilities, values and behaviours contained within the job descriptions. Importantly all of this activity can be mapped back to the requirements of the service as articulated in the key tasks and activities identified. This helps to ensure that any role design is based on an objective identification of service need.

Education and training design

The Framework could also be used to commission or design education and training to support the development of minimum level of knowledge, understanding and core cancer capabilities within the workforce providing care to people affected by cancer in general and specialist services at all levels of practice identified in the career pathway.

The Framework, taken together with its 3 component parts, can be used to design the content for education and training. That is; they include the minimum level of knowledge and understanding identified about cancer in the learning outcomes and also required to achieve the relevant core cancer capabilities in practice. The capabilities can be used by managers/employers as the basis of objective assessment of knowledge and capability in a workplace setting, supplemented by local policies and protocols.

It should be noted that the core cancer capabilities in practice themselves are not “levelled” (with the exception of advanced and consultant levels of practice. It is the career pathway levels which define the level of responsibility and autonomy a role/postholder has. If the capabilities are being used to develop education and training or assessment criteria, then the design of the learning outcomes would determine the relevant educational level; the framework however does give clear guidance on what level of educational attainment is appropriate to each of the levels of the career pathway and corresponding capabilities.

In summary, this Framework in its totality can be used to commission and/or design training, learning, development, education and assessment (as well as accreditation in appropriate circumstances). This Framework can also be used more widely to help individuals, organisations and training providers to improve performance.

For example, they can:

- provide managers with a tool for a wide variety of workforce design, management, succession planning and quality control
- offer a means to manage performance, increase productivity, identify and fill skills gaps
- act as a framework for recruitment, selection and induction
- supply a tool for personal, career and team development

Learning/training needs analysis

A learning or training needs analysis can be conducted across a team or across a service. It is good practice to conduct the analysis at an appropriate point within the appraisal/performance review cycle and to link discussions with staff to their own personal development needs. The analysis can be conducted as a paper-based exercise or in an electronic (Excel spreadsheet) format. There are also templates and tools available commercially which can support this process or there may be an accepted methodology in use within an organisation. Whatever mechanism is deemed appropriate, it will be possible to use the content within the Framework to populate the learning needs analysis.

To further support the implementation/utilisation of the Framework a variety of self-assessment and audit tools and useful documents have been produced. These are as follows:

Appendix 1: Self-assessment tool for practitioners and employers.
Appendix 2: Audit tools for clinical, learning and higher education providers.
Appendix 3. Portfolio Guidance and supporting tools.
Appendix 4. Exemplar ‘high-level’ role descriptors.
Appendix 5. Frequently asked questions.

Appendix 1: Self-assessment tool for practitioners and employers

The Framework articulates core cancer CiPs and an education framework for each level of practice in the career pathway to deliver safe and effective cancer care aligned to the four pillars of professional practice.

The recommended learning outcomes and core cancer CiPs are written at a 'high level' to enable practitioners and employers to contextualise the capabilities for the environment of care in which the service operates and the job/roles adopted for each level of practice. They can be interpreted and applied in the context of individual practitioners' scope of practice, role, practice environment and the patient group(s) with whom they work. In addition, this enables employers with their employees to confirm the scope of practice and a job/role description.

This self-assessment tool enables practitioners and employers to assess their level of knowledge, understanding and capability, to identify the range of evidence to illustrate achievement of these and to identify any continuing professional development needs for their role or to meet future career aspirations in an action plan.

Colour coding for Core cancer CiPs for cancer nursing and allied health professions workforce

Key

	Level of practice
	Supportive
	Assistive
	Pre-Registration (under supervision)
	Registration
	Enhanced
	Advanced
	Consultant

Foundations of Cancer Care – core learning outcomes and syllabus for supportive level and pre-registration level nursing associates, nursing and allied health professions

Foundations of cancer care (FHEQ 4/5; CQFW 4/5; SCQF7/8) or equivalent	**Aims and learning outcomes**	**Syllabus**	**Assessment**	**Evidence:** **UG or PG pre-registration programme** **Fd nursing associate/assistant practitioner/pharmacy technician programme**
Core foundation knowledge and skills for supportive level, pre-registration level trainee nursing associates, nursing and allied health professions students	**Aims:** (1) to provide an introduction to the philosophy, principles and practices underpinning cancer care and the provision of holistic person-centred care of people affected by cancer (2) to provide foundation knowledge, skills and capabilities for the supportive workforce, trainee nursing associates, pre-registration nursing and allied health professional students to provide evidence-based care for people affected by cancer at the point of registration **Learning outcomes:** • Examine current national policies, guidance and local healthcare processes	• Philosophy and principles of cancer care • Person-centred/family centred care • Transitions in cancer care (Risk reduction, screening, prehabilitation, treatment, rehabilitation, late and long-term effects, supportive, palliative and end of life care, bereavement care) • Biological basis/Process of carcinogenesis • Genomics and its applications in cancer diagnosis, prognosis and treatment • Grading and staging cancer • Cancer treatments and decision-making • Multi-professional teamworking	Range of evidence to demonstrate achievement of defined learning outcomes and core cancer capabilities in practice for supportive and pre-registration level	

	influencing organisation of cancer services and care for people affected by cancer • Explore public and professional attitudes to cancer • Describe the biological basis of cancer and examine how this informs practices relating to risk reduction, early detection, screening, diagnosis, staging and grading of cancer, personalised treatment decisions • Analyse the physical, psychological, emotional and social impact of cancer and its treatment across the spectrum of cancer care • Examine the range of support (a) informational, (b) emotional, (c) esteem, (d) social network support, and (e) tangible support needs of people living with and beyond cancer, palliative and end of life care • Analyse models of communication and psychological support for addressing the emotional concerns of patients and/or their caregivers • Examine own professional role as part of multi-professional team contributing to person-centred assessment and care for people affected by cancer	• Range of support needs – models of assessment including psychosocial assessment and support, person-centred assessment and care for people affected by cancer including self-care, self-management and rehabilitation/reablement • Models of communication, supportive conversations, emotional intelligence, wellbeing • Professional accountability, the law and ethical decision making • Principles of effective symptom assessment, management, and care. • Recognising oncological emergencies • Personal and team well-being, clinical supervision • Reflective and evidence-based practice and continuing professional development		

	including self-care, self-management and rehabilitation/reablement • Explore own support and development needs and identifying opportunities for clinical supervision, support and development			

Fundamentals of cancer care – core learning outcomes and syllabus for Registration, Enhanced, Advanced and Consultant level nursing and allied health professions

Fundamentals of cancer care (FHEQ 6; CQFW 6; SCQF 10/9) or Postgraduate level (FHEQ 7; CQFW 7; SCQF 11) or equivalent	**Aims and learning outcomes**	**Syllabus**	**Assessment**	**Evidence:** **PG post-registration module/programme/ workplace experience**
Core for Registered practitioners at all levels To facilitate awareness of limitations of own knowledge and skills and to be able to signpost and refer patients to more specialist/advanced practitioners and/or specialist services. The 'module' includes the biological basis of cancer, risk factors, cancer patient referral and treatment pathways, staging and grading of cancer, treatment modalities and options including precision medicine, care of the acutely unwell patient with cancer, signposting, and referral.	**Aims** (1) to provide fundamental core knowledge and skills for registered nursing and allied health professionals to deliver optimal care for people affected by cancer, based upon the current evidence (2) To provide an in-depth focus on the philosophy, principles and practices of care for people affected by cancer to enable practitioners to undertake person-centred holistic evidence-based assessment and care. **Learning outcomes:** • Critically appraise contemporary national and international policies,	• Philosophy and principles of cancer care • Policies influencing the delivery and quality of cancer care/services • Person-centred assessment, management and care • Transitions in cancer care (Primary prevention, screening, diagnosis, prehabilitation, treatment, rehabilitation, supportive, palliative and end of life care) • Understanding the biology of normal and cancer cells, cancer as a genetic disease/process of carcinogenesis, angiogenesis and metastases, cell growth, cell death and DNA repair, aetiology, epidemiology • Genomics and its applications in cancer diagnosis, prognosis and treatment	Range of evidence to demonstrate achievement of the learning outcomes and defined capabilities in practice for relevant level of practice Demonstrate communication skills to establish authentic, therapeutic relationships with all recipients of cancer care Undertake a person-centred assessment and formulate, communicate (using a range of formats) and deliver an effective, co- ordinated care plan	

It also delivers the principles of symptom assessment and management, care planning, communication skills, ethics, prehabilitation, rehabilitation, supportive care, bereavement care and future care planning. The module includes the principles of team and multi-agency working and co-ordinating care and respecting patient choices throughout the spectrum of cancer care.	guidance and healthcare processes influencing organisation of cancer services and care for people affected by cancer • Apply in-depth knowledge of the biological basis of cancer, risk factors, treatment options, staging and grading of cancer and the development of personalised treatments for cancer • Examine the impact of cancer and its treatment on the physical, psychological, emotional, social, and spiritual wellbeing of people affected by cancer • Critically evaluate models of communication and psychological support for addressing the emotional concerns of patients and/or their caregivers • Critically evaluate evidence-based assessment and personalised care and support strategies for people affected by cancer across the spectrum of care • Critically analyse their professional role in person-centred assessment and	• Presenting symptoms and referral for suspected cancer diagnosis • Cancer pathways • Grading and staging cancer • Cancer treatments, developments in personalised medicine and the rationale for their use • Hazard management related to cancer treatments • Supporting value-based, shared decision-making • Person-centred and holistic models of care • Working within a multi-professional team • Organisation of cancer services, referral and signposting • Models of communication, supportive and advanced communication skills and emotional intelligence • Strategies to maintain own emotional wellbeing • Recognising a person with an acute oncological emergency • Immediate care and escalation of oncological emergencies • Paraneoplastic syndromes • Professional accountability, the law and ethical decision making • Meaningful informed consent and mental capacity		

	care for people affected by cancer • Examine effective teamworking in the assessment and delivery of person-centred holistic care for people affected by cancer across the spectrum of care • Critically appraise the clinical, legal and ethical issues that arise in providing person-centred care and symptom management when caring for people affected by cancer as part of multi-professional teams across the spectrum of care • Debate professional contributions in terms of leadership, communication, and research and how being a reflective practitioner contributes to professional development	• Advance care planning • Principles of effective symptom assessment, management, and care (for people with common or life-threatening symptoms of cancer/cancer treatment) • Psychosocial concerns and needs assessment and care • MDT care for the needs of families/ carers and bereavement support. • Leadership and management in cancer care • Research utilisation and evidence in cancer care		

High- level learning outcomes and syllabus for Graduate/Postgraduate Certificate/Diploma/Masters

Module or award	Credits or equivalent	High level learning outcomes	Evidence: UG or PG pre-registration programme Fd nursing associate/assistant practitioner/pharmacy technician programme
Foundations of cancer care		• Examine current national policies, guidance and local healthcare processes influencing organisation of cancer services and care for people affected by cancer • Explore public and professional attitudes to cancer • Describe the biological basis of cancer and examine how this informs practices relating to risk reduction, early detection, screening, diagnosis, staging and grading of cancer, personalised treatment decisions • Analyse the physical, psychological, emotional and social impact of cancer and its treatment across the spectrum of cancer care • Examine the range of support (a) informational, (b) emotional, (c) esteem, (d) social network support, and (e) tangible support needs of people living with and beyond cancer, palliative and end of life care • Analyse models of communication and psychological support for addressing the emotional concerns of patients and/or their caregivers • Examine own professional role as part of multi-professional team contributing to person-centred assessment and care for people affected by cancer including self-care, self-management and rehabilitation/reablement • Explore own support and development needs and identifying opportunities for clinical supervision, support and development	

Module or award	Credits or equivalent	High level learning outcomes	Evidence: PG post-registration module/programme, workplace experience
Fundamentals of cancer care		• Critically appraise contemporary national and international policies, guidance and healthcare processes influencing organisation of cancer services and care for people affected by cancer • Apply in-depth knowledge of the biological basis of cancer, risk factors, treatment options, staging and grading of cancer and the development of personalised treatments for cancer • Examine the impact of cancer and its treatment on the physical, psychological, emotional, social, and spiritual wellbeing of people affected by cancer • Critically evaluate models of communication and psychological support for addressing the emotional concerns of patients and/or their caregivers • Critically evaluate evidence-based assessment and personalised care and support strategies for people affected by cancer across the spectrum of care • Critically analyse their professional role in person-centred assessment and care for people affected by cancer • Examine effective teamworking in the assessment and delivery of person-centred holistic care for people affected by cancer across the spectrum of care • Critically appraise the clinical, legal and ethical issues that arise in providing person-centred care and symptom management when caring for people affected by cancer as part of multi-professional teams across the spectrum of care • Debate professional contributions in terms of leadership, communication, and research and how being a reflective practitioner contributes to professional development	

Award	Credits or equivalent	High level learning outcomes	Evidence: PG post-registration module/programme/ workplace experience
Graduate/Postgraduate Certificate/ (or equivalent)	30/60	• To provide knowledge and skills for registered nursing and allied health professionals in equipping them with the knowledge and capabilities to provide optimal care for people affected by cancer, based upon the current evidence • To provide an in-depth focus of the philosophy, principles and practices of care for people affected by cancer to enable practitioners to undertake holistic and person-centred assessment and deliver care relevant to their area of practice • To support practitioners to continue to develop their clinical expertise in their sphere of practice whilst acquiring transferable skills • To work in collaboration with other practitioners, multi-professional teams and people affected by cancer in order to provide the optimal level of care	
Postgraduate Diploma (or equivalent)	120	As above plus: • To provide a comprehensive post-registration, postgraduate learning environment that utilises critical thinking, problem solving skills and a critical awareness of the research and evidence base to provide care and develop interventions to improve service user outcomes and promote high quality cancer care practice • To facilitate the reflexive acquisition of specialist knowledge in relation to contemporary issues within the student's area of cancer expertise and the creation of new insights into professional practice through knowledge and application of research, audit and service evaluation • To continue to develop a theoretical knowledge base, comprehensive skills and the professional attitude to share knowledge through teaching,	

		mentorship and/or coaching, and acting as a role model for others.	
Masters	180	As above plus: • To facilitate the development of a comprehensive understanding of the techniques applicable to advance healthcare research and quality improvement demonstrating the ability to lead innovation and manage service developments in cancer care	

Audit Tool Detailed Core Cancer CiPs colour coded for each level of practice

Domain A: Person-centred collaborative working										
1.0 Capabilities: Professional values and behaviours **The practitioner is able to:**	**Practitioner level (See key) Tick level of achievement required**							**Self-assessment**	**Action plan and evidence of success**	**Review date**
1.1 Seek and engage with individuals' perspectives on their condition, their preferences for their care, and what is important to them and their carers in terms of treatment goals and outcomes										
1.2 Demonstrate understanding of the individual and show empathy for the impact of their cancer diagnosis										
1.3 Value and acknowledge the experience and expertise of individuals, their carers and support networks										
1.4 Use their clinical-reasoning skills to undertake an in-depth assessment of the presenting problem, interpret findings, develop working and differential diagnoses, formulate, communicate, implement and evaluate management plans										
1.5 Recognise the wider impact that symptoms of cancer, often persistent, can have on individuals, their families and those close to them										
1.6 Examine their role in supporting and enabling individuals to lead meaningful lives, whether or not cure or resolution is possible										
1.7 Promote and contribute to a consistent and integrated approach throughout the episode of care, focusing on the identified needs of the individual										
1.8 Role model integrated care, support and treatment through forward-planning, working in partnership with individuals, different professionals, teams, diverse communities, a range of organisations including the third sector, and through understanding, respecting and drawing on others' roles and competence										

1.9 Value collaborative involvement and engage people with cancer to improve and co-produce person-centred, quality services										
1.10 Adhere to legal, regulatory and ethical requirements, professional codes, and employer protocols										
1.11 Adopt a critical approach to ethical uncertainty and risk, working with others to resolve conflict										
1.12 Demonstrate safe, effective, autonomous, reflective practice										
1.13 Inform their practice and professional development and remain up to date with the best available evidence through the appropriate use of clinical guidelines and research findings										
1.14 Demonstrate accountability for their decisions and actions and the outcomes of their interventions										
1.15 Work effectively as part of a team, using their professional knowledge and skills, and drawing on those of their colleagues										
1.16 Promote person-centred care to meet individuals' best interests and to optimise service delivery										
1.17 Support clinical research to develop cancer practice										
1.18 Promote, enable and lead research to advance the development of cancer knowledge and practice										

Domain A: Person-centred collaborative working										
2.0 Capabilities: Maintaining an ethical approach and fitness to practice/ law, ethics and safeguarding **The practitioner is able to:**	**Practitioner level (See key) Tick level of achievement required**							**Self-assessment**	**Action plan and evidence of success**	**Review date**
2.1 Demonstrate professional practice in own day to day clinical practice										
2.2 Critically reflect on how own values, attitudes and beliefs might influence own professional behaviour and interactions										
2.3 Use critical self-awareness of their own values, beliefs, prejudices, assumptions and stereotypes to mitigate the impact of these in how they interact with others										
2.4 Identify and act appropriately when own or others' behaviour undermines equality, diversity and human rights										
2.5 Reflect on and address appropriately ethical/moral dilemmas encountered during own work which may impact on care to people affected by cancer. Advocate equality, fairness and respect for people and colleagues in day-to-day practice										
2.6 Keep up to date with mandatory training and/or revalidation requirements, encompassing those requiring evidence related to care for people affected by cancer										
2.7 Recognise and ensure a balance between professional and personal life that meets work commitments, maintain own health, promote well-being and build resilience										
2.8 Demonstrate insight into any personal health issues and take effective steps to address any health issue or habit that is impacting on own performance										
2.9 Respond promptly and impartially when there are concerns about self or colleagues; take advice from appropriate people and, if necessary, engage in a referral procedure										

2.10 Promote mechanisms such as complaints, significant events and performance management processes in order to improve peoples' care										
2.11 Promote mechanisms such as compliments and letters of thanks to acknowledge and promote good practice										

Domain A. Person-centred collaborative working										
3.0 Capabilities: **The practitioner is able to:**	**Practitioner level (See key) Tick level of achievement required**							**Self-assessment**	**Action plan and evidence of success**	**Review date**
3.1 Consistently role model highly developed interpersonal and advanced communication skills to engage in effective, appropriate, enabling and complex interactions with individuals, carers and colleagues in the clinical environments and roles in which they practise										
3.2 Use advanced skills in listening and information-processing, alongside empathetic skills to assess, explore and respond to individuals' complex needs and concerns										
3.3 Select appropriate language and media (including remote consultation such as telephone, skype, sign language, written etc) to facilitate effective communication and interactions with people affected by cancer										
3.4 Respond sensitively to individual preferences and needs and uphold and safeguard individuals' interests										
3.5 Establish and integrate individuals' specific needs, preferences, priorities and circumstances to guide the care and treatment they offer										
3.6 Demonstrate respect for individuals' expertise in their own life and condition and empower and support them to retain control and to make choices that fit with their goals										
3.7 Use active listening and facilitation skills to enable individuals to talk about their concerns and priorities relating to their cancer symptoms and implications of its treatment										
3.8 Help individuals and carers to understand their care options, sharing information on the risks, benefits, consequences, and potential outcomes in a clear, open way to support shared decision-making										

3.9 Promote value-based decision making, critically evaluating and appropriately applying their knowledge and skills in a person-centred way, challenging predetermined protocols or workplace imperatives where necessary										

Domain A. Person-centred collaborative working										
4.0 Capabilities: Communication and consultation skills The practitioner is able to:	**Practitioner level (See key) Tick level of achievement required**							**Self-assessment**	**Action plan and evidence of success**	**Review date**
4.1 Actively listen to and communicate effectively with others, recognising that both are an active, two-way process										
4.2 Critically appraise communication strategies and be able to optimise communication approaches appropriately using skills such as active listening e.g. frequent clarifying, paraphrasing and picking up verbal cues such as pace, pauses and voice intonation										
4.3 Reflect on communication strategies and skilfully adapt those employed to ensure communication strategies foster an environment of person empowerment										
4.4 Communicate in ways that build and sustain relationships, seeking, gathering and sharing information appropriately, efficiently and effectively to expedite and integrate people's care										
4.5 Communicate effectively, respectfully and professionally with service users and carers at times of conflicting priorities and opinions										
4.6 Convey information and address issues in ways that avoid jargon and assumptions; respond appropriately to questions and concerns to promote understanding, including use of verbal, written and digital information										
4.7 Engage with individuals and carers and respond appropriately to questions and concerns about their cancer related symptoms and its impact on their current situation and potentially in the future drawing on practitioners' in-depth knowledge of cancer and its effects										

4.8 Autonomously adapt verbal and non-verbal communication styles in ways that are empathetic and responsive to people's communication and language needs, preferences and abilities (including levels of spoken English and health literacy)										
4.9 Communicate effectively with individuals who require additional assistance, such as sensory or cognitive impairments, to ensure an effective interface with a practitioner, including the use of accessible information										
4.10 Evaluate and remedy situations, circumstances or places which make it difficult to communicate effectively (e.g. noisy, distressing environments which may occur during home visits, care home visits or in emergency situations), and have strategies in place to overcome these barriers										
4.11 Consult in a highly organised and structured way, with professional curiosity as required, whilst understanding the constraints of the time limited nature of consultations and ensure communication is safe and effective										
4.12 Adapt communication approaches to non-face to face situational environments e.g. phone, video, email or remote consultation										
4.13 Contextualise communication approaches to use in group situations										
4.14 Respond to people effectively, respectfully and professionally, including carers and families, especially at times of conflicting priorities and opinions and be able to facilitate shared agenda setting using a triadic consultation approach										
4.15 Select effective, situation and patient appropriate history taking and consultation skills drawing on knowledge and expertise in advanced communication skills										

Domain A. Person-centred collaborative working										
5.0 Capabilities: Personalising the pathway for people living with and affected by cancer The practitioner is able to:	**Practitioner level (See key) Tick level of achievement required**							**Self-assessment**	**Action plan and evidence of success**	**Review date**
5.1 Demonstrate sensitivity to the significance of individuals' background, identity, culture, values and experiences for how their cancer condition impacts on their life, recognising the expertise that individuals bring to managing their own care										
5.2 Work with individuals to develop personalised care plans that: • Reflect their priorities and concerns both now and for the future. • Encourage self-care and self-reporting of significant symptoms, including in an emergency. • Consider the psychological effects of cancer and strategies to manage this. • Incorporate other medical conditions and frailty risk • Consider the risks, benefits and consequences of each available option										
5.3 Take account during care planning of the burden of treatment for individuals with cancer and co-morbidities, including regular appointments that may also be for the management of their other healthcare needs										
5.4 Use protocols and guidelines to create person-centred individual care pathways and documentation e.g. care plans, treatment summaries, late effects surveillance										
5.5 Progress care, recognising that reducing symptoms, restoring and maintaining function and										

independence, and improving quality of life all form clinical outcomes and meaningful goals of treatment										
5.6 Recognise and intervene when deviations occur from expected progress, meaning changes may be needed in the care plan, adapting it to the changing needs, such as cancer recurrence or end of life care										
5.7 Work collaboratively with individuals, their families and the MDT to manage complex situations arising from care plans e.g. differing perspectives of treatment plans										
5.8 Coordinate individualised care across sectors and disciplines according to the needs identified in the care plan										
5.9 Establish processes and ensure physical, psychological and social assessments are incorporated into local care planning systems e.g. health promotion, psychosocial adjustment, work and social functioning										
5.10 Recognise the significance of family, carers and social networks in planning and providing care and the importance of developing partnerships with them, with due regard for the complexity and diversity in family relationships and arrangements										
5.11 Review and audit care plans to promote evidence-based practice and ensure these reflect current best practice										
5.12 Evaluate the implications of, and apply in practice, the relevant legislation for meaningful informed consent and shared decision making (e.g. mental capacity legislation, Fraser Guidelines)										
5.13 Monitor and evaluate services and pathways to ensure these are delivered effectively within own speciality or clinical field to meet the relative risks or complications and complexity of needs										
5.14 Work with local service providers to develop pathways that facilitate rapid access to services when the need to do so is identified e.g. re-entry to acute care services following signs of recurrence										

Domain A. Person-centred collaborative working										
6.0 Capabilities: Helping people make informed choices as they live with or are affected by cancer The practitioner is able to:	**Practitioner level (See key) Tick level of achievement required**							**Self-assessment**	**Action plan and evidence of success**	**Review date**
6.1 Provide information and advice appropriate to the needs, priorities and concerns of individuals										
6.2 Respond to individuals' descriptions of their needs, preferences and concerns to ensure that care plans meet their goals and needs, managing the changing needs and expectations of patients and their families and ensures care plans reflect the new priorities										
6.3 Act as an expert resource for other health and care professionals when dealing with complex communication issues, such as when an individual's choices put them at risk										
6.4 Acknowledge and respect the decisions made by individuals concerning their health and wellbeing in relation to cancer, cancer treatments, survivorship and late effects care										
6.5 Explain the options, including the benefits and risks, that are available to individuals to enable them to reach their own decisions about their treatment, health and wellbeing and set their own priorities										
6.6 Make appropriate decisions to seek help and report concerns to colleagues when an individual's choices place them at risk										
6.7 Identify factors that can affect an individual's ability to request, organise or access services or assistance and take appropriate action to help them receive the care they require (e.g. knowledge, confidence, physical constraints, social isolation)										
6.8 Provide information and assistance to help individuals access the services and resources they require to implement their decisions										

6.9 Promote the participation and inclusion of all service users and ensure that potential barriers are reported to the appropriate personnel										
6.10 Work to ensure that services are inclusive and promotes equal opportunities for access and service provision										
6.11 Recognise and promote the importance of social networks and communities for people and their carers in managing cancer related symptoms										
6.12 Collaborate with other providers to promote services to help individuals make informed choices about their health and wellbeing and to develop information (visual, audio, written and non-text based information) and support to ensure individuals receive information appropriate to their needs and at the right time in the pathway										

Domain A. Person-centred collaborative working										
7.0 Capabilities: Providing information to support self-management and enable independence for people living with and affected by cancer The practitioner is able to:	**Practitioner level (See key) Tick level of achievement required**							**Self-assessment**	**Action plan and evidence of success**	**Review date**
7.1 Provide written, online and verbal information to individuals about their condition, treatment and services available to support self-care and independence										
7.2 Contribute to the development and evaluation of patient information resources for people living with and affected by cancer										
7.3 Provide individuals with accessible information to support their intervention plan, for instance, crib sheet/audio visual material of signs and symptoms to be monitored in relation to cancer, cancer treatments, recurrence or likely late effects										
7.4 Access information from a range of resources and use them to meet the individual needs of service users, translating clinically related topics into language which is understandable both for individuals to self-manage effectively and for the development of patient information										
7.5 Critically assess written information/websites before recommending them										
7.6 Evaluate individual's understanding of information, (including written, visual and audio-based information), communicate effectively to correct misunderstandings and explain complex medical terminology in lay terms										
7.7 Direct individuals and family members to local resources, appropriate agencies and information sources, including online information or non-text based information, on issues that may affect them following cancer treatment, including work and finance matters										

7.8 Offer guidance and support with accessing appropriate online sources of information										
7.9 Work with other teams and agencies to develop information and support resources to ensure individual people living with cancer and palliative care needs receive information appropriate to their needs, involving users in information development										
7.10 Lead and develop support groups for individuals living with and affected by cancer and identifies opportunities/gaps in the provision of support groups at a local level										
7.11 Implement and inform local and national initiatives regarding the development of information and support resources										

Domain A. Person-centred collaborative working										
8.0 Capabilities: Multi-disciplinary, interagency and partnership working **The practitioner is able to:**	**Practitioner level (See key) Tick level of achievement required**							**Self-assessment**	**Action plan and evidence of success**	**Review date**
8.1 Practise within their professional and personal scope of practice and access specialist advice or support for the individual or for themselves when appropriate										
8.2 Engage in effective inter-professional communication and collaboration with clear documentation to optimise the integrated management of the individual with cancer										
8.3 Liaise between service users, relatives and carers when making links to members of the multi-disciplinary team involved in planning an individual patient's care pathway to optimise interventions										
8.4 Act as a key contact with a variety of agencies in relation to current and anticipated needs of individual patients (e.g. employment, education, financial, exercise services), understanding the contributions of different health, social care and voluntary sector services in meeting holistic care needs (e.g. financial, vocational, practical and emotional support)										
8.5 Have a knowledge of the range of services available to support people across the care pathway and how to refer/signpost to them with awareness of when it would be appropriate to refer back to treating centres, including for emergency presentations										
8.6 Coordinate MDT interventions relating to patients with complex care needs after cancer and cancer treatment, working with the MDT and health, social care and voluntary sector agencies care plan e.g. ongoing care, discharge and surveillance community care plans										

8.7 Work effectively within and across teams, managing the complexity of transition from one team to another or membership of multiple teams										
8.8 Work with health, social care and voluntary sector agencies to ensure coordinated care that meets current and anticipated future needs of individuals e.g. employment, financial, educational, late effects										
8.9 Liaise with, signpost to and make referrals to the multi-disciplinary team and other health and care professionals across all settings relating to other co-morbidities (e.g. learning disability, mental health as appropriate for the patient's physical and psychological symptoms)										
8.10 Provide expert advice to other members of the MDT and health, social care and voluntary sector agencies										
8.11 Actively contribute to the development of services in the MDT understanding the importance of effective team dynamics										
8.12 Build partnerships with the health, social care, voluntary and independent sectors to promote engagement with cancer services and late effects care										

Domain A. Person-centred collaborative working										
9.0 Capabilities: Referrals and integrated working to support transitional care for people living with and affected by cancer The practitioner is able to:	**Practitioner level (See key) Tick level of achievement required**							**Self-assessment**	**Action plan and evidence of success**	**Review date**
9.1 Understand the roles that acute, community and primary care services play in supporting people living with and affected by cancer										
9.2 Understand the issues facing individuals as they complete cancer treatment or are discharged from acute hospital follow-up										
9.3 Support individuals to develop confidence in their ability to cope with transition points in their care such as on discharge from hospital care to self-managing at home, supporting independence and acts as an advocate as appropriate										
9.4 Effectively uses the treatment summary and surveillance plan in communication between hospital and primary care services, communicating effectively and working with other HCPs and services to ensure individuals receive appropriate ongoing cancer care										
9.5 Take an active role in working with others to minimise the occurrence of potential crises e.g. inappropriate admission to hospital										
9.6 Provide information and support regarding ongoing late effects surveillance										
9.7 Act as a specialist resource for local health, social care and voluntary sector services regarding transitional care										
9.8 Take a leading role in developing emergency referral pathways and educating the wider MDT on appropriate courses of action										
9.9 Lead and develop strong partnership working with all key stakeholders in a local area and acts as the expert in this area demonstrating effective communication across complex organisations										

9.10 Work with other agencies to develop clear pathways and guidelines for the transfer of long term follow-up to primary services and to different models of follow up care										
9.11 Lead and evaluates the development of education programmes for staff involved in supporting patients who move across different healthcare settings to affect a safe and effective transfer										

Domain B: Assessment, investigations and diagnosis										
10.0 Capabilities: History taking **The practitioner is able to:**	**Practitioner level (See key) Tick level of achievement required**							**Self-assessment**	**Action plan and evidence of success**	**Review date**
10.1 Demonstrate an understanding of the Holistic Needs Assessment and Care Plan (HNA) process, including the physical and psychosocial components, and its implications for practice; understanding the components which might influence personal choice, such as faith, age, culture										
10.2 In collaboration with the individual, use the Holistic Needs Assessment and Care Plan to identify and prioritise needs which require support and informs the development of an appropriate personalised plan with defined outcomes										
10.3 Structure consultations so that the person and/or their carer/family (where applicable) is encouraged to express their ideas, concerns, expectations and understanding										
10.4 Uses specialist skills and knowledge to carry out screening and clinical assessments, conducting assessments using appropriate standardised, evidence-based screening and assessment tools (Examples include, but not limited to: 5 times sit to stand test; 6-minute walk test; cardiopulmonary exercise test; incremental shuttle walk test; MUST; Royal Marsden nutrition screening tool; Patient generated subjective global assessment questionnaire; Patient health questionnaire-9; Generalised anxiety disorder assessment (GAD-7); Hospital anxiety and depression scales (anxiety and/or depression), EORTC QLQ-C-30; Brief fatigue inventory, WHO disability assessment schedule)										

10.5 Use active listening skills and open questions to effectively engage and facilitate shared agenda setting										
10.6 Explore and appraise peoples' ideas, concerns and expectations about their symptoms and condition and whether these may act as a driver or form a barrier										
10.7 Understand and apply a range of consultation models appropriate to the clinical situation and appropriately across physical, mental and psychological presentations										
10.8 Be able to undertake general history-taking, and focused history-taking to elicit and assess 'red flags,' acute oncological presentations, reoccurrence, cancer treatment side effects and late effects										
10.9 Synthesise information, taking account of factors which may include the presenting symptom? existing symptoms? past medical history, genetic predisposition, medications, allergies, risk factors and other determinants of health to establish differential diagnoses										
10.10 Incorporate information on the nature of the person's needs preferences and priorities from various other appropriate sources e.g. third parties, previous histories and investigations										
10.11 Assess the impact of individuals' presenting symptoms, including the impairment of function, limitation of activities and restriction on participation, including work										
10.12 Deliver diagnosis and test/investigation results, (including bad news) sensitively and appropriately in line with local or national guidance, using a range of mediums including spoken word and diagrams for example to ensure the person has understanding about what has been communicated										
10.13 Record all pertinent information gathered concisely and accurately for clinical management,										

and in compliance with local guidance, legal and professional requirements for confidentiality, data protection and information governance										

Domain B: Assessment, investigations and diagnosis										
11.0 Capabilities: Clinical physical and mental health assessment **The practitioner is able to:**	**Practitioner level (See key) Tick level of achievement required**							**Self-assessment**	**Action plan and evidence of success**	**Review date**
11.1 Appropriately obtain consent to physical examination, respect and maintain the patient's privacy, dignity (and comfort as far as practicable), and comply with infection prevention and control procedures										
11.2 Adapt their practice to meet the needs of different groups and individuals (including those with particular needs such as cognitive impairment or learning disabilities), working with chaperones, where appropriate										
11.3 Undertake observational and functional assessments of individuals relevant to their presenting condition to identify and characterise any abnormality										
11.4 Apply a range of physical assessment and clinical examination techniques appropriately, systematically and effectively										
11.5 Use nationally recognised tools where appropriate to assess peoples' condition and symptoms										
11.6 Perform a mental health assessment appropriate to the needs of the patient and the setting										
11.7 Assess the psychological, social and emotional needs of cancer patients, their relatives and carers including coming to terms with a cancer diagnosis and potentially a terminal diagnosis										
11.8 Use knowledge of cancer, its treatment and the risks of late effects complications to ensure assessments are appropriate to individual needs										

(e.g. type of cancer, treatment received, age, co-morbidities)										
11.9 Identify, analyse and interpret potentially significant information from the physical and mental health assessment (including any ambiguities) and consider the need for an appropriate and timely referral										
11.10 Record the information gathered through assessments concisely and accurately, for clinical management and in compliance with local guidance, legal and professional requirements for confidentiality, data protection and information governance										

Domain B: Assessment, investigations and diagnosis										
12.0 Capabilities: Investigations, diagnosis and care planning The practitioner is able to:	**Practitioner level (See key) Tick level of achievement required**							**Self-assessment**	**Action plan and evidence of success**	**Review date**
12.1 Identify possible differential diagnoses for symptoms using a structured problem-solving method informed by an understanding of probability based on prevalence, incidence and of symptoms to aid decision making										
12.2 Understand the role of risk stratification and the implications for the patient in ongoing surveillance for people living with cancer or for those at increased risk of cancer. This might include the identification of those at risk of increased frailty or those with a hereditary gene mutation										
12.3 Lead and develop services based on a risk stratified approach to care in collaboration with the wider multidisciplinary team										
12.4 Assess the importance and meaning of presenting features from the clinical assessment, recognising the different symptoms and conditions commonly seen in first point of contact roles in cancer care										
12.5 Recognise signs and symptoms requiring a change in the care pathway e.g. side effect grading, psychological concerns (such as depression and anxiety) cancer recurrence and end of life care and initiates appropriate interventions										
12.6 Identify risk factors for severity or impact and use tools where they exist to analyse and stratify risk of progression to long term symptoms and disability										
12.7 Assess the impact of cancer diagnosis and treatment on lifestyle and future employment needs and interventions appropriately										

12.8 Understand the importance and implications of findings and results and take appropriate action. This may be urgent referral/escalation as in life threatening situations, or further investigation, treatment or referral										
12.9 Formulate a differential diagnosis based on subjective and where available objective data										
12.10 Exercise clinical judgement and select the most likely diagnosis in relation to all information obtained. This may include the use of time as a diagnostic tool where appropriate										
12.11 Instigate appropriate investigative tests to aid diagnosis and assessment										
12.12 Demonstrate knowledge of tests and investigations commonly used in cancer care, including rationale for use and normal ranges of results										
12.13 Develop individualised patient care plans for tests and investigations and initiate them in accordance with guidelines and protocols										
12.14 Prescribe, initiate, interpret and monitor diagnostic tests and investigations independently according to the individual's clinical need										
12.15 Understand and interpret test results and act appropriately, demonstrating an understanding of the indications and limitations of different tests to inform decision-making and the imperative of using scarce, expensive or potentially harmful investigations judiciously										
12.16 Provide appropriate explanations to individuals regarding the procedures involved and the reasons for tests and investigations										
12.17 Ensure the needs of patients with complex needs are met when obtaining consent for tests and investigations e.g. learning difficulties, dementia, challenging issues relating to consent										

12.18 Provide support and further explanation to the patient and family after the clinician has discussed test results										
12.19 Act as an expert resource for other HCPs when dealing with complex or challenging situations relating to assessment										
12.20 Discuss findings with cancer specialist teams adopting a shared care template ensuring timely and optimum care										
12.21 Recognise when a clinical situation is beyond individual capability or competence and escalate appropriately										
12.22 Recognise other common co-morbidities that may be identified during assessment and makes appropriate referrals for ongoing care										

Domain C: Condition management, treatment and planning										
13.0 Capabilities: Clinical management **The practitioner is able to:**	**Practitioner level (See key) Tick level of achievement required**							**Self-assessment**	**Action plan and evidence of success**	**Review date**
13.1 Vary the management options responsively according to the circumstances, priorities, needs, preferences, risks and benefits for people with cancer at any point of their condition, with an understanding of local service availability and relevant guidelines and resources										
13.2 Consider a 'wait and see' approach for a change in condition or symptom where appropriate										
13.3 Safely prioritise problems in situations using shared agenda setting where the person presents with multiple issues										
13.4 Implement shared management/personalised care/support plans in collaboration with people, and where appropriate carers, families and other healthcare professional										
13.5 Arrange appropriate follow up that is safe and timely to monitor changes in the person's condition in response to treatment and advice, recognising the indications for a changing clinical picture and the need for escalation or alternative treatment as appropriate										
13.6 Evaluate outcomes of care against existing standards and patient outcomes and manage/adjust plans appropriately in line with best available evidence										
13.7 Identify when interventions have been successful and complete episodes of care with the person, offering appropriate follow-on advice to ensure people understand what to do if situations/circumstances change										

13.8 Promote continuity of care as appropriate to the person										
13.9 Suggest a variety of follow-up arrangements that are safe and appropriate, whilst also enhancing the person's autonomy										
13.10 Ensure safety netting advice is appropriate and the person understands when to seek urgent or routine review										
13.11 Support people who might be classed as frail and work with them utilising best practice										
13.12 Recognise, support and proactively manage people who require palliative care and those in their last year of life, extending the support to carers and families as appropriate										

Domain C: Condition management, treatment and planning										
14.0 Capabilities: Managing medical and clinical complexity and risk. **The practitioner is able to:**	**Practitioner level (See key) Tick level of achievement required**							**Self-assessment**	**Action plan and evidence of success**	**Review date**
14.1 Understand the complexities of working with people who have cancer +/- other clinical conditions including physical, psychological, spiritual and psychosocial										
14.2 Simultaneously proactively manage acute and chronic symptoms experienced by people with a cancer diagnosis, including people with other clinical conditions										
14.3 Manage both practitioner and peoples' uncertainty										
14.4 Appropriately support people at risk of or demonstrating signs of acute deterioration, with effective and timely MDT liaison and triage										
14.5 Recognise the conflicts that arise when managing people with multiple problems and take steps to adjust care appropriately										
14.6 Communicate risk effectively to people and involve them appropriately in management strategies and decision making										
14.7 Promote health among high- risk individuals affected by cancer - focuses on the role of advanced level and consultant level practitioners in the care of high-risk patients who require close monitoring and complex care plans for a variety of reasons such as vulnerability, hard to reach group, high risk of recurrence, high risk of treatment complications or experiencing adjustment challenges										
14.8 Consistently encourage prehabilitation, rehabilitation and, where appropriate, recovery										
14.9 Manage situations where care is needed out of hours and understand how to enable the necessary										

arrangements. This should include clear safety netting and escalation instructions for patients and carers										
14.10 Identify the need for immediate treatment of oncology-related palliative and urgent care emergencies such as cancer-associated thrombosis, metastatic spinal cord compression, superior vena cava obstruction and hypercalcaemia										
14.11 Support people appropriately and with regard for other care providers involved in their care										

Domain C: Condition management, treatment and planning										
15.0 Capabilities: Independent prescribing and pharmacotherapy **The practitioner is able to:**	**Practitioner level (See key) Tick level of achievement required**							**Self-assessment**	**Action plan and evidence of success**	**Review date**
15.1 Safely prescribe and/or administer therapeutic medications, relevant and appropriate to scope of practice, including an applied understanding of pharmacology which considers relevant physiological and/or pathophysiological changes and allergies										
15.2 Promote person-centred shared decision making to support medicine taking and side-effect reporting adherence										
15.3 Critically analyse polypharmacy, evaluating pharmacological interactions and the impact upon physical and mental well-being and healthcare provision										
15.4 Keep up-to-date and apply the principles of evidence-based practice, including clinical and cost-effectiveness and associated legal frameworks for prescribing. Follow Royal Pharmaceutical Framework guidelines (e.g. medicines optimisation)										
15.5 Practice in-line with the principles of antibiotic stewardship and antimicrobial resistance using available national resources										
15.6 Ensure pharmacological optimisation of co-morbidities following a diagnosis of cancer, pre, during and post treatment of cancer										
15,7 Appropriately review response to medication, recognising the balance of risks and benefits which may occur. Take account of context including what matters to the person and their experience and impact for them and preferences in the context of their life as well as polypharmacy, multimorbidity,										

frailty, existing medical issues such as kidney or liver issues and cognitive impairment										
15.8 Be able to confidently explain and discuss risk and benefit of non-cancer and chemotherapy medication with people using appropriate tools to assist as necessary										
15.9 Advise people on medicines management, including compliance and the expected benefits and limitations and inform them impartially on the advantages and disadvantages in the context of other management options										
15.10 Understand a range of options available other than drug prescribing (e.g. not prescribing, promoting self-care, advising on the purchase of over-the-counter medicines)										
15.11 Facilitate, refer to and/or prescribe non-medicinal therapies such as psycho-oncology, lifestyle changes, wellbeing information and support, and social prescribing										
15.12 Support people to only take medications they require and deprescribe where appropriate										
15.13 Support people having pharmacological treatment for cancer including knowledge of and management of side effects and when to seek additional advice										
15.14 Maintain accurate, legible and contemporaneous records of medication prescribed and/or administered and advice given in relation to medicine										

Domain C: Condition management, treatment and planning										
16.0 Capabilities: Prehabilitation and rehabilitation interventions The practitioner is able to:	**Practitioner level (See key) Tick level of achievement required**							**Self-assessment**	**Action plan and evidence of success**	**Review date**
16.1 Understand how to screen and assess people with cancer for prehabilitation interventions										
16.2 Understand the importance of prehabilitation interventions at the earliest opportunity from diagnosis and how to implement the elements of effective prehabilitation										
16.3 Understand the prehabilitation interventions and they can support people with cancer										
16.4 Understand the role of common rehabilitation interventions for people with cancer										
16.5 Have an in-depth knowledge of the rationale behind effective prehabilitation and rehabilitation and the role of advanced and consultant level practitioners in leading, designing, delivering services and undertaking research and education in this area of practice										
16.6 Advise on the expected benefits and limitations of different rehabilitation interventions used in managing the symptoms and side effects of cancer and its treatments providing impartial information and advice on the advantages and disadvantages of specific interventions in the context of other management options										
16.7 Provide advice on restoring function, including graded return to normal activity, navigation to self-management resources, and modifying activity for limited time periods										
16.8 Understand that cognitive, psychological and emotional support are the key to successful rehabilitation										

16.9 Understand that some individuals such as those living with disability, mental health issues, multimorbidity and/or frailty may require additional rehabilitation support and that their trajectory of recovery and/ or increased independence may be slower than for others										
16.10 Work in partnership with individuals to explore suitability of prehabilitation (universal, targeted and specialist) and rehabilitation interventions, including social prescribing for those requiring universal support e.g. referring individuals to a range of local non-clinical services such as community-based physical activity programmes, where appropriate										
16.11 Prescribe personal rehabilitation programmes to help individuals enhance, restore and maintain their mobility, function and independence considering the use of digital technology (e.g. apps and wearables) to support adherence where appropriate										
16.12 Refer individuals to highly specialist health and care professionals e.g. allied health professionals where this is appropriate to individuals' needs and wishes										
16.13 If in scope of professional practice, carry out specialist prehabilitation and rehabilitation assessments and treatments										
16.14 Make recommendations to employers regarding individuals' fitness to work, including through the appropriate use of fit not notes and seeking of appropriate occupational health advice										

Domain C: Condition management, treatment and planning										
17.0 Capabilities: Promoting self-management and behaviour change **The practitioner is able to:**	**Practitioner level (See key) Tick level of achievement required**							**Self-assessment**	**Action plan and evidence of success**	**Review date**
17.1 Screen and assess the ability, motivation, self-efficacy and activation of individual cancer patients to self-care developing strategies and interventions to enable individuals to optimise their ability to self-manage, evaluating their effectiveness and actions										
17.2 Understand and use behaviour change techniques such as motivational interviewing and health coaching to facilitate cancer patients to understand the contribution of healthy lifestyle behaviours in promoting and sustaining recovery and well-being prior to, during and after treatment										
17.3 Teach individuals to carry out self-monitoring and self-care, mentoring them in the process, including recognising symptoms that require further advice/investigation and the pathways available for accessing this care										
17.4 Promote the importance of physical activity for general health and advise on what people with cancer related symptoms can and should do										
17.5 Promote the importance of a healthy diet and nutritional requirements to reduce the impact of cancer-related symptoms										
17.6 Advise on the effects of smoking, obesity and inactivity in cancer related symptoms and, where appropriate promote change or refer to relevant services										
17.7 Provide encouragement to individuals attempting to change or adopt new health related behaviours providing positive reinforcement when they are finding it difficult or achieving less than they										

hoped, supporting development of realistic short and long-term goals										
17.8 Signpost individuals to local services that support healthy living, whilst acknowledging and respecting their individual decision making, applying knowledge of the range of services available to support and guide individuals across the care pathway										
17.9 Involve the family/support network (where appropriate) in supporting self-management and self-care										
17.10 Provide practical and emotional support to encourage individuals to take an active role in communicating with health professionals where this is needed, by supporting and encouraging them to ask questions about what is a priority or concern for them										
17.11 Recognise social, economic, and environmental factors that influence behaviour, and those that act as barriers and facilitators, providing intervention and/or signposting to inform and motivate individuals to change behaviour										
17.12 Develop and provide services with interventions designed to support behaviour change, using evidenced behaviour change techniques and tailored to the capabilities, opportunities and motivations of service users										
17.13 Proactively promote the self-care principle at local, national and international forums, supporting other team members to understand models and concepts related to health-related behaviour change and to recognise the ‘teachable moment’ with supporting theories										
17.14 Ensure that effective strategies are in place to maximise the opportunities for self-management and supported self-management										

Domain C: Condition management, treatment and planning										
18.0 Capabilities: Symptom management **The practitioner is able to:**	**Practitioner level (See key) Tick level of achievement required**							**Self-sssessment**	**Action plan and evidence of success**	**Review date**
Examples of disease-related/treatment-related symptoms and complications that patients with cancer can experience, which can occur at different stages in the pathway are provided in Appendix 5										
18.1 Recognise common symptoms and oncological emergencies										
18.2 Assess and recognise treatment-related and disease related symptoms relevant to own area of practice screen for all these symptoms										
18.3 Depending on profession, undertake assessment, plan care for and manage treatment-related and disease related symptoms using appropriate evidence-based screening and assessment tools										
18.4 Have a knowledge of the presentations of treatment-related and disease related symptoms and the red flags that would necessitate escalation, emergency admission and/or onward referral										
18.5 Complete referral or monitoring of any interventions given										
18.6 Report to specialist MDTs concerning progression, deterioration or those with highly specialist need										

Domain C: Condition management, treatment and planning										
19.0 Capabilities: Late effects **The practitioner is able to:**	**Practitioner level (See key) Tick level of achievement required**							**Self-assessment**	**Action plan and evidence of success**	**Review date**
19.1 Demonstrate knowledge of symptoms and care interventions for late effects appropriate to own client group/specialty (e.g. endocrine, bone health, cardiac toxicity, psychosexual issues, fertility, dental health, early menopause)										
19.2 Distinguish between symptoms and intervene to ensure individuals are on the appropriate care pathway e.g. treatment related, late effects, recurrence, progression										
19.3 Use protocols and guidelines to create holistic individual care pathways and documentation e.g. care plans, treatment summaries, late effects surveillance										
19.4 Provide specialist interventions and advice to support symptom management including complex symptoms arising from cancer, cancer treatment and late effects										
19.5 Use knowledge of cancer, its treatment and the risks of late effects complications to ensure assessments are appropriate to individual needs (e.g. type of cancer, treatment received, age, co-morbidities										
19.6 Provide information and support to primary care staff regarding ongoing late effects surveillance										
19.7 Work with other agencies and services to ensure that cancer, late effects and survivorship is fully integrated into the care plans of individuals with new and pre-existing mental health illness										
19.8 Work with health, social care and voluntary sector agencies to ensure coordinated care that										

meets current and anticipated future needs of individuals e.g. employment, financial, educational, late effects										
19.9 Develop systems for documenting symptoms that help to build knowledge about late effects and late effects services										
19.10 Develop systems for documenting assessment findings that help to increase wider knowledge about cancer, its treatment consequences and survivorship, late effects and care services										
19.11 Build partnerships with the health, social care, voluntary and independent sectors to promote engagement with cancer services and late effects care										
19.12 Play a leading role in local, network and national audits of late effects and cancer services										

Domain C: Condition management, treatment and planning										
20.0 Capabilities: Palliative and end of life care The practitioner is able to:	**Practitioner level (See key) Tick level of achievement required**							**Self-assessment**	**Action plan and evidence of success**	**Review date**
20.1 Take a structured history of a patient presenting with palliative care needs or in the last days of life										
20.2 Undertake appropriate system and symptom assessment and examination										
20.3 Provide well evidenced differential diagnosis and suggested management plan, to include the use of non-pharmacological interventions.										
20.4 Understand and practice within the key legal framework relating to end of life care such as: • Advanced Directives • Legal Power of Attorney • Do not resuscitate • Treatment escalation plans										
20.5 Identify and rationalise any need for additional support for the patient and carer / family, socially, psychologically and medically										
20.6 Identify the need for additional clinical and professional support such as referral, second opinion										

Domain D: Leadership and collaborative practice										
21.0 Capabilities: Leadership, management and organisation The practitioner is able to:	**Practitioner level (See key) Tick level of achievement required**							**Self-assessment**	**Action plan and evidence of success**	**Review date**
21.1 Be organised with due consideration for people and colleagues, carrying out both clinical and non-clinical aspects of work in a timely manner, demonstrating effective time management within the constraints of the time limited nature of healthcare										
21.2 Respond positively when services are under pressure, acting in a responsible and considered way to ensure safe practice										
21.3 Act appropriately when services deficiencies are identified (e.g. frequent long waiting times) that have the potential to affect the effective management of individuals' care and condition, including by taking corrective action, where needed										
21.4 Demonstrate leadership and resilience, managing situations that are unfamiliar, complex or unpredictable and seeking to build confidence in others										
21.5 Demonstrate receptiveness to challenge and preparedness to constructively challenge others, escalating concerns that affect people, families, carers, communities and colleagues' safety and well-being when necessary. clarity of roles within teams, to encourage productive working										
21.6 Demonstrate awareness of policies and procedures relevant to their own area of practice in cancer services and support service developments to improve patient outcomes										
21.7 Negotiate an individual's scope of practice within legal, ethical, professional and organisational policies, governance and procedures, with a focus on managing risk and upholding safety										

21.8 Influence policies for people living with and beyond cancer at local/regional/national level and feed back to own teams and external organisations, services, systems										
21.9 Demonstrate awareness of the funding, commissioning and development of cancer services to meet local needs										
21.10 Know the evidence required to influence funding and commissioning of cancer services, including cost, benefits, outcomes and utilisation and how these are used by decision makers										
21.11 Lead locally on the implementation of national guidance for services for people with cancer										
21.12 Represent services for people with cancer or own discipline at national and/or network meetings										
21.13 Regularly apply and lead the development of innovative service models across the pathway										
21.14 Capture and evaluate the required evidence and work with local enablers (e.g. departmental manager or general manager) to influence commissioning agendas locally and regionally										
21.15 Develop and implement robust governance systems and systematic documentation processes, keeping the need for modifications under critical review										
21.16 Respond to compliments and complaints appropriately, following professional standards and applicable local policy										
21.17 Actively participate in internal and external reviews for example, Significant/Serious Incident Review, peer review, CQC, cancer patient experience surveys and share the learning across services										
21.8 Engage people within own organisation/network and other key stakeholders in defining own organisation's/network's direction and committing their energies and expertise to achieving its results										

21.9 Work collaboratively at a strategic level with local, regional, system and national services/voluntary organisations to engage in short- and long-term strategic planning, peer review and team/service and system evaluation to encourage innovation, facilitate effective change and evaluate impact of clinical practice and quality of cancer care and services									

Domain E: Developing evidence-based practice and improving quality										
22.0 Capabilities: Research and evidence-based practice **The practitioner is able to:**	**Practitioner level (See key) Tick level of achievement required**							**Self-assessment**	**Action plan and evidence of success**	**Review date**
22.1 Demonstrate a detailed understanding of the importance of clinical research and evidence-based practice and applies to own area of practice										
22.2 Access appropriate sources of evidence to support their own practice in cancer and palliative care services (e.g. journals, literature reviews, research articles, audits, and arts-based practices)										
22.3 Understand and utilise the evidence of best practice to inform own practice										
22.4 Demonstrate an understanding of the principles of clinical research, and can explain to service users common terms and concepts in relation to their cancer treatments (e.g. placebo, randomisation, quantitative and qualitative research, critical appraisal, patient-reported outcomes, informed consent)										
22.5 Demonstrate working knowledge of: • the range of qualitative and quantitative methodologies available and their purpose • the concepts of validity and reliability in relation to the design of data collection, collation and analysis. • the processes used to critique a research paper and how to consider the implications for practice										
22.6 Use specialist knowledge to contribute to the development of evidence-based policies and procedures										

22.7 Contribute data to systems to be used for research, audit or service evaluation and understands own contribution to these processes										
22.8 Understand the ethical and legal issues around data collection and information handling, including confidentiality, consent, data protection and storage										
22.9 Work to advance the development of a research strategy for cancer, including prehabilitation, palliative care and/or living with cancer and lead their own or collaborative research projects										
22.10 Apply a range of quality assurance and research methodologies, selecting and applying rigorous and systematic methods, to evaluate own and other clinical practice, disseminating and using the findings to identify strategies to improve/enhance/innovate in cancer care and services										
22.11 Apply principles of ethical good clinical practice in relation to research, audit and service evaluation (e.g. working within local governance systems and policies, informed consent and confidentiality)										
22.12 Ensure that systems are in place to guarantee that project design and data management and dissemination meet ethical practice standards										
22.13 Take a critical approach to identify gaps in the evidence base and its application to practice, alerting appropriate individuals and organisations to these and how they might be addressed in a safe and pragmatic way. This may involve acting as an educator, leader, innovator and contributor to research activity and/or seeking out and applying for research funding										
22.14 Proactively network to develop and facilitate collaborative links with specialist cancer services and active researchers in academic and clinical settings to identify potential for further research in										

cancer care and opportunities to apply for funding, disseminate research and quality improvement through relevant media and fora										
22.15 Formulate and implement strategies to act on learning from range of sources (audit, service user feedback, research, policy) and knowledge of the funding of cancer care services in the NHS and third sector to make improvements, influence and lead new practice and service/system redesign solutions to reduce variation, promote access to underserved communities and enhance quality in response to feedback, evaluation and need										

Domain F: Developing evidence-based practice and improving quality										
23.0 Capabilities: Service evaluation and quality improvement **The practitioner is able to:**	**Practitioner level (See key) Tick level of achievement required**							**Self-assessment**	**Action plan and evidence of success**	**Review date**
23.1 Initiate, lead and guide investigation and review of services and subjects relating to people living with and affected by cancer symptom management										
23.2 Demonstrate the impact of advanced and consultant level clinical practice on service function and effectiveness, and quality (i.e. outcomes of care, experience and safety)										
23.3 Assist with service evaluations and audits of key aspects of own and shared practice e.g. patient satisfaction, local service standards										
23.4 Instigate developing practice in response to changing population health need, engaging in horizon scanning for future developments and to add value (e.g. impacts of genomics, new treatments and changing social challenges)										
23.4 Procure services that continually improve the pathway for people and supports lifestyle choices and future employment needs where applicable										
23.5 Identify areas of the current service that could be developed including identification of the gaps and potential opportunities										
23.6 Collect data required for service evaluations, audits or research in services for people living with and affected by cancer										
23.7 Develop systems for measuring outcomes for individuals, groups and services that enable accurate and meaningful reviews of progress and services										
23.8 Actively involve a range of service users in evaluating services, applying the principles of										

equality, diversity and anti-discriminatory practice and actively promotes cancer related research projects										
23.9 Interpret and summarise data relating to individuals, groups of patients and local cancer services to create information and knowledge that can influence the clinical trajectory (i.e. to recognise the need to commence palliative care or end of life services, service delivery and/or affect small scale service improvement)										
23.10 Evaluate the effectiveness of screening and assessment tools and guidelines used locally, nationally and internationally, as well as own data produced in terms of impact on patient outcomes and services and outcome measures linked to key drivers and evidence-based practice										
23.11 Critically evaluate local and national service change in similar cancer/palliative care services comparing the data and knowledge generated against own services to inform business cases and commissioning opportunities										
23.12 Use data supported information to drive both small- and large-scale service improvement and local research programme development										
23.13 Work with individuals and groups who are considered to be at high-risk due to their cancer experience and groups of service users to promote their inclusion in the development and review of services for people living with and beyond cancer and leads on delegated projects										
23.14 Ensure and monitor that own and local services meet the wide range of needs of people living with a cancer diagnosis from prehabilitation to living well (health promotion), to active surveillance and complex symptom management										
23.15 Set up monitoring to ensure that regional and network services meet the wide range of needs of people living with a cancer diagnosis from										

prehabilitation to living well (health promotion), to active surveillance and complex symptom management and lead on innovations in service delivery										
23.16 Contribute to the development and completion of peer review, service review, audits and research within local services										
23.16 Establish the development and completion of peer review, service review, audits and research within local/regional services evaluating and presenting findings to inform strategic service developments										

Domain G: Educating and developing self and other										
24.0 Capabilities: Education **The practitioner is able to:**	**Practitioner level (See key) Tick level of achievement required**							**Self-assessment**	**Action plan and evidence of success**	**Review date**
24.1 Critically assess and address own learning needs, negotiating a personal development plan that reflects the breadth of ongoing professional development across the four pillars of clinical practice										
24.2 Engage in self-directed learning, critically reflecting on practice to maximise advanced clinical skills and knowledge, as well as own potential to lead and develop both care and services locally and regionally										
24.3 Plan, engage in and record learning and development relevant to their role and in fulfilment of professional, regulatory and employment requirements										
24.4 Advocate for and contribute to a culture of organisational learning to inspire future and existing staff										
24.5 Act as a role model, educator, supervisor, coach and mentor, seeking to instil and develop the confidence of others, actively facilitating the development of others										
24.6 Establish, deliver and evaluate teaching/learning and development opportunities for the workforce providing general and specialist cancer care in a range of settings, including supervising and assessing those on clinical placements										
24.7 Contribute to curriculum development and delivery of cancer and/or palliative care										

modules/programmes at undergraduate and postgraduate level with education providers										
24.8 Instigate, promote and utilise clinical supervision for self and other members of the healthcare team to support and facilitate professional development										
24.9 Lead learning and development needs analyses to inform commissioning to build capacity and capability of the workforce providing care to people affected by cancer through work-based and interprofessional learning, and accredited modules and courses										
24.10 Disseminate and explain the findings best practice research, quality improvement projects and data through appropriate media, using language and terminology appropriate to the intended audience (e.g. service users, MDTs, network meeting)										
24.11 Establish opportunities to collaborate with those involved in providing services for people with cancer to generate ideas for spread and adoption of good practice, research, audits, service reviews and journal clubs										
24.12 Support other staff in the implementation of services for people with cancer										
24.13 Promote awareness and implementation of national guidance for rehabilitation relating to cancer, palliative care and end of life care, for example exercise and bone metastases guidance										
24.14 Promote the availability of local, regional and national cancer/palliative care learning opportunities within own service/system and foster links and placements for pre-registration learners and trainees, and the supportive, assistive and registered workforce to facilitate achievement of core cancer learning outcomes and capabilities in practice										
24.15 Write for publication and present at local and national conferences on own specialty/practice										

24.16 In collaboration with clinical, research and academic partners, disseminate research/knowledge exchange and innovation activities through presentations at national and international conferences and writing for publication										
24.17 Develop relationships with other agencies to promote research and enterprise, build partnerships to improve experiences and services for people living with and affected by cancer										
24.18 Engage in research supervision as member of supervisory teams for health and social care students/staff undertaking research										
24.19 Recognise people as a source of learning, in their stories, experiences and perspectives, and as peers to co-design and co-deliver educational opportunities. Appraise and respond to learning/information needs of individuals, families, carers and communities delivering informal learning opportunities and formal/structured education and training to people with cancer, their families and carers to promote self-care, support health literacy and empower participation in decision-making about aspects of their care, management and treatment										
24.20 Critically analyse and instigate the development of the workplace/system as a learning environment to enhance the knowledge, skills and capabilities of health and care colleagues to deliver evidence-based generalist and specialist cancer care, evaluating the impact and application of learning to clinical practice, patient and service outcomes										
24.21 Set up, procure or instigate business case to develop members of the wider multi-professional specialist cancer team as educators, supervisors and assessors for the workforce providing general and specialist cancer care										

Appendix 2: Audit Tools for Clinical, Learning and Higher Education Providers

Mapping template for clinical, learning and higher education providers

The mapping template has been developed to:

- inform curriculum development
- facilitate mapping of, and demonstrate the extent to which, pre-registration programmes enable students/learners to achieve the learning outcomes identified for the ‘module’ Foundations of Cancer Care and the pre-registration core cancer capabilities in practice at the point of registration
- facilitate mapping of, and demonstrate the extent to which, CPD and workplace learning opportunities and accredited modules (at undergraduate and postgraduate levels) enable the Supportive and Assistive workforce to achieve the learning outcomes identified for the ‘module’ Foundations of Cancer Care (equivalent to academic level X) and the core cancer-capabilities identified for their respective level and scope of practice
- facilitate mapping of, and demonstrate the extent to which, CPD opportunities and accredited programmes (at undergraduate and postgraduate levels) enable Registered Nursing and Allied Health Professionals to achieve the learning outcomes identified for the ‘module’ Fundamentals of cancer care and the core cancer-capabilities identified for their respective level and scope of practice
- facilitate collaborative working between education providers, employers, service providers and commissioners to promote learning opportunities which enable the supportive, assistive and registered nursing and allied health professions workforce (Registration, Enhanced, Advanced and Consultant levels) to meet the identified learning outcomes and cancer-specific capabilities in practice

Foundations of cancer care – core learning outcomes and syllabus for supportive level and pre-registration level nursing associates, nursing and allied health professions

Foundations of cancer care (FHEQ 4/5; CQFW 4/5; SCQF7/8) or equivalent	**Aims and learning outcomes**	**Syllabus**	**Assessment**	**Evidence of inclusion: (Tick relevant programme) UG or PG pre-registration programme Fd nursing associate/assistant practitioner/pharmacy technician programme**
Core foundation knowledge and skills for supportive level, pre-registration level trainee nursing associates, nursing and allied health professions students	**Aims:** (1) to provide an introduction to the philosophy, principles and practices underpinning cancer care and the provision of holistic person-centred care of people affected by cancer (2) to provide foundation knowledge, skills and capabilities for the supportive workforce, trainee nursing associates, pre-registration nursing and allied health professional students to provide evidence-based care for people affected by cancer at the point of registration **Learning outcomes:**	• Philosophy and principles of cancer care • Person-centred/family centred care • Transitions in cancer care (Risk reduction, screening, prehabilitation, treatment, rehabilitation, late and long-term effects, supportive, palliative and end of life care, bereavement care) • Biological basis/Process of carcinogenesis • Genomics and its applications in cancer diagnosis, prognosis and treatment • Grading and staging cancer • Cancer treatments and decision-making	Range of evidence to demonstrate achievement of defined learning outcomes and core cancer capabilities in practice for supportive and pre-registration level	

	• Examine current national policies, guidance and local healthcare processes influencing organisation of cancer services and care for people affected by cancer • Explore public and professional attitudes to cancer • Describe the biological basis of cancer and examine how this informs practices relating to risk reduction, early detection, screening, diagnosis, staging and grading of cancer, personalised treatment decisions • Analyse the physical, psychological, emotional and social impact of cancer and its treatment across the spectrum of cancer care • Examine the range of support (a) informational, (b) emotional, (c) esteem, (d) social network support, and (e) tangible support needs of people living with and beyond cancer, palliative and end of life care • Analyse models of communication and psychological support for addressing the emotional concerns of patients and/or their caregivers • Examine own professional role as part of multi-professional team contributing to person-centred assessment and care	• Multi-professional teamworking • Range of support needs – models of assessment including psychosocial assessment and support, person-centred assessment and care for people affected by cancer including self-care, self-management and rehabilitation/reablement • Models of communication, supportive conversations, emotional intelligence, wellbeing • Professional accountability, the law and ethical decision making • Principles of effective symptom assessment, management, and care. • Recognising oncological emergencies • Personal and team well-being, clinical supervision, • Reflective and evidence-based practice and continuing professional development		

	for people affected by cancer including self-care, self-management and rehabilitation/reablement • Explore own support and development needs and identifying opportunities for clinical supervision, support and development			

Fundamentals of cancer care – core learning outcomes and syllabus for Registration, Enhanced, Advanced and Consultant level nursing and allied health professions

Fundamentals of cancer care (FHEQ 6; CQFW 6; SCQF 10/9) or Postgraduate level (FHEQ 7; CQFW 7; SCQF 11) or equivalent	**Aims and learning outcomes**	**Syllabus**	**Assessment**	**Evidence of inclusion: (Tick relevant programme) PG post-registration module/programme**
Core for Registered practitioners at all levels To facilitate awareness of limitations of own knowledge and skills and to be able to signpost and refer patients to more specialist/advanced practitioners and/or specialist services. The 'module' includes the biological basis of cancer, risk factors, cancer patient referral and treatment pathways, staging and grading of cancer, treatment modalities and options including precision medicine, care of the acutely unwell patient with cancer, signposting, and referral.	**Aims** (1) to provide fundamental core knowledge and skills for registered nursing and allied health professionals to deliver optimal care for people affected by cancer, based upon the current evidence (2) To provide an in-depth focus on the philosophy, principles and practices of care for people affected by cancer to enable practitioners to undertake person-centred holistic evidence-based assessment and care **Learning outcomes:** • Critically appraise contemporary national and international policies,	• Philosophy and principles of cancer care • Policies influencing the delivery and quality of cancer care/services • Person-centred assessment, management and care • Transitions in cancer care (Primary prevention, screening, diagnosis, prehabilitation, treatment, rehabilitation, supportive, palliative and end of life care) • Understanding the biology of normal and cancer cells, cancer as a genetic disease/process of carcinogenesis, angiogenesis and metastases, cell growth, cell death and DNA repair, aetiology, epidemiology • Genomics and its applications in cancer diagnosis, prognosis and treatment • Presenting symptoms and referral for suspected cancer diagnosis	Range of evidence to demonstrate achievement of the learning outcomes and defined capabilities in practice for relevant level of practice Demonstrate communication skills to establish authentic, therapeutic relationships with all recipients of cancer care Undertake a person-centred assessment and formulate, communicate (using a range of formats) and deliver an effective, co- ordinated care plan	

It also delivers the principles of symptom assessment and management, care planning, communication skills, ethics, prehabilitation, rehabilitation, supportive care, bereavement care and future care planning. The module includes the principles of team and multi-agency working and co-ordinating care and respecting patient choices throughout the spectrum of cancer care.	guidance and healthcare processes influencing organisation of cancer services and care for people affected by cancer • Apply in-depth knowledge of the biological basis of cancer, risk factors, treatment options, staging and grading of cancer and the development of personalised treatments for cancer • Examine the impact of cancer and its treatment on the physical, psychological, emotional, social, and spiritual wellbeing of people affected by cancer • Critically evaluate models of communication and psychological support for addressing the emotional concerns of patients and/or their caregivers • Critically evaluate evidence-based assessment and personalised care and support strategies for people affected by cancer across the spectrum of care • Critically analyse their professional role in person-centred assessment and care for people affected by cancer	• Cancer pathways • Grading and staging cancer • Cancer treatments, developments in personalised medicine and the rationale for their use • Hazard management related to cancer treatments • Supporting value-based, shared decision-making • Person-centred and holistic models of care • Working within a multi-professional team, • Organisation of cancer services, referral and signposting • Models of communication, supportive and advanced communication skills and emotional intelligence • Strategies to maintain own emotional wellbeing • Recognising a person with an acute oncological emergency • Immediate care and escalation of oncological emergencies • Paraneoplastic syndromes • Professional accountability, the law and ethical decision making • Meaningful informed consent and mental capacity • Advance care planning • Principles of effective symptom assessment, management, and care (for		

	• Examine effective teamworking in the assessment and delivery of person-centred holistic care for people affected by cancer across the spectrum of care • Critically appraise the clinical, legal and ethical issues that arise in providing person-centred care and symptom management when caring for people affected by cancer as part of multi-professional teams across the spectrum of care • Debate professional contributions in terms of leadership, communication, and research and how being a reflective practitioner contributes to professional development	people with common or life-threatening symptoms of cancer/cancer treatment) • Psychosocial concerns and needs assessment and care • MDT care for the needs of families/ carers and bereavement support • Leadership and management in cancer care • Research utilisation and evidence in cancer care		

High- level learning outcomes and syllabus for Graduate/Postgraduate Certificate/Diploma/Masters

Module or award	Credits or equivalent	High level learning outcomes	Evidence of inclusion: (Tick relevant programme) UG or PG pre-registration programme Fd nursing associate/assistant practitioner/pharmacy technician programme
Foundations of cancer care		• Examine current national policies, guidance and local healthcare processes influencing organisation of cancer services and care for people affected by cancer • Explore public and professional attitudes to cancer • Describe the biological basis of cancer and examine how this informs practices relating to risk reduction, early detection, screening, diagnosis, staging and grading of cancer, personalised treatment decisions • Analyse the physical, psychological, emotional and social impact of cancer and its treatment across the spectrum of cancer care • Examine the range of support (a) informational, (b) emotional, (c) esteem, (d) social network support, and (e) tangible support needs of people living with and beyond cancer, palliative and end of life care • Analyse models of communication and psychological support for addressing the emotional concerns of patients and/or their caregivers • Examine own professional role as part of multi-professional team contributing to person-centred assessment and care for people affected by cancer including self-care, self-management and rehabilitation/reablement • Explore own support and development needs and identifying opportunities for clinical supervision, support and development	

Module or award	Credits or equivalent	High level learning outcomes	Evidence of inclusion: (Tick relevant programme) PG post-registration module/programme
Fundamentals of cancer care		• Critically appraise contemporary national and international policies, guidance and healthcare processes influencing organisation of cancer services and care for people affected by cancer • Apply in-depth knowledge of the biological basis of cancer, risk factors, treatment options, staging and grading of cancer and the development of personalised treatments for cancer • Examine the impact of cancer and its treatment on the physical, psychological, emotional, social, and spiritual wellbeing of people affected by cancer • Critically evaluate models of communication and psychological support for addressing the emotional concerns of patients and/or their caregivers • Critically evaluate evidence-based assessment and personalised care and support strategies for people affected by cancer across the spectrum of care • Critically analyse their professional role in person-centred assessment and care for people affected by cancer • Examine effective teamworking in the assessment and delivery of person-centred holistic care for people affected by cancer across the spectrum of care • Critically appraise the clinical, legal and ethical issues that arise in providing person-centred care and symptom management when caring for people affected by cancer as part of multi-professional teams across the spectrum of care • Debate professional contributions in terms of leadership, communication, and research and how being a reflective practitioner contributes to professional development	

Award	Credits or equivalent	High level learning outcomes	Evidence of inclusion: (Tick relevant programme) PG post-registration module/programme
Graduate/Postgraduate Certificate/ (or equivalent)	30/60	• To provide knowledge and skills for registered nursing and allied health professionals in equipping them with the knowledge and capabilities to provide optimal care for people affected by cancer, based upon the current evidence • To provide an in-depth focus of the philosophy, principles and practices of care for people affected by cancer to enable practitioners to undertake holistic and person-centred assessment and deliver care relevant to their area of practice • To support practitioners to continue to develop their clinical expertise in their sphere of practice whilst acquiring transferable skills • To work in collaboration with other practitioners, multi-professional teams and people affected by cancer in order to provide the optimal level of care	
Postgraduate Diploma (or equivalent)	120	As above plus: • To provide a comprehensive post-registration, postgraduate learning environment that utilises critical thinking, problem solving skills and a critical awareness of the research and evidence base to provide care and develop interventions to improve service user outcomes and promote high quality cancer care practice • To facilitate the reflexive acquisition of specialist knowledge in relation to contemporary issues within the student's area of cancer expertise and the creation of new insights into professional practice through knowledge and application of research, audit and service evaluation • To continue to develop a theoretical knowledge base, comprehensive skills and the professional	

		attitude to share knowledge through teaching, mentorship and/or coaching, and acting as a role model for others	
Masters	180	As above plus: • To facilitate the development of a comprehensive understanding of the techniques applicable to advance healthcare research and quality improvement demonstrating the ability to lead innovation and manage service developments in cancer care	

Domain A: Person-centred collaborative working								
1.0 Capabilities: Professional values and behaviours **The practitioner is able to:**	**Practitioner level (See key) Tick level of achievement required**							**Evidence of inclusion:** **(Tick relevant programme)** **UG or PG pre-registration programme** **Fd nursing associate/assistant practitioner/pharmacy technician programme** **PG post-registration module/programme**
1.1 Seek and engage with individuals' perspectives on their condition, their preferences for their care, and what is important to them and their carers in terms of treatment goals and outcomes								
1.2 Demonstrate understanding of the individual and show empathy for the impact of their cancer diagnosis								
1.3 Value and acknowledge the experience and expertise of individuals, their carers and support networks								
1.4 Use their clinical-reasoning skills to undertake an in-depth assessment of the presenting problem, interpret findings, develop working and differential diagnoses, formulate, communicate, implement and evaluate management plans								
1.5 Recognise the wider impact that symptoms of cancer, often persistent, can have on individuals, their families and those close to them								
1.6 Examine their role in supporting and enabling individuals to lead meaningful lives, whether or not cure or resolution is possible								
1.7 Promote and contribute to a consistent and integrated approach throughout the episode of care, focusing on the identified needs of the individual								
1.8 Role model integrated care, support and treatment through forward-planning, working in partnership with individuals, different professionals, teams, diverse communities, a range of organisations including the third sector, and through understanding, respecting and drawing on others' roles and competence								

1.9 Value collaborative involvement and engage people with cancer to improve and co-produce person-centred, quality services								
1.10 Adhere to legal, regulatory and ethical requirements, professional codes, and employer protocols								
1.11 Adopt a critical approach to ethical uncertainty and risk, working with others to resolve conflict								
1.12 Demonstrate safe, effective, autonomous, reflective practice								
1.13 Inform their practice and professional development and remain up to date with the best available evidence through the appropriate use of clinical guidelines and research findings								
1.14 Demonstrate accountability for their decisions and actions and the outcomes of their interventions								
1.15 Work effectively as part of a team, using their professional knowledge and skills, and drawing on those of their colleagues								
1.16 Promote person-centred care to meet individuals' best interests and to optimise service delivery								
1.17 Support clinical research to develop cancer practice								
1.18 Promote, enable and lead research to advance the development of cancer knowledge and practice								

Domain A: Person-centred collaborative working								
2.0 Capabilities: Maintaining an ethical approach and fitness to practice/ law, ethics and safeguarding **The practitioner is able to:**	**Practitioner level (See key) Tick level of achievement required**							**Evidence of inclusion:** **(Tick relevant programme)** **UG or PG pre-registration programme** **Fd nursing associate/assistant practitioner/pharmacy technician programme** **PG post-registration module/programme**
2.1 Demonstrate professional practice in own day to day clinical practice								
2.2 Critically reflect on how own values, attitudes and beliefs might influence own professional behaviour and interactions								
2.3 Use critical self-awareness of their own values, beliefs, prejudices, assumptions and stereotypes to mitigate the impact of these in how they interact with others								
2.4 Identify and act appropriately when own or others' behaviour undermines equality, diversity and human rights								
2.5 Reflect on and address appropriately ethical/moral dilemmas encountered during own work which may impact on care to people affected by cancer. Advocate equality, fairness and respect for people and colleagues in day to day practice								
2.6 Keep up to date with mandatory training and/or revalidation requirements, encompassing those requiring evidence related to care for people affected by cancer								
2.7 Recognise and ensure a balance between professional and personal life that meets work commitments, maintain own health, promote well-being and build resilience								
2.8 Demonstrate insight into any personal health issues and take effective steps to address any health issue or habit that is impacting on own performance								
2.9 Respond promptly and impartially when there are concerns about self or colleagues; take advice from								

appropriate people and, if necessary, engage in a referral procedure								
2.10 Promote mechanisms such as complaints, significant events and performance management processes in order to improve peoples' care								
2.11 Promote mechanisms such as compliments and letters of thanks to acknowledge and promote good practice								

Domain A. Person-centred collaborative working								
3.0 Capabilities: **The practitioner is able to:**	**Practitioner level (See key) Tick level of achievement required**							**Evidence of inclusion:** **(Tick relevant programme)** **UG or PG pre-registration programme** **Fd nursing associate/assistant practitioner/pharmacy technician programme** **PG post-registration module/programme**
3.1 Consistently role model highly developed interpersonal and advanced communication skills to engage in effective, appropriate, enabling and complex interactions with individuals, carers and colleagues in the clinical environments and roles in which they practise								
3.2 Use advanced skills in listening and information-processing, alongside empathetic skills to assess, explore and respond to individuals' complex needs and concerns								
3.3 Select appropriate language and media (including remote consultation such as telephone, skype, sign language, written etc) to facilitate effective communication and interactions with people affected by cancer								
3.4 Respond sensitively to individual preferences and needs and uphold and safeguard individuals' interests								
3.5 Establish and integrate individuals' specific needs, preferences, priorities and circumstances to guide the care and treatment they offer								
3.6 Demonstrate respect for individuals' expertise in their own life and condition and empower and support them to retain control and to make choices that fit with their goals								
3.7 Use active listening and facilitation skills to enable individuals to talk about their concerns and priorities relating to their cancer symptoms and implications of its treatment								
3.8 Help individuals and carers to understand their care options, sharing information on the risks,								

benefits, consequences, and potential outcomes in a clear, open way to support shared decision-making								
3.9 Promote value-based decision making, critically evaluating and appropriately applying their knowledge and skills in a person-centred way, challenging predetermined protocols or workplace imperatives where necessary								

Domain A. Person-centred collaborative working								
4.0 Capabilities: Communication and consultation skills The practitioner is able to:	**Practitioner level (See key) Tick level of achievement required**							**Evidence of inclusion: (Tick relevant programme) UG or PG pre-registration programme Fd nursing associate/assistant practitioner/pharmacy technician programme PG post-registration module/programme**
4.1 Actively listen to and communicate effectively with others, recognising that both are an active, two-way process								
4.2 Critically appraise communication strategies and be able to optimise communication approaches appropriately using skills such as active listening e.g. frequent clarifying, paraphrasing and picking up verbal cues such as pace, pauses and voice intonation								
4.3 Reflect on communication strategies and skilfully adapt those employed to ensure communication strategies foster an environment of person empowerment								
4.4 Communicate in ways that build and sustain relationships, seeking, gathering and sharing information appropriately, efficiently and effectively to expedite and integrate people's care								
4.5 Communicate effectively, respectfully and professionally with service users and carers at times of conflicting priorities and opinions								
4.6 Convey information and address issues in ways that avoid jargon and assumptions; respond appropriately to questions and concerns to promote understanding, including use of verbal, written and digital information								
4.7 Engage with individuals and carers and respond appropriately to questions and concerns about their cancer related symptoms and its impact on their current situation and potentially in the future drawing on practitioners' in-depth knowledge of cancer and its effects								

4.8 Autonomously adapt verbal and non-verbal communication styles in ways that are empathetic and responsive to people's communication and language needs, preferences and abilities (including levels of spoken English and health literacy)								
4.9 Communicate effectively with individuals who require additional assistance, such as sensory or cognitive impairments, to ensure an effective interface with a practitioner, including the use of accessible information								
4.10 Evaluate and remedy situations, circumstances or places which make it difficult to communicate effectively (e.g. noisy, distressing environments which may occur during home visits, care home visits or in emergency situations), and have strategies in place to overcome these barrier								
4.11 Consult in a highly organised and structured way, with professional curiosity as required, whilst understanding the constraints of the time limited nature of consultations and ensure communication is safe and effective								
4.12 Adapt communication approaches to non-face to face situational environments e.g. phone, video, email or remote consultation								
4.13 Contextualise communication approaches to use in group situations								
4.14 Respond to people effectively, respectfully and professionally, including carers and families, especially at times of conflicting priorities and opinions and be able to facilitate shared agenda setting using a triadic consultation approach								
4.15 Select effective, situation and patient appropriate history taking and consultation skills drawing on knowledge and expertise in advanced communication skills								

Domain A. Person-centred collaborative working								
5.0 Capabilities: Personalising the pathway for people living with and affected by cancer **The practitioner is able to:**	**Practitioner level (See key) Tick level of achievement required**							**Evidence of inclusion:** **(Tick relevant programme)** **UG or PG pre-registration programme** **Fd nursing associate/assistant practitioner/pharmacy technician programme** **PG post-registration module/programme**
5.1 Demonstrate sensitivity to the significance of individuals' background, identity, culture, values and experiences for how their cancer condition impacts on their life, recognising the expertise that individuals bring to managing their own care								
5.2 Work with individuals to develop personalised care plans that: • Reflect their priorities and concerns both now and for the future. • Encourage self-care and self-reporting of significant symptoms, including in an emergency. • Consider the psychological effects of cancer and strategies to manage this. • Incorporate other medical conditions and frailty risk • Consider the risks, benefits and consequences of each available option								
5.3 Take account during care planning of the burden of treatment for individuals with cancer and co-morbidities, including regular appointments that may also be for the management of their other healthcare needs								
5.4 Use protocols and guidelines to create person-centred individual care pathways and documentation e.g. care plans, treatment summaries, late effects surveillance								
5.5 Progress care, recognising that reducing symptoms, restoring and maintaining function and								

independence, and improving quality of life all form clinical outcomes and meaningful goals of treatment								
5.6 Recognise and intervene when deviations occur from expected progress, meaning changes may be needed in the care plan, adapting it to the changing needs, such as cancer recurrence or end of life care								
5.7 Work collaboratively with individuals, their families and the MDT to manage complex situations arising from care plans e.g. differing perspectives of treatment plans								
5.8 Coordinate individualised care across sectors and disciplines according to the needs identified in the care plan								
5.9 Establish processes and ensure physical, psychological and social assessments are incorporated into local care planning systems e.g. health promotion, psychosocial adjustment, work and social functioning								
5.10 Recognise the significance of family, carers and social networks in planning and providing care and the importance of developing partnerships with them, with due regard for the complexity and diversity in family relationships and arrangements								
5.11 Review and audit care plans to promote evidence-based practice and ensure these reflect current best practice								
5.12 Evaluate the implications of, and apply in practice, the relevant legislation for meaningful informed consent and shared decision making (e.g. mental capacity legislation, Fraser Guidelines)								
5.13 Monitor and evaluate services and pathways to ensure these are delivered effectively within own speciality or clinical field to meet the relative risks or complications and complexity of needs								
5.14 Work with local service providers to develop pathways that facilitate rapid access to services when the need to do so is identified e.g. re-entry to acute care services following signs of recurrence								

Domain A. Person-centred collaborative working								
6.0 Capabilities: Helping people make informed choices as they live with or are affected by cancer **The practitioner is able to:**	**Practitioner level (See key) Tick level of achievement required**							**Evidence of inclusion:** **(Tick relevant programme)** **UG or PG pre-registration programme** **Fd nursing associate/assistant practitioner/pharmacy technician programme** **PG post-registration module/programme**
6.1 Provide information and advice appropriate to the needs, priorities and concerns of individuals								
6.2 Respond to individuals' descriptions of their needs, preferences and concerns to ensure that care plans meet their goals and needs, managing the changing needs and expectations of patients and their families and ensures care plans reflect the new priorities								
6.3 Act as an expert resource for other health and care professionals when dealing with complex communication issues, such as when an individual's choices put them at risk								
6.4 Acknowledge and respect the decisions made by individuals concerning their health and wellbeing in relation to cancer, cancer treatments, survivorship and late effects care								
6.5 Explain the options, including the benefits and risks, that are available to individuals to enable them to reach their own decisions about their treatment, health and wellbeing and set their own priorities								
6.6 Make appropriate decisions to seek help and report concerns to colleagues when an individual's choices place them at risk								
6.7 Identify factors that can affect an individual's ability to request, organise or access services or assistance and take appropriate action to help them receive the care they require (e.g. knowledge, confidence, physical constraints, social isolation)								

6.8 Provide information and assistance to help individuals access the services and resources they require to implement their decisions								
6.9 Promote the participation and inclusion of all service users and ensure that potential barriers are reported to the appropriate personnel								
6.10 Work to ensure that services are inclusive and promotes equal opportunities for access and service provision								
6.11 Recognise and promote the importance of social networks and communities for people and their carers in managing cancer related symptoms								
6.12 Collaborate with other providers to promote services to help individuals make informed choices about their health and wellbeing and to develop information (visual, audio, written and non-text based information) and support to ensure individuals receive information appropriate to their needs and at the right time in the pathway								

Domain A. Person-centred collaborative working								
7.0 Capabilities: Providing information to support self-management and enable independence for people living with and affected by cancer The practitioner is able to:	**Practitioner level (See key) Tick level of achievement required**							**Evidence of inclusion: (Tick relevant programme) UG or PG pre-registration programme Fd nursing associate/assistant practitioner/pharmacy technician programme PG post-registration module/programme**
7.1 Provide written, online and verbal information to individuals about their condition, treatment and services available to support self-care and independence								
7.2 Contribute to the development and evaluation of patient information resources for people living with and affected by cancer								
7.3 Provide individuals with accessible information to support their intervention plan, for instance, crib sheet/audio visual material of signs and symptoms to be monitored in relation to cancer, cancer treatments, recurrence or likely late effects								
7.4 Access information from a range of resources and use them to meet the individual needs of service users, translating clinically related topics into language which is understandable both for individuals to self-manage effectively and for the development of patient information								
7.5 Critically assess written information/websites before recommending them								
7.6 Evaluate individual's understanding of information, (including written, visual and audio-based information), communicate effectively to correct misunderstandings and explain complex medical terminology in lay terms								
7.7 Direct individuals and family members to local resources, appropriate agencies and information sources, including online information or non-text based information, on issues that may affect them following cancer treatment, including work and finance matters								

7.8 Offer guidance and support with accessing appropriate online sources of information								
7.9 Work with other teams and agencies to develop information and support resources to ensure individual people living with cancer and palliative care needs receive information appropriate to their needs, involving users in information development								
7.10 Lead and develop support groups for individuals living with and affected by cancer and identifies opportunities/gaps in the provision of support groups at a local level								
7.11 Implement and inform local and national initiatives regarding the development of information and support resources								

Domain A. Person-centred collaborative working								
8.0 Capabilities: Multi-disciplinary, interagency and partnership working **The practitioner is able to:**	**Practitioner level (See key) Tick level of achievement required**							**Evidence of inclusion:** **(Tick relevant programme)** **UG or PG pre-registration programme** **Fd nursing associate/assistant practitioner/pharmacy technician programme** **PG post-registration module/programme**
8.1 Practise within their professional and personal scope of practice and access specialist advice or support for the individual or for themselves when appropriate								
8.2 Engage in effective inter-professional communication and collaboration with clear documentation to optimise the integrated management of the individual with cancer								
8.3 Liaise between service users, relatives and carers when making links to members of the multi-disciplinary team involved in planning an individual patient's care pathway to optimise interventions								
8.4 Act as a key contact with a variety of agencies in relation to current and anticipated needs of individual patients (e.g. employment, education, financial, exercise services), understanding the contributions of different health, social care and voluntary sector services in meeting holistic care needs (e.g. financial, vocational, practical and emotional support)								
8.5 Have a knowledge of the range of services available to support people across the care pathway and how to refer/signpost to them with awareness of when it would be appropriate to refer back to treating centres, including for emergency presentations								
8.6 Coordinate MDT interventions relating to patients with complex care needs after cancer and cancer treatment, working with the MDT and health, social care and voluntary sector agencies care plan e.g. ongoing care, discharge and surveillance community care plans								

8.7 Work effectively within and across teams, managing the complexity of transition from one team to another or membership of multiple teams								
8.8 Work with health, social care and voluntary sector agencies to ensure coordinated care that meets current and anticipated future needs of individuals e.g. employment, financial, educational, late effects								
8.9 Liaise with, signpost to and make referrals to the multi-disciplinary team and other health and care professionals across all settings relating to other co-morbidities (e.g. learning disability, mental health as appropriate for the patient's physical and psychological symptoms)								
8.10 Provide expert advice to other members of the MDT and health, social care and voluntary sector agencies								
8.11 Actively contribute to the development of services in the MDT understanding the importance of effective team dynamics								
8.12 Build partnerships with the health, social care, voluntary and independent sectors to promote engagement with cancer services and late effects care								

Domain A. Person-centred collaborative working								
9.0 Capabilities: Referrals and integrated working to support transitional care for people living with and affected by cancer **The practitioner is able to:**	**Practitioner level (See key) Tick level of achievement required**							**Evidence of inclusion:** **(Tick relevant programme)** **UG or PG pre-registration programme** **Fd nursing associate/assistant practitioner/pharmacy technician programme** **PG post-registration module/programme**
9.1 Understand the roles that acute, community and primary care services play in supporting people living with and affected by cancer								
9.2 Understand the issues facing individuals as they complete cancer treatment or are discharged from acute hospital follow-up								
9.3 Support individuals to develop confidence in their ability to cope with transition points in their care such as on discharge from hospital care to self-managing at home, supporting independence and acts as an advocate as appropriate								
9.4 Effectively uses the treatment summary and surveillance plan in communication between hospital and primary care services, communicating effectively and working with other HCPs and services to ensure individuals receive appropriate ongoing cancer care								
9.5 Take an active role in working with others to minimise the occurrence of potential crises e.g. inappropriate admission to hospital								
9.6 Provide information and support regarding ongoing late effects surveillance								
9.7 Act as a specialist resource for local health, social care and voluntary sector services regarding transitional care								
9.8 Take a leading role in developing emergency referral pathways and educating the wider MDT on appropriate courses of action								
9.9 Lead and develop strong partnership working with all key stakeholders in a local area and acts as the expert in this area demonstrating effective communication across complex organisations								

9.10 Work with other agencies to develop clear pathways and guidelines for the transfer of long term follow-up to primary services and to different models of follow up care								
9.11 Lead and evaluates the development of education programmes for staff involved in supporting patients who move across different healthcare settings to affect a safe and effective transfer								

Domain B: Assessment, investigations and diagnosis								
10.0 Capabilities: History taking **The practitioner is able to:**	**Practitioner level (See key) Tick level of achievement required**							**Evidence of inclusion:** **(Tick relevant programme)** **UG or PG pre-registration programme** **Fd nursing associate/assistant practitioner/pharmacy technician programme** **PG post-registration module/programme**
10.1 Demonstrate an understanding of the Holistic Needs Assessment and Care Plan (HNA) process, including the physical and psychosocial components, and its implications for practice; understanding the components which might influence personal choice, such as faith, age, culture								
10.2 In collaboration with the individual, use the Holistic Needs Assessment and Care Plan to identify and prioritise needs which require support and informs the development of an appropriate personalised plan with defined outcomes								
10.3 Structure consultations so that the person and/or their carer/family (where applicable) is encouraged to express their ideas, concerns, expectations and understanding								
10.4 Uses specialist skills and knowledge to carry out screening and clinical assessments, conducting assessments using appropriate standardised, evidence-based screening and assessment tools (Examples include, but not limited to: 5 times sit to stand test; 6-minute walk test; cardiopulmonary exercise test; incremental shuttle walk test; MUST; Royal Marsden nutrition screening tool; Patient generated subjective global assessment questionnaire; Patient health questionnaire-9; Generalised anxiety disorder assessment (GAD-7); Hospital anxiety and depression scales (anxiety and/or depression), EORTC QLQ-C-30; Brief fatigue inventory, WHO disability assessment schedule)								

10.5 Use active listening skills and open questions to effectively engage and facilitate shared agenda setting								
10.6 Explore and appraise peoples' ideas, concerns and expectations about their symptoms and condition and whether these may act as a driver or form a barrier								
10.7 Understand and apply a range of consultation models appropriate to the clinical situation and appropriately across physical, mental and psychological presentations								
10.8 Be able to undertake general history-taking, and focused history-taking to elicit and assess 'red flags,' acute oncological presentations, reoccurrence, cancer treatment side effects and late effects								
10.9 Synthesise information, taking account of factors which may include the presenting symptom? existing symptoms? past medical history, genetic predisposition, medications, allergies, risk factors and other determinants of health to establish differential diagnoses								
10.10 Incorporate information on the nature of the person's needs preferences and priorities from various other appropriate sources e.g. third parties, previous histories and investigations								
10.11 Assess the impact of individuals' presenting symptoms, including the impairment of function, limitation of activities and restriction on participation, including work								
10.12 Deliver diagnosis and test/investigation results, (including bad news) sensitively and appropriately in line with local or national guidance, using a range of mediums including spoken word and diagrams for example to ensure the person has understanding about what has been communicated								
10.13 Record all pertinent information gathered concisely and accurately for clinical management,								

and in compliance with local guidance, legal and professional requirements for confidentiality, data protection and information governance								

Domain B: Assessment, investigations and diagnosis								
11.0 Capabilities: Clinical physical and mental health assessment **The practitioner is able to:**	**Practitioner level (See key) Tick level of achievement required**							**Evidence of inclusion:** **(Tick relevant programme)** **UG or PG pre-registration programme** **Fd nursing associate/assistant practitioner/pharmacy technician programme** **PG post-registration module/programme**
11.1 Appropriately obtain consent to physical examination, respect and maintain the patient's privacy, dignity (and comfort as far as practicable), and comply with infection prevention and control procedures								
11.2 Adapt their practice to meet the needs of different groups and individuals (including those with particular needs such as cognitive impairment or learning disabilities), working with chaperones, where appropriate								
11.3 Undertake observational and functional assessments of individuals relevant to their presenting condition to identify and characterise any abnormality								
11.4 Apply a range of physical assessment and clinical examination techniques appropriately, systematically and effectively								
11.5 Use nationally recognised tools where appropriate to assess peoples' condition and symptoms								
11.6 Perform a mental health assessment appropriate to the needs of the patient and the setting								
11.7 Assess the psychological, social and emotional needs of cancer patients, their relatives and carers including coming to terms with a cancer diagnosis and potentially a terminal diagnosis.								
11.8 Use knowledge of cancer, its treatment and the risks of late effects complications to ensure assessments are appropriate to individual needs								

(e.g. type of cancer, treatment received, age, co-morbidities)								
11.9 Identify, analyse and interpret potentially significant information from the physical and mental health assessment (including any ambiguities) and consider the need for an appropriate and timely referral								
11.10 Record the information gathered through assessments concisely and accurately, for clinical management and in compliance with local guidance, legal and professional requirements for confidentiality, data protection and information governance								

Domain B: Assessment, investigations and diagnosis								
12.0 Capabilities: Investigations, diagnosis and care planning **The practitioner is able to:**	**Practitioner level (See key) Tick level of achievement required**							**Evidence of inclusion:** **(Tick relevant programme)** **UG or PG pre-registration programme** **Fd nursing associate/assistant practitioner/pharmacy technician programme** **PG post-registration module/programme**
12.1 Identify possible differential diagnoses for symptoms using a structured problem-solving method informed by an understanding of probability based on prevalence, incidence and of symptoms to aid decision making								
12.2 Understand the role of risk stratification and the implications for the patient in ongoing surveillance for people living with cancer or for those at increased risk of cancer. This might include the identification of those at risk of increased frailty or those with a hereditary gene mutation								
12.3 Lead and develop services based on a risk stratified approach to care in collaboration with the wider multidisciplinary team								
12.4 Assess the importance and meaning of presenting features from the clinical assessment, recognising the different symptoms and conditions commonly seen in first point of contact roles in cancer care								
12.5 Recognise signs and symptoms requiring a change in the care pathway e.g. side effect grading, psychological concerns (such as depression and anxiety) cancer recurrence and end of life care and initiates appropriate interventions								
12.6 Identify risk factors for severity or impact and use tools where they exist to analyse and stratify risk of progression to long term symptoms and disability								
12.7 Assess the impact of cancer diagnosis and treatment on lifestyle and future employment needs and interventions appropriately								

12.8 Understand the importance and implications of findings and results and take appropriate action. This may be urgent referral/escalation as in life threatening situations, or further investigation, treatment or referral								
12.9 Formulate a differential diagnosis based on subjective and where available objective data								
12.10 Exercise clinical judgement and select the most likely diagnosis in relation to all information obtained. This may include the use of time as a diagnostic tool where appropriate								
12.11 Instigate appropriate investigative tests to aid diagnosis and assessment								
12.12 Demonstrate knowledge of tests and investigations commonly used in cancer care, including rationale for use and normal ranges of results								
12.13 Develop individualised patient care plans for tests and investigations and initiate them in accordance with guidelines and protocols								
12.14 Prescribe, initiate, interpret and monitor diagnostic tests and investigations independently according to the individual's clinical need								
12.15 Understand and interpret test results and act appropriately, demonstrating an understanding of the indications and limitations of different tests to inform decision-making and the imperative of using scarce, expensive or potentially harmful investigations judiciously								
12.16 Provide appropriate explanations to individuals regarding the procedures involved and the reasons for tests and investigations								
12.17 Ensure the needs of patients with complex needs are met when obtaining consent for tests and investigations e.g. learning difficulties, dementia, challenging issues relating to consent								

12.18 Provide support and further explanation to the patient and family after the clinician has discussed test results								
12.19 Act as an expert resource for other HCPs when dealing with complex or challenging situations relating to assessment								
12.20 Discuss findings with cancer specialist teams adopting a shared care template ensuring timely and optimum care								
12.21 Recognise when a clinical situation is beyond individual capability or competence and escalate appropriately								
12.22 Recognise other common co-morbidities that may be identified during assessment and makes appropriate referrals for ongoing care								

Domain C: Condition management, treatment and planning								
13.0 Capabilities: Clinical management **The practitioner is able to:**	**Practitioner level (See key) Tick level of achievement required**							**Evidence of inclusion:** **(Tick relevant programme)** **UG or PG pre-registration programme** **Fd nursing associate/assistant practitioner/pharmacy technician programme** **PG post-registration module/programme**
13.1 Vary the management options responsively according to the circumstances, priorities, needs, preferences, risks and benefits for people with cancer at any point of their condition, with an understanding of local service availability and relevant guidelines and resources								
13.2 Consider a 'wait and see' approach for a change in condition or symptom where appropriate								
13.3 Safely prioritise problems in situations using shared agenda setting where the person presents with multiple issues								
13.4 Implement shared management/personalised care/support plans in collaboration with people, and where appropriate carers, families and other healthcare professionals								
13.5 Arrange appropriate follow up that is safe and timely to monitor changes in the person's condition in response to treatment and advice, recognising the indications for a changing clinical picture and the need for escalation or alternative treatment as appropriate								
13.6 Evaluate outcomes of care against existing standards and patient outcomes and manage/adjust plans appropriately in line with best available evidence								
13.7 Identify when interventions have been successful and complete episodes of care with the person, offering appropriate follow-on advice to ensure people understand what to do if situations/circumstances change								

13.8 Promote continuity of care as appropriate to the person								
13.9 Suggest a variety of follow-up arrangements that are safe and appropriate, whilst also enhancing the person's autonomy								
13.10 Ensure safety netting advice is appropriate and the person understands when to seek urgent or routine review								
13.11 Support people who might be classed as frail and work with them utilising best practice								
13.12 Recognise, support and proactively manage people who require palliative care and those in their last year of life, extending the support to carers and families as appropriate								

Domain C: Condition management, treatment and planning								
14.0 Capabilities: Managing medical and clinical complexity and risk. **The practitioner is able to:**	**Practitioner level (See key) Tick level of achievement required**							**Evidence of inclusion:** **(Tick relevant programme)** **UG or PG pre-registration programme** **Fd nursing associate/assistant practitioner/pharmacy technician programme** **PG post-registration module/programme**
14.1 Understand the complexities of working with people who have cancer +/- other clinical conditions including physical, psychological, spiritual and psychosocial								
14.2 Simultaneously proactively manage acute and chronic symptoms experienced by people with a cancer diagnosis, including people with other clinical conditions								
14.3 Manage both practitioner and peoples' uncertainty								
14.4 Appropriately support people at risk of or demonstrating signs of acute deterioration, with effective and timely MDT liaison and triage								
14.5 Recognise the conflicts that arise when managing people with multiple problems and take steps to adjust care appropriately								
14.6 Communicate risk effectively to people and involve them appropriately in management strategies and decision making								
14.7 Promote health among high- risk individuals affected by cancer - focuses on the role of advanced level and consultant level practitioners in the care of high-risk patients who require close monitoring and complex care plans for a variety of reasons such as vulnerability, hard to reach group, high risk of recurrence, high risk of treatment complications or experiencing adjustment challenges								
14.8 Consistently encourage prehabilitation, rehabilitation and, where appropriate, recovery.								

14.9 Manage situations where care is needed out of hours and understand how to enable the necessary arrangements. This should include clear safety netting and escalation instructions for patients and carers								
14.10 Identify the need for immediate treatment of oncology-related palliative and urgent care emergencies such as cancer-associated thrombosis, metastatic spinal cord compression, superior vena cava obstruction and hypercalcaemia								
14.11 Support people appropriately and with regard for other care providers involved in their care								

Domain C: Condition management, treatment and planning								
15.0 Capabilities: Independent prescribing and pharmacotherapy **The practitioner is able to:**	**Practitioner level (See key) Tick level of achievement required**							**Evidence of inclusion:** **(Tick relevant programme)** **UG or PG pre-registration programme** **Fd nursing associate/assistant practitioner/pharmacy technician programme** **PG post-registration module/programme**
15.1 Safely prescribe and/or administer therapeutic medications, relevant and appropriate to scope of practice, including an applied understanding of pharmacology which considers relevant physiological and/or pathophysiological changes and allergies								
15.2 Promote person-centred shared decision making to support medicine taking and side-effect reporting adherence								
15.3 Critically analyse polypharmacy, evaluating pharmacological interactions and the impact upon physical and mental well-being and healthcare provision								
15.4 Keep up-to-date and apply the principles of evidence-based practice, including clinical and cost-effectiveness and associated legal frameworks for prescribing. Follow Royal Pharmaceutical Framework guidelines (e.g. medicines optimisation)								
15.5 Practice in-line with the principles of antibiotic stewardship and antimicrobial resistance using available national resources								
15.6 Ensure pharmacological optimisation of co-morbidities following a diagnosis of cancer, pre, during and post treatment of cancer								
15,7 Appropriately review response to medication, recognising the balance of risks and benefits which may occur. Take account of context including what matters to the person and their experience and impact for them and preferences in the context of their life as well as polypharmacy, multimorbidity,								

frailty, existing medical issues such as kidney or liver issues and cognitive impairment								
15.8 Be able to confidently explain and discuss risk and benefit of non-cancer and chemotherapy medication with people using appropriate tools to assist as necessary								
15.9 Advise people on medicines management, including compliance and the expected benefits and limitations and inform them impartially on the advantages and disadvantages in the context of other management options								
15.10 Understand a range of options available other than drug prescribing (e.g. not prescribing, promoting self-care, advising on the purchase of over-the-counter medicines)								
15.11 Facilitate, refer to and/or prescribe non-medicinal therapies such as psycho-oncology, lifestyle changes, wellbeing information and support, and social prescribing								
15.12 Support people to only take medications they require and deprescribe where appropriate								
15.13 Support people having pharmacological treatment for cancer including knowledge of and management of side effects and when to seek additional advice								
15.14 Maintain accurate, legible and contemporaneous records of medication prescribed and/or administered and advice given in relation to medicine								

Domain C: Condition management, treatment and planning								
16.0 Capabilities: Prehabilitation and rehabilitation interventions **The practitioner is able to:**	**Practitioner level (See key) Tick level of achievement required**							**Evidence of inclusion:** **(Tick relevant programme)** **UG or PG pre-registration programme** **Fd nursing associate/assistant practitioner/pharmacy technician programme** **PG post-registration module/programme**
16.1 Understand how to screen and assess people with cancer for prehabilitation interventions								
16.2 Understand the importance of prehabilitation interventions at the earliest opportunity from diagnosis and how to implement the elements of effective prehabilitation								
16.3 Understand the prehabilitation interventions and they can support people with cancer								
16.4 Understand the role of common rehabilitation interventions for people with cancer								
16.5 Have an in-depth knowledge of the rationale behind effective prehabilitation and rehabilitation and the role of advanced and consultant level practitioners in leading, designing, delivering services and undertaking research and education in this area of practice								
16.6 Advise on the expected benefits and limitations of different rehabilitation interventions used in managing the symptoms and side effects of cancer and its treatments providing impartial information and advice on the advantages and disadvantages of specific interventions in the context of other management options								
16.7 Provide advice on restoring function, including graded return to normal activity, navigation to self-management resources, and modifying activity for limited time periods								
16.8 Understand that cognitive, psychological and emotional support are the key to successful rehabilitation								

16.9 Understand that some individuals such as those living with disability, mental health issues, multimorbidity and/or frailty may require additional rehabilitation support and that their trajectory of recovery and/ or increased independence may be slower than for others								
16.10 Work in partnership with individuals to explore suitability of prehabilitation (universal, targeted and specialist) and rehabilitation interventions, including social prescribing for those requiring universal support e.g. referring individuals to a range of local non-clinical services such as community-based physical activity programmes, where appropriate								
16.11 Prescribe personal rehabilitation programmes to help individuals enhance, restore and maintain their mobility, function and independence considering the use of digital technology (e.g. apps and wearables) to support adherence where appropriate								
16.12 Refer individuals to highly specialist health and care professionals e.g. allied health professionals where this is appropriate to individuals' needs and wishes								
16.13 If in scope of professional practice, carry out specialist prehabilitation and rehabilitation assessments and treatments								
16.14 Make recommendations to employers regarding individuals' fitness to work, including through the appropriate use of fit not notes and seeking of appropriate occupational health advice								

Domain C: Condition management, treatment and planning								
17.0 Capabilities: Promoting self-management and behaviour change **The practitioner is able to:**	**Practitioner level (See key) Tick level of achievement required**							**Evidence of inclusion:** **(Tick relevant programme)** **UG or PG pre-registration programme** **Fd nursing associate/assistant practitioner/pharmacy technician programme** **PG post-registration module/programme**
17.1 Screen and assess the ability, motivation, self-efficacy and activation of individual cancer patients to self-care developing strategies and interventions to enable individuals to optimise their ability to self-manage, evaluating their effectiveness and actions								
17.2 Understand and use behaviour change techniques such as motivational interviewing and health coaching to facilitate cancer patients to understand the contribution of healthy lifestyle behaviours in promoting and sustaining recovery and well-being prior to, during and after treatment								
17.3 Teach individuals to carry out self-monitoring and self-care, mentoring them in the process, including recognising symptoms that require further advice/investigation and the pathways available for accessing this care								
17.4 Promote the importance of physical activity for general health and advise on what people with cancer related symptoms can and should do								
17.5 Promote the importance of a healthy diet and nutritional requirements to reduce the impact of cancer-related symptoms								
17.6 Advise on the effects of smoking, obesity and inactivity in cancer related symptoms and, where appropriate promote change or refer to relevant services								
17.7 Provide encouragement to individuals attempting to change or adopt new health related behaviours providing positive reinforcement when they are finding it difficult or achieving less than they								

hoped, supporting development of realistic short and long-term goals								
17.8 Signpost individuals to local services that support healthy living, whilst acknowledging and respecting their individual decision making, applying knowledge of the range of services available to support and guide individuals across the care pathway								
17.9 Involve the family/support network (where appropriate) in supporting self-management and self-care								
17.10 Provide practical and emotional support to encourage individuals to take an active role in communicating with health professionals where this is needed, by supporting and encouraging them to ask questions about what is a priority or concern for them								
17.11 Recognise social, economic, and environmental factors that influence behaviour, and those that act as barriers and facilitators, providing intervention and/or signposting to inform and motivate individuals to change behaviour								
17.12 Develop and provide services with interventions designed to support behaviour change, using evidenced behaviour change techniques and tailored to the capabilities, opportunities and motivations of service users								
17.13 Proactively promote the self-care principle at local, national and international forums, supporting other team members to understand models and concepts related to health-related behaviour change and to recognise the ‘teachable moment’ with supporting theories								
17.14 Ensure that effective strategies are in place to maximise the opportunities for self-management and supported self-management								

Domain C: Condition management, treatment and planning								
18.0 Capabilities: Symptom management **The practitioner is able to:**	**Practitioner level (See key) Tick level of achievement required**							**Evidence of inclusion:** **(Tick relevant programme)** **UG or PG pre-registration programme** **Fd nursing associate/assistant practitioner/pharmacy technician programme** **PG post-registration module/programme**
Examples of disease-related/treatment-related symptoms and complications that patients with cancer can experience, which can occur at different stages in the pathway are provided in Appendix 5								
18.1 Recognise common symptoms and oncological emergencies								
18.2 Assess and recognise treatment-related and disease related symptoms relevant to own area of practice screen for all these symptoms								
18.3 Depending on profession, undertake assessment, plan care for and manage treatment-related and disease related symptoms using appropriate evidence-based screening and assessment tools								
18.4 Have a knowledge of the presentations of treatment-related and disease related symptoms and the red flags that would necessitate escalation, emergency admission and/or onward referral								
18.5 Complete referral or monitoring of any interventions given								
18.6 Report to specialist MDTs concerning progression, deterioration or those with highly specialist need								

Domain C: Condition management, treatment and planning								
19.0 Capabilities: Late effects **The practitioner is able to:**	**Practitioner level (See key) Tick level of achievement required**							**Evidence of inclusion:** **(Tick relevant programme)** **UG or PG pre-registration programme** **Fd nursing associate/assistant practitioner/pharmacy technician programme** **PG post-registration module/programme**
19.1 Demonstrate knowledge of symptoms and care interventions for late effects appropriate to own client group/specialty (e.g. endocrine, bone health, cardiac toxicity, psychosexual issues, fertility, dental health, early menopause)								
19.2 Distinguish between symptoms and intervene to ensure individuals are on the appropriate care pathway e.g. treatment related, late effects, recurrence, progression								
19.3 Use protocols and guidelines to create holistic individual care pathways and documentation e.g. care plans, treatment summaries, late effects surveillance								
19.4 Provide specialist interventions and advice to support symptom management including complex symptoms arising from cancer, cancer treatment and late effects								
19.5 Use knowledge of cancer, its treatment and the risks of late effects complications to ensure assessments are appropriate to individual needs (e.g. type of cancer, treatment received, age, co-morbidities								
19.6 Provide information and support to primary care staff regarding ongoing late effects surveillance								
19.7 Work with other agencies and services to ensure that cancer, late effects and survivorship is fully integrated into the care plans of individuals with new and pre-existing mental health illness								
19.8 Work with health, social care and voluntary sector agencies to ensure coordinated care that								

meets current and anticipated future needs of individuals e.g. employment, financial, educational, late effects								
19.9 Develop systems for documenting symptoms that help to build knowledge about late effects and late effects services								
19.10 Develop systems for documenting assessment findings that help to increase wider knowledge about cancer, its treatment consequences and survivorship, late effects and care services								
19.11 Build partnerships with the health, social care, voluntary and independent sectors to promote engagement with cancer services and late effects care								
19.12 Play a leading role in local, network and national audits of late effects and cancer services								

Domain C: Condition management, treatment and planning								
20.0 Capabilities: Palliative and end of life care The practitioner is able to:	**Practitioner level (See key) Tick level of achievement required**							**Evidence of inclusion: (Tick relevant programme) UG or PG pre-registration programme Fd nursing associate/assistant practitioner/pharmacy technician programme PG post-registration module/programme**
20.1 Take a structured history of a patient presenting with palliative care needs or in the last days of life								
20.2 Undertake appropriate system and symptom assessment and examination								
20.3 Provide well evidenced differential diagnosis and suggested management plan, to include the use of non-pharmacological interventions								
20.4 Understand and practice within the key legal framework relating to end of life care such as: • Advanced Directives • Legal Power of Attorney • Do not resuscitate • Treatment escalation plans								
20.5 Identify and rationalise any need for additional support for the patient and carer / family, socially, psychologically and medically								
20.6 Identify the need for additional clinical and professional support such as referral, second opinion								

Domain D: Leadership and collaborative practice								
21.0 Capabilities: Leadership, management and organisation **The practitioner is able to:**	**Practitioner level (See key) Tick level of achievement required**							**Evidence of inclusion:** **(Tick relevant programme)** **UG or PG pre-registration programme** **Fd nursing associate/assistant practitioner/pharmacy technician programme** **PG post-registration module/programme**
21.1 Be organised with due consideration for people and colleagues, carrying out both clinical and non-clinical aspects of work in a timely manner, demonstrating effective time management within the constraints of the time limited nature of healthcare								
21.2 Respond positively when services are under pressure, acting in a responsible and considered way to ensure safe practice								
21.3 Act appropriately when services deficiencies are identified (e.g. frequent long waiting times) that have the potential to affect the effective management of individuals' care and condition, including by taking corrective action, where needed								
21.4 Demonstrate leadership and resilience, managing situations that are unfamiliar, complex or unpredictable and seeking to build confidence in others								
21.5 Demonstrate receptiveness to challenge and preparedness to constructively challenge others, escalating concerns that affect people, families, carers, communities and colleagues' safety and well-being when necessary. clarity of roles within teams, to encourage productive working								
21.6 Demonstrate awareness of policies and procedures relevant to their own area of practice in cancer services and support service developments to improve patient outcomes								
21.7 Negotiate an individual's scope of practice within legal, ethical, professional and organisational policies, governance and procedures, with a focus on managing risk and upholding safety								

21.8 Influence policies for people living with and beyond cancer at local/regional/national level and feed back to own teams and external organisations, services, systems								
21.9 Demonstrate awareness of the funding, commissioning and development of cancer services to meet local needs								
21.10 Know the evidence required to influence funding and commissioning of cancer services, including cost, benefits, outcomes and utilisation and how these are used by decision makers								
21.11 Lead locally on the implementation of national guidance for services for people with cancer								
21.12 Represent services for people with cancer or own discipline at national and/or network meetings								
21.13 Regularly apply and lead the development of innovative service models across the pathway								
21.14 Capture and evaluate the required evidence and work with local enablers (e.g. departmental manager or general manager) to influence commissioning agendas locally and regionally								
21.15 Develop and implement robust governance systems and systematic documentation processes, keeping the need for modifications under critical review								
21.16 Respond to compliments and complaints appropriately, following professional standards and applicable local policy								
21.17 Actively participate in internal and external reviews for example, Significant/Serious Incident Review, peer review, CQC, cancer patient experience surveys and share the learning across services								
21.8 Engage people within own organisation/network and other key stakeholders in defining own organisation's/network's direction and committing their energies and expertise to achieving its results								

21.9 Work collaboratively at a strategic level with local, regional, system and national services/voluntary organisations to engage in short- and long-term strategic planning, peer review and team/service and system evaluation to encourage innovation, facilitate effective change and evaluate impact of clinical practice and quality of cancer care and services								

Domain E: Developing evidence-based practice and improving quality								
22.0 Capabilities: Research and evidence-based practice **The practitioner is able to:**	**Practitioner level (See key) Tick level of achievement required**							**Evidence of inclusion:** **(Tick relevant programme)** **UG or PG pre-registration programme** **Fd nursing associate/assistant practitioner/pharmacy technician programme** **PG post-registration module/programme**
22.1 Demonstrate a detailed understanding of the importance of clinical research and evidence-based practice and applies to own area of practice								
22.2 Access appropriate sources of evidence to support their own practice in cancer and palliative care services (e.g. journals, literature reviews, research articles, audits, and arts-based practices)								
22.3 Understand and utilise the evidence of best practice to inform own practice								
22.4 Demonstrate an understanding of the principles of clinical research, and can explain to service users common terms and concepts in relation to their cancer treatments (e.g. placebo, randomisation, quantitative and qualitative research, critical appraisal, patient-reported outcomes, informed consent)								
22.5 Demonstrate working knowledge of: • the range of qualitative and quantitative methodologies available and their purpose • the concepts of validity and reliability in relation to the design of data collection, collation and analysis • the processes used to critique a research paper and how to consider the implications for practice								
22.6 Use specialist knowledge to contribute to the development of evidence-based policies and procedures								

22.7 Contribute data to systems to be used for research, audit or service evaluation and understands own contribution to these processes								
22.8 Understand the ethical and legal issues around data collection and information handling, including confidentiality, consent, data protection and storage								
22.9 Work to advance the development of a research strategy for cancer, including prehabilitation, palliative care and/or living with cancer and lead their own or collaborative research projects								
22.10 Apply a range of quality assurance and research methodologies, selecting and applying rigorous and systematic methods, to evaluate own and other clinical practice, disseminating and using the findings to identify strategies to improve/enhance/innovate in cancer care and services								
22.11 Apply principles of ethical good clinical practice in relation to research, audit and service evaluation (e.g. working within local governance systems and policies, informed consent and confidentiality)								
22.12 Ensure that systems are in place to guarantee that project design and data management and dissemination meet ethical practice standards								
22.13 Take a critical approach to identify gaps in the evidence base and its application to practice, alerting appropriate individuals and organisations to these and how they might be addressed in a safe and pragmatic way. This may involve acting as an educator, leader, innovator and contributor to research activity and/or seeking out and applying for research funding								
22.14 Proactively network to develop and facilitate collaborative links with specialist cancer services and active researchers in academic and clinical settings to identify potential for further research in								

cancer care and opportunities to apply for funding, disseminate research and quality improvement through relevant media and fora								
22.15 Formulate and implement strategies to act on learning from range of sources (audit, service user feedback, research, policy) and knowledge of the funding of cancer care services in the NHS and third sector to make improvements, influence and lead new practice and service/system redesign solutions to reduce variation, promote access to underserved communities and enhance quality in response to feedback, evaluation and need								

Domain F: Developing evidence-based practice and improving quality								
23.0 Capabilities: Service evaluation and quality improvement **The practitioner is able to:**	**Practitioner level (See key) Tick level of achievement required**							**Evidence of inclusion:** **(Tick relevant programme)** **UG or PG pre-registration programme** **Fd nursing associate/assistant practitioner/pharmacy technician programme** **PG post-registration module/programme**
23.1 Initiate, lead and guide investigation and review of services and subjects relating to people living with and affected by cancer symptom management								
23.2 Demonstrate the impact of advanced and consultant level clinical practice on service function and effectiveness, and quality (i.e. outcomes of care, experience and safety)								
23.3 Assist with service evaluations and audits of key aspects of own and shared practice e.g. patient satisfaction, local service standards								
23.4 Instigate developing practice in response to changing population health need, engaging in horizon scanning for future developments and to add value (e.g. impacts of genomics, new treatments and changing social challenges)								
23.4 Procure services that continually improve the pathway for people and supports lifestyle choices and future employment needs where applicable								
23.5 Identify areas of the current service that could be developed including identification of the gaps and potential opportunities								
23.6 Collect data required for service evaluations, audits or research in services for people living with and affected by cancer								
23.7 Develop systems for measuring outcomes for individuals, groups and services that enable accurate and meaningful reviews of progress and services								
23.8 Actively involve a range of service users in evaluating services, applying the principles of								

equality, diversity and anti-discriminatory practice and actively promotes cancer related research projects								
23.9 Interpret and summarise data relating to individuals, groups of patients and local cancer services to create information and knowledge that can influence the clinical trajectory (i.e. to recognise the need to commence palliative care or end of life services, service delivery and/or affect small scale service improvement)								
23.10 Evaluate the effectiveness of screening and assessment tools and guidelines used locally, nationally and internationally, as well as own data produced in terms of impact on patient outcomes and services and outcome measures linked to key drivers and evidence-based practice								
23.11 Critically evaluate local and national service change in similar cancer/palliative care services comparing the data and knowledge generated against own services to inform business cases and commissioning opportunities								
23.12 Use data supported information to drive both small- and large-scale service improvement and local research programme development								
23.13 Work with individuals and groups who are considered to be at high-risk due to their cancer experience and groups of service users to promote their inclusion in the development and review of services for people living with and beyond cancer and leads on delegated projects								
23.14 Ensure and monitor that own and local services meet the wide range of needs of people living with a cancer diagnosis from prehabilitation to living well (health promotion), to active surveillance and complex symptom management								
23.15 Set up monitoring to ensure that regional and network services meet the wide range of needs of people living with a cancer diagnosis from								

prehabilitation to living well (health promotion), to active surveillance and complex symptom management and lead on innovations in service delivery								
23.16 Contribute to the development and completion of peer review, service review, audits and research within local services								
23.16 Establish the development and completion of peer review, service review, audits and research within local/regional services evaluating and presenting findings to inform strategic service developments								

Domain G: Educating and developing self and other								
24.0 Capabilities: Education **The practitioner is able to:**	**Practitioner level (See key) Tick level of achievement required**							**Evidence of inclusion:** **(Tick relevant programme)** **UG or PG pre-registration programme** **Fd nursing associate/assistant practitioner/pharmacy technician programme** **PG post-registration module/programme**
24.1 Critically assess and address own learning needs, negotiating a personal development plan that reflects the breadth of ongoing professional development across the four pillars of clinical practice								
24.2 Engage in self-directed learning, critically reflecting on practice to maximise advanced clinical skills and knowledge, as well as own potential to lead and develop both care and services locally and regionally								
24.3 Plan, engage in and record learning and development relevant to their role and in fulfilment of professional, regulatory and employment requirements								
24.4 Advocate for and contribute to a culture of organisational learning to inspire future and existing staff								
24.5 Act as a role model, educator, supervisor, coach and mentor, seeking to instil and develop the confidence of others, actively facilitating the development of others								
24.6 Establish, deliver and evaluate teaching/learning and development opportunities for the workforce providing general and specialist cancer care in a range of settings, including supervising and assessing those on clinical placements								
24.7 Contribute to curriculum development and delivery of cancer and/or palliative care								

modules/programmes at undergraduate and postgraduate level with education providers								
24.8 Instigate, promote and utilise clinical supervision for self and other members of the healthcare team to support and facilitate professional development								
24.9 Lead learning and development needs analyses to inform commissioning to build capacity and capability of the workforce providing care to people affected by cancer through work-based and interprofessional learning, and accredited modules and courses								
24.10 Disseminate and explain the findings best practice research, quality improvement projects and data through appropriate media, using language and terminology appropriate to the intended audience (e.g. service users, MDTs, network meeting)								
24.11 Establish opportunities to collaborate with those involved in providing services for people with cancer to generate ideas for spread and adoption of good practice, research, audits, service reviews and journal clubs								
24.12 Support other staff in the implementation of services for people with cancer								
24.13 Promote awareness and implementation of national guidance for rehabilitation relating to cancer, palliative care and end of life care, for example exercise and bone metastases guidance								
24.14 Promote the availability of local, regional and national cancer/palliative care learning opportunities within own service/system and foster links and placements for pre-registration learners and trainees, and the supportive, assistive and registered workforce to facilitate achievement of core cancer learning outcomes and capabilities in practice								
24.15 Write for publication and present at local and national conferences on own specialty/practice								

24.16 In collaboration with clinical, research and academic partners, disseminate research/knowledge exchange and innovation activities through presentations at national and international conferences and writing for publication								
24.17 Develop relationships with other agencies to promote research and enterprise, build partnerships to improve experiences and services for people living with and affected by cancer								
24.18 Engage in research supervision as member of supervisory teams for health and social care students/staff undertaking research								
24.19 Recognise people as a source of learning, in their stories, experiences and perspectives, and as peers to co-design and co-deliver educational opportunities. Appraise and respond to learning/information needs of individuals, families, carers and communities delivering informal learning opportunities and formal/structured education and training to people with cancer, their families and carers to promote self-care, support health literacy and empower participation in decision-making about aspects of their care, management and treatment								
24.20 Critically analyse and instigate the development of the workplace/system as a learning environment to enhance the knowledge, skills and capabilities of health and care colleagues to deliver evidence-based generalist and specialist cancer care, evaluating the impact and application of learning to clinical practice, patient and service outcomes								
24.21 Set up, procure or instigate business case to develop members of the wider multi-professional specialist cancer team as educators, supervisors and assessors for the workforce providing general and specialist cancer care								

Appendix 3: Portfolio guidance and supporting tools

Portfolio guidance

Portfolios should contain a range of evidence which is linked to the capabilities. Each piece of evidence should state why it demonstrates capability. It is often the case that one piece of evidence can demonstrate more than one capability.

All members of the cancer care workforce should develop and maintain a portfolio as they can be used for appraisal and revalidation purposes.

The capabilities contained within this Framework should not be seen in isolation but viewed holistically as they are all needed to demonstrate safe and effective practice at all practice levels. For example, a quality improvement project could lead to a change in process requiring leadership skills to implement.

Shared learning from this type of work, when presented at a local group/meeting could demonstrate some educational capabilities.

The following range of tools are provided to support people developing evidence of their capability however their use is not mandatory.

Consultation Observation Tool (COT) - Guidance

Clinical Supervisors use the Consultation Observation Tool (COT) to support holistic judgements about a practitioner is one of the tools used to collect evidence of capability, as a Workplace Based Assessment.

Selecting consultations for COT

Either record a number of consultations on video and select one for assessment and discussion or arrange for your clinical supervisor to observe a consultation. Complex consultations are likely to generate more evidence.

Consultations should be drawn from a range of people presentation that reflect the scope of the role.

Collecting evidence from the consultation

Practitioners should ensure there is sufficient time to review the consultation with their clinical supervisor, who will relate their observations to the capability framework as identified on the COT form. The Clinical Supervisor then makes an overall judgement and provides formal feedback, with recommendations for further development.

Case Based Discussion (CBD) – Guidance

Case based discussions (CBD) are a great way to explore capability, clinical reasoning and critical thinking. The CBD is a structured interview designed to assess your professional judgement in clinical cases. CBD is one of the tools used to collect evidence for your Portfolio of evidence of capability, as a Workplace Based Assessment.

They should be pre-planned and based on the clinical record. The CBD form has an area to write pre-planned questions by the clinical supervisor (CS).

Good practice would be for practitioners to send (with appropriate permissions) the cases/notes relevant in order for the clinical supervisor (CS) to review.

Consultations should be drawn from a range of patient contacts that reflect the scope of the practitioner's role. For example; children, older adults, mental health. The CS can then ask questions and a discussion can follow.

What's covered in the discussion?
The discussion is framed around the actual case rather than hypothetical events. Questions should be designed to elicit evidence of capability; the discussion should not shift into a test of knowledge.

The clinical supervisor will aim to cover as many relevant capabilities as possible in the time available. It's unrealistic to expect all capabilities to be covered in a single CBD, but if there are too few you won't have enough evidence of progress. It's helpful to establish at the start of the discussion which capability areas your supervisor is expecting to look at.

The clinical supervisor records the evidence harvested for the CBD in the Portfolio, against the appropriate capabilities.

It is recommended that each discussion should take about 30-60 minutes, including the discussion itself, completing relevant documentation and providing feedback.

At the end, the CS should provide some written feedback for the practitioner, covering the following two points as a minimum:

- What went well and why.
- Areas for further development/points to consider for future practice.

Guidance when assessing Clinical Examination Procedures (CEPs) for Practitioners

CEPs is a workplace-based assessment. It provides a way of assessing what the practitioner does in practice, day to day – how they apply their knowledge, skills, communication skills. Whilst CEPs exist to capture skills it is important to assess some common shared themes.

Suggested areas for consideration would be:

- Is there a clinical need for the examination?
- Has this been explained appropriately to the person?
- Has consent been granted?
- Has a chaperone been offered?
- Are there good hygiene practices?
- Is there an understanding of the relevant anatomy?
- Is the person treated with respect and provided with privacy?
- Does the practitioner maintain an empathetic approach throughout?
- Does the practitioner explain what is going on throughout the procedure?
- Are their findings accurate? – findings should be checked by the clinical supervisor.
- Does the practitioner provide an appropriate explanation of their findings to the person and the implications?
- Is there an appropriate management/personalised care and support plan made with the person?

Please note: a grading of ‘needs further development’ is not a failure but a suggestion that more practice and exposure to similar clinical scenarios is required.

Multi-Source Feedback (MSF) Guidance

Multi-source feedback is collected from colleagues. Good practice would be to send out a questionnaire to a range of both clinical and non-clinical colleagues. This process requires an optimum number of 5 clinical and 5 nonclinical responses. Ideally the responses should be looked at by the clinical supervisor and feedback given to the practitioner.

Portfolio Reflection Template

Date seen	
What happened – brief description - Presenting problem	
Reflection – what did you learn?	
Impact on your practice – what will you do the same or differently next time and why?	
Supervisor's comments – capabilities demonstrated, learning points?	

Employee: .....

Supervisor/Manager: .....

Consultation Observation Tool: Marking/Notes Sheet – Cancer Care Framework

Practitioner Name:	
Clinical Supervisor Name:	
Presenting Case:	
Date:	

GRADES	**I** – Insufficient evidence	**N** – Needs further development	**C** - Capable	**E** - Excellent

Criterion	Grade	Evidence
Discovers the reason for the person's attendance		
Encourages the person's contribution		
Responds to cues		
Places presenting problem in appropriate psychosocial context		

Criterion	Grade	Evidence
Explores person's health understanding		
Defines the clinical problem		
Includes/excludes relevant significant condition		
Appropriate physical or mental state examination		
Makes appropriate working diagnosis		
Explains the problem to the person		
Explains the problem in appropriate language		
Addresses the person's problem		
Seeks to confirm the person's understanding		
Makes an appropriate shared management/ Personalised care/ support plan		
Person is given the opportunity to be		

Criterion	Grade	Evidence
involved in significant management decisions		
Makes effective use of the consultation		
Makes effective use of resources		
Condition and interval for follow up are specified		
Feedback and recommendations for further development		

Agreed action plan:

Case Based Discussion – Cancer Care Framework

Practitioner Name:	
Clinical Supervisor Name:	
Presenting Case:	
Date:	

GRADES	**I** – Insufficient evidence	**N** – Needs further development	**C** - Capable	**E** - Excellent

Please insert which capabilities are being used for the discussion

NO.	CAPABILITIES	QUESTIONS	EVIDENCE OBTAINED	GRADE

FEEDBACK
ACTION PLAN

Clinical Examination Procedure (CEP) Assessment Template – Cancer Care Workforce

Practitioner Name:	
Clinical Supervisor:	
Date:	

TYPE OF PROCEDURE: Please provide a brief description below.
DESCRIPTION OF CEP ASSESSED. With reference to the items on the CEPs guidance sheet.
WHAT WAS DONE WELL?
WORKING POINTS?
LEARNING NEEDS?

Multi-Source Feedback (MSF) Template – Cancer Care Workforce

Practitioner Name:	
Location of MSF undertaken:	
Date of MSF undertaken:	

Part 1

This part should be completed by **all** respondents

Please state your job title

Please provide your assessment of the practitioners overall professional behaviour (please circle)

Very poor	**Poor**	**Fair**	**Good**	**Very Good**	**Excellent**	**Outstanding**

Notes: You may wish to consider the following:

The practitioner:

- Is caring and respectful of people
- Shows no prejudice in the care of people
- Communicates effectively with people
- Respects other colleagues' roles in the health care team
- Works constructively in the health care team
- Communicates effectively with colleagues'
- Demonstrates commitment to their work as a member of the team
- Takes responsibility for own learning.

Comments (Where possible please justify comments with examples).

Highlights in performance areas (areas to be commented)

Possible suggested areas for development in performance

Part 2

To be completed by Clinical Supervisor

Please provide your assessment of overall clinical performance (please circle)

Very poor	Poor	Fair	Good	Very Good	Excellent	Outstanding

You may wish to consider the following:

- Ability to identify peoples' problems
- Take a personalised, holistic approach
- People management skills
- Independent learning habits
- Range of clinical and technical skills

Comments (where possible please justify comments with examples)

Highlights in performance (areas to be commended):

Possible suggested areas for development in performance:

Appendix 4: Exemplar 'high-level' role descriptors

An aspiration of this Framework is to support service transformation. This is, that organisations use the Framework to review their current arrangements for practice and use the Framework to develop roles and teams. To enable this a number of high-level role descriptors have been worked up. They are not intended to be lifted and dropped into practice as further local/more contextualised work would need to be undertaken as well as developing an appropriate person specification. They do however provide a basis for role (re)design and are aligned to the identified level of practice within the Framework. They should not be viewed as exhaustive nor exclusive. To assist the top of each role descriptor is aligned to a corresponding level of practice from the Framework itself.

	Supportive

Exemplar role descriptor
Post: Healthcare assistant

Job purpose:

To provide high quality and effective support in the care and management of patients, relatives and their friends under the direction of the registered nurse.

Main responsibilities:

- Assists with the care of patients by:
    - participating in basic nursing care and procedures
    - assisting in meeting the nutritional needs of patients
    - ensuring a clean and safe environment for patients and escalating any concerns
    - handling patient's personal possessions, ensuring money and valuables are kept securely.
    - providing personal care to patients
    - carrying out of cardio-pulmonary resuscitation as required
    - fluid balance monitoring
    - taking of peripheral bloods as required
    - processing VBG sample
    - answering patient buzzers
    - weighing patients
    - assisting, directing and escorting patients/visitors where and when appropriate
    - taking and delivering messages, including answering telephones as requested as part of the ward team
    - communicating well within the team at all times
    - acting as a chaperone when requested

- Maintains a clean and safe environment for patients and adheres to infection control policies and guidance.
- Undertakes cleaning duties for the areas / rooms they are responsible for, as well as offering support to other team members as required, including cleaning of all side room low surfaces i.e., lockers, tables, beds windowsills, and equipment in patient rooms.
- Ensures overall cleanliness of ward areas and follows schedules and procedures for the ward around room cleaning.
- To check the ward linen stock is adequate until the next due delivery, in the absence of a housekeeper.
- Ensure patient beds are changed daily as a minimum and that patients receive clean towels daily.
- To strip, clean, remake beds and clean inside/outside drawers and wardrobes upon patient discharge.
- To collect full bags of soiled linen and move to collection points.
- Undertake cleaning of equipment/environment as per disinfection/cleaning policy including drip stands / suction points etc.
- Complete food charts for patients and escalate if there are any concerns about patient intake.
- Communicates effectively and appropriately in:
    - giving and receiving verbal information
    - written communications
    - maintaining confidentiality with regard to patient information
    - communication with a range of people on a range of matters
- Assist others as required.
- Demo, create and promote a good working relationship.
- Reports all accidents and complaints according to the agreed policy.

	Supportive

Exemplar role descriptor
Post: Cancer support worker

Job summary:

To support cancer patients and their family/friends under the guidance and supervision of a registered practitioner during their cancer journey from referral to diagnosis, through treatment and follow-up with living with and beyond cancer, covering elements of the recovery package. This involves psychological and informational support respecting at all times patients' diverse cultural back grounds, with courtesy, dignity and privacy. To provide evidence-based patient information sensitive to individual need.

To liaise and effectively communicate with members of the multi-disciplinary team and allied health care professionals to provide co-ordinated high-quality patient-centred care.

The post will also act as a point of contact for those patients who will have been prepared by their clinical team for self-managing their follow up - and will be able to sign post patients to appropriate resources and support which will help them to a more effective recovery and rehabilitation.

The post holder will provide support and cover to the Team Co-ordinators, preparing meeting, ensuring all results are available and taking notes of decisions made regarding patients discussed.

Main responsibilities:

- Triage incoming calls from patients using protocols and initiate appropriate responses base on appropriate tools and procedures.
- Coordinate the necessary assessments, investigations and appointments to fast-track patients back for specialist review.
- Be able to refer and sign post to the clinical team as appropriate for complex decisions.
- Provide basic telephone advice where appropriate and sign post other sources of support.
- Monitor, audit and report on response times for access to specialist review when deemed necessary.
- Contribute to the Holistic Needs Assessment and care plan and review in line with practitioner guidance, protocols and procedures.
- Evaluate outcomes of care support with the registered practitioner.
- Make pre planned outbound telephone calls to patients under the guidance of the registered practitioner.
- Support information prescription delivery in consultation with health professionals and according to any agreed information pathways, including printing of information prescriptions.
- Support the planning, delivery and evaluation of health and well-being events in collaboration with clinical teams, users and user groups and the wide range of key stakeholders in the Trust and community setting.
- Support the planning, delivery and evaluation of Treatment Summaries for acute phases of Treatment.
- Collaborate and work closely with local providers of validated and high-quality information resources, users and user groups including the Macmillan cancer Information and Support Centre.

- Be responsible for ordering supplies and equipment relating to this function on behalf of the budget holder.
- Input Data to provide an annual report on the outputs and outcomes of the self-management interventions and resources provided and accessed including types of events, registrations and nonattendance, time period in follow up, evaluations of events of patients, carers and clinical staff and need for future developments.
- Support the planning, delivery and evaluation of Health and Wellbeing events in collaboration with clinical teams, users and user groups and the wide range of key stakeholders in the Trust and community setting.
- Work closely with the MDT Co-Ordinators to manage the weekly Priority Tracking List.
- Ensure that all information to facilitate monitoring of cancer referral targets is available for data entry.
- Contribute to clinical/IT team's reviews of implementation issues of the remote surveillance systems and support and contribute to solution identification and resolution.
- Be able to show patients how to use the software on either the patient's PC or provided iPad so that the patients are able to complete their HNAs at home.
- In collaboration with other key providers of self-management programmes locally, map the range of provision and availability in order to be able to signpost patients and the carers to appropriate events and resources to enable effective self-management.
- Demonstrate an awareness of limits of practice and seek appropriate support and guidance.
- Identify personal education needs and skills development with registered practitioner.

	Assistive

Exemplar role descriptor
Post: Cancer care co-ordinator

Job summary:

The Cancer Care Coordinator role, whose main purpose is to support those people to navigate the complex health and social care system during and following completion of cancer treatment.
The role will be responsible and accountable for their practice and behaviour under the management of a registered practitioner.

Main duties and responsibilities:

- Triage incoming calls and initiate appropriate response according to protocols and individual pathways, using excellent communication skills, basic clinical awareness and appropriate tools and procedures, liaising as appropriate when non routine and refer complex decisions to the team for assessment and review.
- Provide basic telephone advice and refer on or signpost to other sources of support.
- Coordinate the necessary assessments, appointments or investigations to fast-track people back into the system if required.
- Demonstrate the ability to recognise and respond appropriately when faced with a sudden deterioration or an emergency situation, alerting the team or enabling rapid response as appropriate.
- Communicate and signpost to appropriate needs related information.
- Guide people through the use of self-assessment resources.
- Document and monitor all aspects of care coordination and service delivery, supporting data collection for audit.
- Coordinate the care for a defined group of patients assessed by a registered practitioner as having level one care needs for supported self-management.
- Organise and prioritise the designated workload in relation to identified needs.
- Contribute to the holistic needs assessment and the development of an individual care plan.
- Implement, monitor and review the care plan with the patient and carer, in line with standard operating procedures and protocols and modify as appropriate.
- Evaluate outcomes of care delivery with the registered practitioner.
- Coordinate and organise appointments and assessments as required.
- Make pre planned outbound telephone calls to patients to assess ongoing needs to enable a proactive prevention approach.
- Identify indicators of need or changes in need through telephone contact and respond appropriately.
- Coordinate the handover with other teams to facilitate safe and effective transition of care between services in order to provide seamless support for people.
- Act as advocate and facilitator to resolve issues that may be perceived as barriers to care.
- Support people to access appropriate information and support, by signposting to a range of support services and take an approach which helps people to self-manage where appropriate.

- Keep up to date with relevant information and contacts with local services.
- Advise patients on individual self-care management principles and provide consistent planned aftercare to reinforce and further promote this information.
- Deliver patient-centred, self-management support and education as necessary to non-complex patients, including how to self-assess.
- Support the delivery of patient and carer training and education.
- Encourage and support active and healthy lifestyle choices.
- Coach patients and carers to understand what signs, symptoms or situations to be aware of that would indicate concern.
- Coach patients and carers on how to make contact when they feel that their condition or needs have changed, including what to do out of hours.
- Support and contribute to audit processes, governance, research, clinical research trials and service development.
- Develop new patient information, following guidance from the clinical teams.
- Collating relevant resources / development of information packs for patients.
- Support clinical teams in the development and delivery or prehabilitation programmes.
- Provide general supervision of less experienced staff and support to other new Cancer Support Workers.
- Demonstrate self-directed learning, actively seeking role development opportunities to enhance practice, knowledge and role progression.
- Identify personal education needs and skills development with the registered practitioner.
- Make sure that people affected by cancer are aware that they are interacting with a cancer professional and know about the full range of resources and services available.
- Carry out some administration duties required by the role.
- Order supplies and equipment.
- Understand that there will be frequent exposure to distressing/highly distressing situations and when to seek appropriate support/advice.
- Demonstrate an awareness of the limits of own practice and knowledge and when to seek appropriate support/advice.
- Communicate effectively with patients and their families.
- Maintain accurate and contemporary patient records and data sets.
- Act as patient advocate.
- Effectively communicate with professional colleagues.
- Ensure the data sets are available within your organisation in a timely manner.
- Attend and contribute to multi-disciplinary meetings as required.

	Assistive

Exemplar role descriptor
Post: Nursing associate

Job summary:

The Nursing Associate has a breadth of knowledge across the lifespan and across the fields of nursing, providing holistic and person-centred care and support for people of all ages and in a variety of settings. The Nursing Associate works independently under the leadership of registered nurses, working within the sphere of nursing and care and within all aspects of the nursing process.
Nursing Associates are equipped with the knowledge, understanding, skills, attitudes and behaviours relevant to employment as a Nursing Associate and will work to the Nursing and Midwifery Council (NMC) Code and Standards for Nursing Associates. The following criteria identify the core components of the roles, responsibilities and accountabilities of Nursing Associates.
They identify what Nursing Associates can contribute to the health and wellbeing of patients and service users and apply across all health and care settings. Integral to all of these is the ability to communicate effectively, with sensitivity and compassion, and to manage relationships with people, making reasonable adjustments where necessary. They will be able to communicate effectively across a wide range of channels and with a wide range of individuals, the public, health and social care professionals, maintaining the focus of communication on delivering and improving health and care services. They will work with the team delivering care; they will be aware of the distinct roles in the team and understand their role within it. They will work as part of a multi-disciplinary team.

Main responsibilities:

- Be responsible for delivering high quality, patient centred, compassionate care under the direction of a Registered Nurse (or other registered care professional dependent on setting) with a focus on promoting health and independence, with an emphasis on empathy, respect and trust.
- Have proficient attitudes and behaviours compatible with NHS Values.
- Work within clearly defined accountability frameworks and boundaries of limitation to provide the best possible care in collaboration with colleagues, patients and their carers.
- Work as part of a designated clinical and care team delivering care that focuses on the direct needs of the individual.
- Carry out specific clinical and care tasks and responsibilities to a high standard, under the direction of a registered nurse or other registered care professionals dependent on setting.
- Have the ability to work without direct supervision, at times delivering care independently in line with the individual's defined plan of care, within the parameters of practice of the Nursing Associate role, accessing clinical and care advice when needed.
- Develop understanding of all elements of the nursing process and be able to assist the registered nurse in the on-going assessment, planning, management and evaluation of care.
- Provide and monitor care.
- Support individuals with all aspects of care including daily living, providing person-centred care and promoting health and independence through awareness raising and care navigation to other professionals as appropriate.
- Perform and record clinical observations including blood pressure, temperature, respirations, pulse.
- Be prepared to undertake additional skills.

- Ensure the privacy, dignity and safety of individuals is maintained at all times.
- Demonstrate the ability to recognise changing priorities seeking advice and guidance from the Registered Nurse or other registered care professionals as appropriate.
- Report back and share information with the registered nurses on the condition, behaviour, activity and responses of individuals.
- Assist in the assessment of and contribute to the management of risk across several areas within the environment where care is being administered.
- Assist in the implementation of appropriate action to meet the specific physical, emotional and psychological, social, cultural and spiritual needs of individuals and carers.
- Assist in the delivery of complex care as prescribed by the registered nurse.
- Develop understanding of caring for individuals with particular conditions for example dementia, mental illness, learning disabilities.
- Develop skills in relation to coaching/teaching individuals/carers/other staff.
- Assist with the implementation and monitoring of clinical standards and outcomes.
- Develop a working knowledge of other providers' resources and referral systems to ensure individual's needs are met, within parameters of practice.
- Engage in reflective practice including management of self and reflection on own reactions, asking questions and reflecting on answers given.
- Demonstrate good understanding of principles of consent and ensure valid consent is obtained prior to undertaking nursing and care procedures.
- Demonstrate good understanding of the Mental Capacity Act / Deprivation of Liberties and applies principles to everyday practice seeking advice / guidance from the Registered Nurse or registered care professional as required.
- Plan and manage competing demands of job role, study and placement activities.
- Work in an effective and organised manner demonstrating excellent time management and organisational skills to effectively deliver person-centred care for an allocated group of individuals.
- Deliver effective care following treatment plans determined by the Registered Nurse or registered care professional and provide feedback on progress against the plans.
- Ensure clear, concise, accurate and legible records are made and that all communication is maintained in relation to care delivery adhering to local and national guidance.
- Exercise personal responsibility and work independently within defined parameters of practice, taking the initiative in a variety of situations and performing a range of clinical and care skills consistent with the role, responsibilities and professional values of a Nursing Associate.
- Exercise judgment in assessing patient condition, comfort and wellbeing using analysis of a range of factors.
- Ensure that only those activities for which competence has been achieved are undertaken without supervision and that recognition is given to the impact and consequences of practising outside capability.
- Administer medicines safety and in a timely manner; (NB Nursing Associates will only administer medicines, if suitably trained and competent, in settings where it is deemed appropriate and where this is guided by organisational medicines management policies).
- Be responsible for increasing their own professional research knowledge by promoting an analytical approach to care.
- Contribute to and participate in the developments involving the clinical governance agenda, e.g. audit, research programmes, etc.
- Be proactive in seeking opportunities to develop own knowledge and skills, achieving clinical competencies within agreed timeframes. Seeks support/guidance in timely manner if any difficulties are encountered.

- Develop and improve practical and theoretical knowledge, competence and skills throughout the Nursing Associate Role and maintain all evidence required.
- Contribute towards developing a culture of learning and innovation, developing high quality learning environments.
- Work in partnership with manager to develop and deliver on Specific, Measurable, Achievable, Relevant and Time-bound (SMART) objectives at annual appraisal and personal development planning meeting.
- Act as an excellent role model by upholding and implementing good practice in the workplace. Recognising and either directly challenging or seeks support to challenge any poor practice observed.

	Registration

Exemplar role descriptor
Post: Cancer care nurse

Job summary:

The nurse is a member of a multi-professional team whose aim is to deliver a co-ordinated, comprehensive and holistic service for patients with a cancer and haematology diagnosis. They will work together with the Clinical Nurse Specialists and other Chemotherapy and Haematology nurses to deliver an excellent patient focused service for patients having all aspects of treatment including chemotherapy, transfusion.

Main responsibilities:

- To plan, assess and evaluate the problems and needs of individual patients and their families, undergoing a wide range of treatments and supportive therapies.
- Acts at all times in accordance with the NMC Code of Conduct and within the principles of the scope of Professional Practice and ensures other members of the team also work within these.
- To be knowledgeable of identified treatment regimens and side effects, adopting a problem-solving approach in managing the potential complications of treatment and therapies.
- To ensure all relevant investigations are carried out prior to implementation of treatment and to complete all relevant documentation.
- Establish effective communication links with patients, their carers and all staff working in the cancer Support Team to provide information, support and guidance, ensuring the delivery of the care remains patient focused.
- In conjunction with the Clinical Nurse Specialist initiate research projects and improvements in nursing care and chemotherapy service delivery.
- To encourage and implement evidence-based practice.
- To ensure safe and high standards of nursing care are maintained in accordance with policies and procedures and National Cancer Service Guidelines.
- To carry out practical clinic tasks as identified providing care and supervision required by the identified patient group.
- To receive and provide patients and their families with, sensitive and complex information, using developed empathy, reassurance and counselling skills.
- To establish close liaison and communication with and between all disciplines involved in the care of patients and their families in order to facilitate a coordinated service within the care environment.
- To have the ability to communicate with others in a way that will enhance learning and education and have full participation in the palliative care education programme for nurses student nurses and non-clinical staff.
- To be aware of own limitations and emotional effort needed and regularly attend clinical supervision.
- To deputise in the absence of more senior members of the team in all aspects of their role in order to provide a high-quality service for cancer patients.
- To mentor and appraise more junior staff with the support of Clinical Nurse Specialist.

- In conjunction with the Clinical Nurse Specialist, is responsible for the effective organization and daily management of the clinical environment.
- To be competent in the use of the computer systems and developing the skills of others.
- Handle queries that arise which may be (but could include others) from junior doctors on the wards, nurse colleagues, primary care staff, district nurses and GP's.
- To have expert knowledge of all emergency procedures and remain updated in related statutory training and ensure more junior nurses are proficient in these areas of practice.
- Ensure effective use of available resources working within budgetary controls to contribute to a cost-effective health economy.
- To undertake regular individual performance review in conjunction with the Clinical Nurse Specialist and agree personal development plans in line with service objectives and NMC requirements.
- To have an understanding of the principles of Clinical Governance and its implementation in practice.
- To undertake the line management of more junior staff and carry out their individual performance review.
- Participate in keeping accurate and legible records and be aware of the legal implications of these documents.

	Enhanced

Exemplar role descriptor
Post: Occupational therapist: personalised care and support – cancer

Job summary:

The post-holder will act as an autonomous practitioner, providing Occupational Therapy assessment and treatment, and managing their own patient caseload within Oncology.
They will supervise and train junior members of staff, technical instructors and students as required.

Main responsibilities:

- To provide a comprehensive assessment of cancer patients including those with diverse or complex presentations/ multi pathologies and use advanced clinical reasoning skills and assessment techniques to formulate an appropriate evidence-based management package.
- To ensure that all treatment/management plans are regularly reviewed and revised as appropriate, formulating accurate prognoses and developing comprehensive discharge plans.
- To assess capacity for consent with all patients and whenever possible ensure that valid informed consent is agreed with the patient working within the legal framework. This will involve fully explaining the outcome of assessment and assessing patients understanding of the options for treatment proposed thereby reaching agreed treatment plans and goals.
- To be responsible for organising and planning own caseload to meet service and patient priorities.
- To maintain good working knowledge of national and local standards and monitor own and others clinical practice as appropriate.
- To communicate with and work alongside physiotherapy colleagues and other health and social care staff where joint treatment and/or management is indicated.
- To participate in clinics, patient review meetings and multi-disciplinary case conferences where appropriate.
- To represent the service and/or individual patients to ensure the delivery of a co-ordinated multidisciplinary service and integrate Occupational Therapy (OT) treatment/management into the global management strategy for each patient.
- To monitor the caseloads and record keeping of more junior staff (including students).
- To communicate effectively with patients and carers to maximise a patients rehabilitation potential.
- To be responsible for ensuring accurate and comprehensive patient treatment records are kept in line with relevant organisational and professional standards.
- To be responsible for the safe and competent use of all equipment, patient appliances and aids and ensure through teaching, training and supervision of practice that junior staff and assistants attain and retain competency prior to use.
- To seek advice and support from senior staff where appropriate.
- To manage clinical risk within own patient caseload.
- To coordinate virtual home visits and assessments as an integral part of the OT plan to maximise patient function in their home environment.
- To independently make recommendations for follow-up especially for housing adaptations.

- From information available classify patients into order of priority and degree of complexity to enable appropriate self-management of the caseload. OTs will manage demand and capacity by developing effective time-management skills alongside case-load weighting tools and case-load management techniques.
- To use remedial and compensatory approaches to treat deficits in the areas of occupational performance and to use recognised treatment approaches within scope of practise.
- Actively contribute to Multi-Disciplinary Team working as required to maximise the effectiveness of Occupational Therapy intervention.
- Regularly liaise with team members from the palliative care team, Macmillan support workers, health, social services and voluntary agencies to ensure an integrated and comprehensive service is provided.
- Ensure that records and reports are an accurate representation of clinical intervention and are maintained to the agreed department standard.
- To take joint responsibility for own clinical supervision by being prepared for each session and acting on feedback on performance.
- To have prior experience of treating patients with a cancer diagnosis, working with palliative care patients and supporting end of life discharge planning.
- To have professional and legal accountability in accordance with the Royal College of Occupational Therapists (RCOT) Professional Standards and ethics and the Health and Care Professions Council (HCPC) standards of proficiency, conduct, performance and ethics.
- To be responsible for ensuring your own Continuing Professional Development, professional and personnel development and maintaining and developing a high degree of specialist expertise.
- To undertake measurement and evaluation of your work and current practice through the use of evidence-based practice (EBP), audit and outcome measures.
- To maintain and develop up to date knowledge of EBP in cancer care.
- To support evidence-based practice, audit and research activity within the team, service and specialty.
- To actively participate in Service and Directorate meetings informing discussions and contributing ideas and proposals regarding policy and service delivery/development.
- To assist in the evaluation and development of the Occupational Therapy service in order to provide the best patient care within the resources available. This may involve undertaking a pilot project or clinical audit, evaluating the results and if agreed implementing change.
- To participate, both as an appraiser and an appraisee, in the Individual Development Performance Review and be responsible for working to the agreed plan objectives.
- To teach, assess, appraise, mentor and undertake IDPR and Individual Personal Plan meetings with junior and assistant staff.
- To act as a clinical supervisor for undergraduate students and be responsible for teaching to graduate level on Occupational Therapy skills and knowledge within the core clinical areas whilst the students are on placement.
- To be an active member, attending and participating in, the departmental in-service training programme and other training opportunities as identified through development plans.
- To take an active role in delivering post graduate education and the department in-service training programme, including the training and supervision of junior and assistant staff assessing and evaluating capability.
- To actively participate and deliver the education and training of other disciplines as required.
- To teach relatives/carers and other healthcare workers as required.

	Advanced

Exemplar role descriptor
Post: Advanced clinical practitioner (ACP)

Job summary:

The post holder will demonstrate a high level of expertise within the specialist service providing advice, education and support to staff, patients, their families and carers.

The post holder will be practising autonomously as an advanced practitioner within the designated speciality area to provide patient-centred clinical care. This will encompass the skills of advanced clinical assessment, examination, diagnosis and treatment within an agreed scope of practice throughout the division.

The post holder will support new ways of working that emphasises a more efficient and patient focused service, and will ensure the safe treatment, referral and discharge of patients with undifferentiated and undiagnosed presentations in their area.

The post holder will hold responsibility for leading the on-going development of clinical practice and standards of care within the service, including the development of policies, procedures, protocols and guidelines in collaboration with multidisciplinary colleagues.

The post holder will be required to adhere to all aspects of the ACP Governance standards and procedures document.

Main responsibilities:

- Work autonomously as an advanced practitioner within the specialty, managing a caseload of patients delivering individualised direct patient care with educational support and clinical supervision as identified within the ACP governance standard and procedure document.
- Demonstrate a critical understanding of their broadened level of responsibility and autonomy and limits of own competence and professional scope of practice.
- Direct responsibility for assessment, examination, investigation and diagnosis of patients within their area of work.
- Use expertise and decision-making skills to inform clinical reasoning to appropriately treat patients, resulting in the safe management and appropriate referral or discharge of patients with undifferentiated and undiagnosed presentations.
- Receive referrals via a variety of sources, including direct patient referral. Manage own caseload and clinical priorities according to agreed protocols and working practices.
- Work in a variety of areas as job plan requires including in multidisciplinary clinics, participate in ward rounds, patient reviews and multidisciplinary team meetings.
- Undertake a variety of clinical skills and provide treatment/ advice as per speciality and scope of practice. Using agreed protocols of clinical practice and professional guidelines. This service may be provided within an acute secondary healthcare facility or in primary, community or home care settings.

- Within scope of practice and clinical competence request and / or undertake diagnostic procedures and clinical investigations related to plans of care following appropriate training and assessment of competence.
- Utilise scope of practice to undertake Non-Medical Prescribing role and provide advice on medicine management issues associated with the patient specialty group. Work within Trust policy for Medicines Management.
- Utilise advanced knowledge and skills relating to the speciality to provide specialist advice to other members of the multidisciplinary team on the basis of patient assessment.
- Provide a seamless, high quality service from referral through to assessment, diagnosis, treatment and review, referring to other specialists as required. Provide guidance to staff, patients and their families and carers on pathway navigation.
- Lead in the development and updating of referral guidelines and policies for the service.
- Use highly developed communication skills to effectively communicate with colleagues, patients and their relatives/carers, making reports and liaising as required with medical staff and other members of the multidisciplinary team both verbally and in writing.
- Use professional judgement to act as an advocate for patients to ensure a patient focused approach to the delivery of care. Support and enable patients and carers to make informed decisions relating to their treatment and management. Escalate any concerns via the nursing / professional structures as required.
- Work towards safe and timely discharge and/ or transfer of care of patients from or between hospitals and services and healthcare professionals, ensuring barriers to discharge / transfer are identified and acted upon appropriately.
- Ensure effective and accurate verbal or written handover of patients between healthcare professionals.
- Ensure that high standards of all documentation are maintained, with accurate, complete and up-to date information regarding patient care are kept in accordance with Trust standards.
- Monitor the quality and standard of care provided by all members of the team and all staff in clinical areas. Identifying any skills or training gaps and escalating to the appropriate Manager or Clinical Lead.
- Undertake training to develop further advanced clinical practice roles required by the service in order to provide a high standard of patient care.
- Provide evidence of clinical competence with the maintenance of an advanced practice clinical portfolio for submission as part of the annual review of clinical practice process.
- Practice in compliance with their respective code of conduct and within their scope of practice, being responsible and accountable for their decisions, actions and omissions at this level of practice.
- Provide highly visible and accessible professional leadership and demonstrate expert knowledge and standards of clinical practice.
- Lead and develop a defined area of Advanced Clinical practice within the designated area of practice promoting interdisciplinary team and collaborative working practices.
- Meet regularly with team members as a team and on an individual basis as required to support their personal and professional development.
- Promote team working; build rapport and collaborative working practices with multidisciplinary team.
- Liaise with inter-hospital departments and personnel across organisational and professional groups.
- Ensuring effective communication and interpersonal skills with other disciplines and organisations.
- Act as a clinical role model demonstrating exacting standards of advanced clinical practice and provide support or advice to other staff when necessary.
- Lead and support the development of the role according to changing patient’s needs, service requirements and evidence based practice.

- Lead and actively participate in service/ departmental projects, quality initiatives and statutory accreditation processes. This will include the setting and monitoring of clinical standards of care.
- Adhere to all relevant Trust policies and procedures and to ensure that they are correctly implemented.
- Lead in the implementation of multidisciplinary service objectives that reflect Trust strategies for patient care.
- Demonstrate effective leadership skills, supporting the management team.
- Monitor standards and maintain high quality care. Report any clinical incidents via the Trust electronic reporting system and escalate issues promptly and appropriately.
- Utilise the highest level of interpersonal and communication skills when dealing with complex, sensitive or emergency situations.
- Maintain an awareness of professional and ethical issues to ensure care is delivered in a professional timely and courteous manner by all members of the team, respecting the different spiritual and cultural backgrounds of colleagues, patients and relatives.
- Escalate any concerns or complaint s promptly.
- Participate in the recruitment and selection of staff.
- Responsibility for completing or delegating the preparation and daily review of staff duty rotas, ensuring that the team provides most effective service provision.
- Maintain a working knowledge of local and national professional policy and strategy.
- Attend and when required chair multidisciplinary meetings as a representative of the service.
- Ensure minutes and agreed actions are communicated to stakeholders according to agreed timescales.
- Act as an expert educational resource for clinical staff, patients, and carers by providing formal and informal education.
- Act as mentor/ assessor to staff members and students as required, providing educational advice and support.
- Lead and actively participate in the delivery of educational programmes for all grades of nursing, medical and allied health professional staff.
- Provide support and guidance to all levels of staff in their clinical role.
- Ensure that learners receive appropriate learning experience whilst allocated to the directorate.
- Participate in provision and identification of in-service training need for all team staff.
- Participate in education and practice development on a Trust wide basis liaising with Trust wide.
- educational leads to ensure overall Trust educational objectives are delivered.
- Recognise the limits of own professional practice and competence, undertake further training and academic qualifications as required to maintain own specialist knowledge.
- Critically assess and address own learning needs, ensuring personal development plan reflects the breadth of ongoing professional development across the four pillars of advanced clinical practice.
- Take responsibility for ensuring personal and completion of any statutory or mandatory training as required for. Informing line manager if there is any deviance from training attendance.
- Adapt clinical knowledge and skills to different clinical settings.
- Participate in the annual appraisal process, delegating duties to team members as appropriate to ensure all staff within the team have personal development plans which support revalidation.
- Maintain close links with local HEI’s and participate in in the development and delivery of new and established advanced practice programmes.
- Participate and where required lead or assist in research projects as required, disseminating and ensuring utilisation of research results to change practice.

- Utilise research findings in the delivery of advanced clinical patient care, developing new ways of working.
- Be aware of research /trails being undertaken within the specialist field of practice.
- Participate and where required lead audit projects as required by the specialty, involving collating, analysing and reporting on results of the audit process.
- Provide support, encouragement and advice to MDT staff undertaking audit and research.
- Facilitate collaborative links between clinical practice and research through proactive engagement, networking with academic, clinical and other researchers.
- Collate, analyse and present reports on varying aspects of the speciality activity as required by directorate or divisional team.
- Ensure the results of audit and research conducted by the team are disseminated at local, regional and national level.
- Disseminate best practice research findings and quality improvement projects through appropriate forums i.e. publications, attendance/presentation, peer review.

	Consultant/Strategic

Exemplar role descriptor
Post: Consultant practitioner

Job summary:

The post holder will be a clinical expert in the field of cancer care and treatment, with an interest in and will fulfil the four domains of the Consultant Practitioner function:

1. Advanced and expert level practice within the field of oncology
2. Leadership and consultancy
3. Development and provision of education and training
4. Service development, evaluation, research and audit

The post holder will practice at an advanced clinical level and exercise high levels of judgement, discretion and decision making in the clinical care. There is an expectation that a minimum of 50% of the post holder's portfolio will be spent in direct autonomous clinical practice, having clinical responsibility from an oncology perspective and providing leadership for clinicians.
Working as an independent practitioner within their specialised cancer disease site, the role will provide clinical leadership, expert practice and advanced knowledge, integrating research evidence into practice and contributing to/leading on research in acute cancer care and treatment.

The post holder will monitor and improve standards of care, implemented through supervision of practice, clinical audit, identifying research questions, disseminating research findings and promoting their translation into practice. The role will also play an active role in teaching and supporting professional colleagues and the provision of skilled professional leadership. The post holder will contribute to clinical effectiveness across the organisation by participating in audit and research as part of the MDT in the field of cancer care and treatment, contributing across the health economy as required.

Main responsibilities:

- Have a highly visible clinical profile, providing both advisory and clinical input into patient care, spending 50% of their time in clinical practice in the acute setting. Through working in partnership with patients and families/ carers to achieve a therapeutic relationship to enable them to make informed choices.
- Apply advanced theoretical, evidence based and practical knowledge to the care and treatment of patients with a cancer diagnosis contributing to the delivery and shaping of the services.
- Lead in-depth discussions about the patients' particular diagnosis, all available treatment options, including research-based treatments with sensitivity, knowledge and expertise to enable patients to make informed choices. Acting as patient advocate when appropriate and respecting patient confidentiality and privacy with respect for diverse cultural backgrounds and requirements.

- Plan and organise in direct clinical care settings through history taking, systematic physical examination and formulate a clinical management plan. Managing the patient from presentation until discharge through planning, delivering and evaluating interventions and/or treatments when there are complex issues and/or serious illness.
- Arrange or refer the patient for appropriate diagnostic tests, investigations or to other professional colleagues.
- Check and interpret results, taking action as clinically appropriate using excellent clinical reasoning and clinical decision-making skills.
- Prescribe medication, anti-cancer therapies and allocate treatments adhering to trust policy and existing site specific local and national treatment frameworks.
- Work autonomously or collaboratively with multidisciplinary teams, working across professional boundaries to optimise clearly defined patient care plans, outcomes and a stratified follow up programme, to achieve an integrated approach through patient centred care.
- Provide leadership, guidance and exercise judgment in making challenging patient centred decisions within current best practice guidance, relevant legal frameworks and with clear understanding of the relevant professional and applied ethical frameworks.
- Explore and implement ways of preventing unscheduled admissions to hospital by working collaboratively with services across the region.
- Assist to meet and develop strategies which support the needs of culturally diverse patients. Achieving equality and values diversity.
- Develop and maintain expertise in highly developed skills and appropriate competencies, ensuring the highest level of precision to maintain patient safety in line with Trust and regulatory frameworks.
- Identify and implement new developments, treatments and technologies into clinical practice.
- Promote the translation of evidence based/research findings and best practice guidance into practice.
- Prepare accurate and concise reports both verbally and written.
- Utilising a broad range of interpersonal skills, develop effective communication strategies to ensure that information and knowledge is imparted sensitively according to the needs of patients, relatives, staff, students in training and visitors.
- Be a member of relevant Trust and Network committees and groups providing expert advice and contributing to the development of Nursing and Midwifery policy and strategy.
- Be a member of relevant tumour site subcommittee/MDT groups/cancer alliances providing expert advice and contributing to the development, auditing and reviewing of services. Also including involvement of peer review, GIRFT (Getting it right first time) review and implementing any recommendations from the National Patient Experience Survey.
- Advise and negotiate with all medical and multi-disciplinary staff, patients and carers in matters relating to meeting the standards and protocols across the Trust.
- Participate in Case Conferences and other professional meetings as required.
- Develop knowledge and skills to ensure continual improvements to the quality of patient-centred care services, whilst pushing the boundaries of nurse-led clinical practice.
- Work with HEI’s and workforce development professionals to influence the development of pre and post graduate curriculum for all health professionals in relation to their specialist field.
- Through role modelling, mentorship, clinical supervision, as well as education and facilitation, equip the multidisciplinary team for role development and expansion, acting as an educational resource within the trust and wider cancer Alliance.
- Teach multidisciplinary and interdisciplinary groups within the Trust and within HEI on a range of subjects relating to the field of specialised cancer services. As required, work with relevant HEI’s to develop post registration practice and expertise in cancer care, treatments and living with and beyond cancer.
- Ensure personal peer support and clinical supervision needs are met.

- Ensure own self-development, clinically and academically is reviewed during an annual appraisal and personal development plans and achieved.
- Develop services as appropriate learning environments to promote life-long learning, persona effectiveness and accountability for staff working in them.
- Ensure the clinical environment is conducive to supporting the education and learning of all staff and students.
- Contribute to primary research projects maximising the contributions of nurses and the wider interprofessional team. Initiate, facilitate or undertake appropriate high-quality research collaborating as appropriate with relevant partners (clinical and academic).
- Promote the translation of research into practice. Critically appraise the outcomes of research, evaluation and audit, and apply them to improve practice. Act as an expert resource and demonstrate knowledge of current research in all aspects of specialised cancer services.
- Develop databases for collation of information to allow audit and research adhering to local data protection policies.
- Contribute to research publications and present developments and research findings locally, nationally and internationally.
- Identify need for service development through audit/research, facilitate sharing/implementation of innovative ideas and concepts in working practice, overcoming barriers, and manage conflict and resistance to improve outcomes for patients.
- Develop academic relationships to support the development of a clinical academic career.
- Engage with key stakeholders in the identification of need and in the development, implementation and evaluation of clinical procedures, guidelines and clinical capabilities.
- Promote the shared objectives of the multidisciplinary team by working closely to ensure that best practice is achieved utilising clinical benchmarking.
- Develop and sustain appropriate relationships, partnerships and networks to influence and improve health, outcomes and healthcare delivery systems.
- Provide transformational leadership in the development of cancer care nursing at clinical and organisational levels and contribute to the national, regional and local agenda.
- Demonstrate strategic decision making and influencing skills, in both forming and translating policy.
- Advise and negotiate with all medical and multi-disciplinary staff, patients and carers in matters relating to meeting the standards and protocols.
- Recruit and induct staff, ensuring the probationary reviews are undertaken and mandatory/ core training and education is provided and completed.
- Lead and participate in clinical governance systems to ensure continuous improvement in quality at both an individual, team and service level.
- Assess and manage clinical risk for the safety of self, colleagues and patients, in line with the Trust Risk.
- Lead and provide clinical leadership in the undertaking of root cause analysis investigations of clinical incidents.
- In relating to complaints, working with patient, advice and Liaison service (PALS) and colleagues to develop good practice and improvement strategies in response to themes. Acting swiftly to resolve any concerns raised by patients, relatives, carers and staff.
- Comply with risk assessments, health and safety legislation, infection prevention and control policies.
- Maintain own knowledge, skills and competence by identifying training requirements.
- Keep an up-to-date professional portfolio to support the knowledge and skills framework and ensure own professional self-development.
- Develop personal practice and skills working within protocols, guidelines and evidence-based best practice.
- Develop the role by using evidence-based practice and continuously improve one’s own knowledge, following national guidelines for professional development.

- Fully engage in own appraisal process and regular one to one meeting.
- Network with others regionally, nationally and internationally and incorporate initiatives and standards of practice, where appropriate.

Consultant/Strategic

Exemplar role descriptor
Post: Lead cancer nurse

Job summary:

The Lead Cancer Nurse will play a crucial role in terms of improving the outcome and experience of people whose lives are affected by cancer. The post holder will work closely with others to oversee, develop, and continually improve cancer services across the organisation and beyond.

The post holder will be a highly experienced specialist within the field of cancer nursing and a credible practitioner.

The post holder will have a corporate professional oversight of the specialist nursing workforce for cancer across multiple tumour sites and care groups, ensuring there is equity in provision for cancer patients as well as ongoing development of expertise within the clinical teams.

The post holder will have a clear role in leading expert practice, supporting the delivery of the organisational cancer strategy, supporting the delivery of the Personalised Care agenda, Prehabilitation, as well as lead on the development and roll out of the other programmes for cancer patients. The post holder will be required to have a focus on patient experience and engagement, as well as raising the awareness of inequalities in cancer care.

The Lead Cancer Nurse will also be required to lead on submissions to the Quality Surveillance Team Peer Review process (QSIS) and participate in the internal validation process, as well as lead on the response and actions arising from patient experience surveys, including National Cancer Patient.

The Lead Cancer Nurse role will have a clear role in leading expert practice, shaping and developing the service, contributing strategically to reviews and service developments.

The role will be actively involved and provide leadership to the cancer education programme.

The post holder will act as an ambassador for cancer nursing care, both within RCHT and across organisational and professional boundaries, cultivating a diverse range of services to establish an integrated approach to patient care and delivering quality outcomes in cancer.

The post holder will be a highly competent, proactive, visible, and experienced practitioner who uses their specialist knowledge and advanced skills to support the care of cancer patients electively and acutely.

The post holder will be able to resolve clinical issues quickly and effectively; to minimise any negative impact on the quality of patient care and to monitor safety within their areas of responsibility by reviewing and triangulating information.

Main duties and responsibilities:

- In collaboration with key stakeholders identify and liaise with medical and nursing education across primary and secondary care settings to support the delivery of the organisational Cancer Strategy.
- Promote collaborative working across boundaries, integrating multidisciplinary team working practices, in order to prevent duplication and promote seamless care focused on patients' needs.
- To inform, direct and provide clinical leadership in developing cancer services in all aspects of nursing care throughout the organisation and beyond.
- Provide organisational-wide professional leadership for cancer nursing teams, to advance the development and practice of evidence-based cancer nursing in the Trust, in line with national recommendations and standards where these are available.
- Take joint responsibility for the development of the Trust Cancer by leading relevant workstreams of the cancer improvement programmes.
- To be the point of contact for the Trust's interface for nursing, AHP and supportive care related issues and positively contribute to the future direction of cancer services.
- Work alongside relevant nursing leaders to influence and guide cancer education.
- Play a strategic corporate leadership role in ensuring and consistently developing a high quality, cancer nursing services and workforce across the organisation.
- To be a highly visible role model and act as a clinical advisor on issues and developments concerning specialist cancer nursing. The post holder will be a highly experience nurse within the field of cancer nursing and recognised as a credible practitioner.
- Ensure compliance with National Guidance and initiatives for specialist cancer nursing.
- Provide expert advice with respect to specialist cancer nursing to internal and external stakeholders.
- Lead in facilitating patient/user feedback and evaluation of cancer services in conjunction with the Cancer Team and Trust Lead for patient experience.
- Contribute and lead on national directives and pathways with relevance to cancer.
- Work in partnership with the key stakeholders in the organisation to ensure that the services meet the Manual of Cancer Services standards and the NICE quality standards.
- Work closely with Cancer Services to deliver the Personalised Care and Support agenda for those affected by cancer, including the roll out of remote monitoring systems, treatment summaries, Holistic Needs Assessments and stratified follow up pathways.
- Be instrumental in aligning national health promotion campaigns specific to cancer in conjunction with site specific teams.
- Be clinically competent to work across inpatient and outpatient cancer services including maintaining systematic anti-cancer therapy skills.
- Be able to offer advice and training to colleagues.
- Act as a resource for staff advising on local, trust and national policy, procedures and guidelines ensuring patient safety and clinical governance is maintained.
- Work autonomously making complex clinical decisions with minimal supervision whilst working within local and national policies and being responsible for how these policies are interpreted.
- Autonomously assess patients; receive and make referrals; assess, order, interpret and act upon investigative tests; consider differential diagnosis; evaluate, treat, plan, refer and discharge patients/clients within the Trust.
- Work in partnership with the existing senior clinical multi- disciplinary teams and medical teams, driving departmental development and change.

- Support staff development in order to maximise potential, encouraging everyone to learn from each other and from external good practice.
- Possess effective time management and personal organisation skills.
- Develop and contribute to local guidelines, interpreting and adapting national protocols and standards to enhance patient care and safety.
- The post holder will develop and contribute to local guidelines, interpreting and adapting national protocols and standards to enhance patient care and safety.
- The post holder will contribute to the strategic direction of service lines and specialties through meeting key performance indicators and national and local activity targets.
- Contribute to the delivery of equality, diversity and public health initiatives.
- Understand and take consideration of customs, values and spiritual beliefs of both patients and colleagues.
- Take responsibility for own learning and performance including participation in clinical supervision and maintaining awareness of relevant research evidence.
- Develop education in collaboration with the multi-disciplinary team ensuring that all patient care is based on current research and best practice.
- Act as a constant source of clinical and theoretical knowledge for all grades and disciplines of staff as well as patients and their significant others, providing support and clinical advice.
- Responsible for utilising, mobilising knowledge into practice, involvement and participation in research/audit/ evaluation and encouraging research and participate in developing research and development programmes or activities.
- Develop and facilitate education to support clinical colleagues, students, other health and social care providers working with service providers and academic institutions.
- Responsible for initiating and developing research and development programmes or activities.
- Teach and support nursing, medical and other members of the multidisciplinary team to ensure standards are maintained.
- Recognise and work within own competence and professional code of conduct as regulated by the Nursing and Midwifery Council (NMC).
- Identify personal career development pathway as part of formal appraisal system.
- Ensure that all elements contained within their profession’s Code of Conduct are adhered to and those relating to professional accountability and revalidation. Through supervision and mentorship, identify personal learning needs; participating in personal continuing education and other activities to promote one’s own personal growth.
- Develop and further clinical knowledge and professional skills through relevant training and study.

Appendix 5: Frequently Asked Questions

Who is the framework for?
The Framework is for the Supportive, Assistive, Nursing and Allied Health Professions Workforce who provide care to people affected by cancer in general settings/services and specialist cancer settings/services/roles across the United Kingdom (UK).

Does this framework replace any existing frameworks in circulation?
No. This Framework is unique in that it focuses on a clinical career pathway of the workforce in scope linked to cancer care and has not been designed with a single professional group in mind.

How can the framework be used?
The framework can be used by staff to better understand the development needs of themselves as individuals and the wider workforce. It can help them understand how to maximise the contribution of the existing workforce, identify opportunities for new ways of working and where appropriate, identify the need for new roles.

The framework can be used to review and recognise how existing capabilities are individually and collectively being utilised across a team and/or area of care.

The framework can be used as the basis to conduct formal or informal appraisal and training needs analysis, comparing current capabilities with those identified in the framework. This framework can also be used to support career progression and development in a challenging environment and engagement in continuing professional development.

The framework enables employers to consider objectively how their current workforce's performance aligns to the capabilities and ensure any workforce development is based on service need/outcomes.

A further aspiration in providing this framework is to support service transformation i.e., that organisations use the framework to review their current arrangements for practice and use the framework to develop roles and teams. The framework also provides potential benchmarking of service provision at an organisational level and for employers to identify appropriate/further development.

Use of this national framework also supports organisational and system wide effectiveness and efficiencies by encouraging the delivery of education and training that is focused on developing core capabilities and optimises opportunities for inter-professional learning; focussed on outcomes-based curricula which equips individuals with the attributes required to meet the needs of the population. In so doing, it aims to increase consistency in knowledge and skills development, prevent unnecessary duplication in education and training delivery and strengthen skill mix and teamworking.

Why has this framework been produced?
Cancer is a complex and significant disease that will affect 1 in 2 of us during our lifetime. In the UK, the number of people living with a cancer diagnosis is set to double from more than 2 million in 2021 to 4 million in 2030. At the same time, the diagnosis, treatment and management of cancer are becoming more complex with the advancement of scientific and technological innovations, which have the potential to transform our ability to prevent, diagnose, treat and care for people affected by cancer.

We know that significant parts of the workforce are under pressure now and, unless we act, we risk being without the right number of health professionals with the right knowledge, skills and capabilities to effectively deliver care to UK population.

How was the framework produced?
The framework's development was guided by the ACCEND Steering group representing key stakeholders/organisations with expertise in cancer, cancer care and cancer delivery. Four nation and wider service and public user representation was achieved via an Expert Advisory Group.

Initial desk research was undertaken to identify key references, resources and significant frameworks. Initial versions of the Framework were developed based on the findings of the desk research and consultation with the workstream steering group.

A consultation period was also established (July-August 2022) to include a more diverse range of organisations and individuals that wished to be updated about the development of the framework and to provide comments or feedback. Individuals were able to register their interest on a project web page.

Hosted by Skills for Health, in July and August 2022, a wider online consultation survey was conducted with a total of 494 respondents.

Based on an analysis of these survey outcomes, further amendments and refinements were undertaken, leading to a final meeting of the workstream steering group.

How will HEE and others be supporting uptake of the framework once it is launched?
To support uptake and understanding of the framework a comprehensive implementation document has been produced.

The framework is one workstream of the overall ACCEND programme of work. There are other workstreams who are engaging in work to support workforce development and more information can be found be found on the ACCEND webpages.

When will the framework next be updated?
Utilisation of the framework will be monitored on an ongoing basis however it is anticipated that a formal update of the framework will not occur before 2024.

I have comments on the framework, or I want to share how I am using it - who do I contact?
Please share your information by contacting the ACCEND team at: accend@hee.nhs.uk