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 for supportive and assistive levels including self-assessment tool

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:

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 is for practitioners at **supportive and assistive levels**.

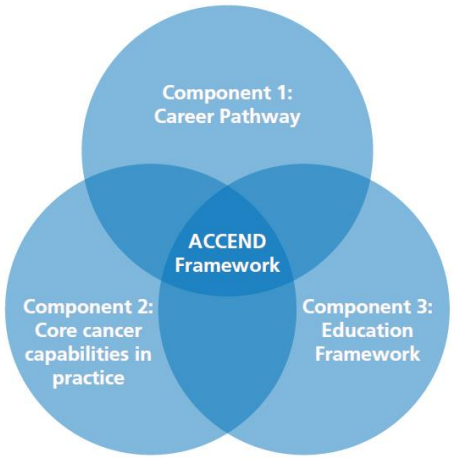
It should be read in conjunction with the **Career Pathway, Core Cancer Capabilities and Education Framework for the Supportive, Assistive, Nursing and Allied Health Professions Workforce (the 'Framework).** This guide is provided to help practitioners and employers understanding of the utility of the Framework, as well as to showcase 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 outwith the scope of this Framework.

The Framework provides insight into what 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 service

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:

For those practitioners providing care to people affected by cancer in general and specialist services and roles at supportive and assistive levels of practice, the education framework and core cancer capabilities may be useful for:

- developing and reviewing their job/role descriptions
- undertaking self-assessment using the learning outcomes identified for the Foundations of Cancer Care module, and the knowledge, understanding and capabilities recommended for these levels of practice to evidence your current knowledge and capabilities and/or to identify learning and development needs
- identifying opportunities for role specific development or progression to the next level of practice to meet individual career aspirations
- performance appraisal

Supportive and assistive level practitioners can use the Self-assessment tool (Appendix 1) template provided to:

- identify your current level of practice and role expectations/requirements within own care context (general or specialist cancer care)
- identify and develop knowledge and capabilities in aspects of cancer care to realise the potential of own role
- plan a personal career pathway by identifying learning and development needs
- identify opportunities to influence the development of cancer practice
- discuss the education framework and cancer-specific core capabilities recommendations at your performance review/ appraisal meetings to identify learning, development and support needs, and to review progress to demonstrate achievement of the cancer-specific learning outcomes and capabilities in practice
- develop an action plan and summarise the evidence which demonstrates personal achievement of the cancer-specific knowledge and capabilities relevant to own role or career aspirations

Evidence may include examples of:

- care plans developed
- short reflective accounts of specific cases incorporating reference to relevant theory and research
- copies of care/clinical pathways contributed to the development of analysis of key local, national and international policy documents
- service improvement projects led or contributed to mentor/peer observation.
- higher education accredited modules and programmes
- collate evidence relating to the cancer-specific learning outcomes for professional revalidation

Appendix 1: Self-assessment tool for practitioners and employers.
Tools for assessment and recording evidence are also available in the Implementation/User Guide and the ACCEND website.

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**	**Self-assessment and sources of evidence including:** Care certificate Fd Nursing Associate/Assistant Practitioner/Pharmacy Technician programme Workplace experience
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	• 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	Range of evidence to demonstrate achievement of defined learning outcomes and core cancer capabilities in practice for supportive and pre-registration level	

	Learning outcomes: • 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	• Cancer treatments and decision-making • 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 and management and care • Recognising oncological emergencies • Personal and team well-being, clinical supervision • Reflective and evidence based practice and continuing professional development		

	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			

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:**			**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:**			**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:**			**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 work place imperatives where necessary					

Domain A. Person-centred collaborative working					
4.0 Capabilities: Communication and Consultation Skills The practitioner is able to:			**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:			**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:**	**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:**			**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:**			**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/sign-post 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:**			**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:**			**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:			**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:**	**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:				**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 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:			**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:**			**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:			**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:			**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:	**Self Assessment**			**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:**			**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:			**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:**			**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:**			**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:**			**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:**			**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					