My career journey began when I trained as a nurse at St Bartholomew’s Hospital, London, in 1982. As part of an introduction to the course, we had to carry out a group project; I persuaded my supervisors to do it on complementary therapy. One member of my group said: ‘If you believe in all that, why are you doing nursing?’ I’m glad to say I still trained as a nurse. However, complementary therapy remained an interest for me and a developing skill alongside those of a trained nurse.

I first heard of the complementary therapy coordinator role in a chance meeting with a nurse who had this role in a London hospice. I knew at once that this was what I wanted to do, although I had no idea whether such a job would be possible in Norfolk. I couldn’t think of a better use for therapies than to use them to support patients receiving palliative care and their carers. This meeting inspired me to do further training in complementary therapies in cancer and palliative care, so I would be suitably qualified if such a job became available. In 2009, the position I had been waiting for was advertised for a complementary therapy coordinator at the Priscilla Bacon Centre for Specialist Palliative Care in Norwich.

**THE BENEFITS OF COMPLEMENTARY THERAPY IN A PALLIATIVE CARE SETTING**

Complementary therapies, alongside conventional medicine, provide valuable benefits and support to those receiving palliative care, enhancing feelings of relaxation and wellbeing for patients and relatives who may not be able to find this elsewhere. The treatments provide them with the comfort of touch and enable them to feel supported, which helps them to cope with their situation and to manage issues such as the symptom control of fatigue, breathlessness, nausea and pain.

Application of complementary therapies in palliative care settings has been acknowledged since the Calman-Hine report in 1995, with a growing number of therapists supporting people after a cancer diagnosis. The use of complementary therapies is also included in the 2004 NICE guidance on improving supportive and palliative care for adults with cancer. Many people find complementary therapy helpful if they are coping with loss or illness, and by building a therapeutic relationship, the therapist is able to support the person through their journey. The time spent having a treatment can provide valuable ‘me’ time and a safe space in which to reflect or relax. Not everyone wants complementary therapy, but even this can be beneficial because saying ‘no’ can provide a person with some control which they may feel has been taken away due to illness. The outcomes of receiving complementary therapy can be very positive and provide valuable coping mechanisms.

**BECOMING A COMPLEMENTARY THERAPY COORDINATOR**

When I joined the Norfolk team, the Anglia Cancer Network (ACN) was the advisory NHS group on cancer services for the East of England and produced guidance on the provision of complementary therapy in palliative care. This outlined the requirements of therapists, including qualifications, registration with a professional association, insurance and...
a Disclosure and Barring Service check. The implementation of these guidelines continued even after the disbanding of the ACN.

At the time, the complementary therapy service was delivered by a loyal team of self-employed therapists and a volunteer, overseen by a senior physiotherapist. I was the first complementary therapy coordinator to be employed in this NHS unit, which was partially funded by a charitable support group who were funding the complementary therapy service.

When I started, I was given the following long-term objectives:

1. To integrate the complementary therapy service into the specialist palliative care (SPC) setting
2. For the complementary therapy team to become integrated into the multidisciplinary team
3. To develop a robust complementary therapy policy that would encompass delivery of complementary therapy across the whole community team.

Other more immediate short-term goals included:

- Developing a model of outreach care for patients who would prefer to receive therapies at home
- Developing a method for evaluating the complementary therapy treatments
- Providing assistance to staff caring for patients requiring malodorous wound care using aromatherapy.

In order to achieve my long-term goals, I first needed to familiarise myself with the service that was in place and to develop a model that would be affordable, sustainable and provide the best quality of patient care. I also had goals of my own which I hoped to bring to fruition. At my interview, I was asked what my goals would be, and I said that I would like to introduce a wider variety of therapies on offer within the first six months. It transpired that this was an admirable goal but not very realistic, as I learned it can take some time to change existing policies and procedures in an NHS hospice.

Before tackling the long-term goals, there were some pressing short-term issues which required attention as part of the complementary therapy service's integration into the multidisciplinary team,
such as difficulty obtaining referrals, and lack of training and supervision for the complementary therapists (CTs). Everyone in the unit had the patient’s best interests at heart, but the CTs were often not able to carry out their work efficiently because staff were often too busy to complete referral forms, and some couldn’t see the point of them. This was a challenge for the CTs, as they clearly just wanted to treat the patients but were unable to obtain the information that they needed to work safely and effectively. It was also proving expensive as the CTs would want to stay on until they had seen a patient who needed their help, and were paid an hourly rate.

INTEGRATING COMPLEMENTARY THERAPY INTO THE MULTIDISCIPLINARY TEAM
As part of my role, I attended the multidisciplinary team meetings, enabling me to raise the profile of the complementary therapy service by suggesting when I thought a therapy may be helpful during the discussions about each patient. I was also able to obtain referrals and express the need for completed referral forms. The CTs found that having a coordinator enabled them to concentrate on delivering treatments as I could manage referrals on their behalf and provide clinical supervision. We commenced bi-monthly complementary therapy meetings and distributed minutes to senior nursing and medical staff. The role of a link nurse was developed, which gave us a named member of staff to approach to resolve issues quickly and effectively, and improved communication. I had expected everyone to be as enthusiastic about the service as I was and was surprised when this was not always the case. Some staff had been championing complementary therapy for some time but there were areas of resistance and to facilitate change it was necessary to overcome this – so I developed an education programme.

IMPROVING SERVICE DELIVERY
A complementary therapy policy was developed to formalise its delivery. It ensures a consistent approach to provide safe and effective complementary therapy for anyone using it with this client group and is based on the National Institute for Health and Care Excellence (NICE) and the Prince of Wales Foundation for Integrated Healthcare national guidelines. It states the roles and responsibilities of those practising complementary therapies, sets standards for their service provision and provides indications and outcomes. The policy was signed off across the NHS highlights the challenge of delivering complementary therapy in an NHS setting. Job descriptions for the therapists were developed alongside the policy.

"There were areas of resistance to complementary therapies and to facilitate change it was necessary to overcome this - so I developed an education programme."

Development of a bespoke model for home visits was piloted following requests from patients who were unable to come to the unit. Patients were asked to attend the unit for complementary therapies, if possible, and transport could be provided if necessary. However, if they were unable to travel and were approaching end-of-life care, we would offer up to four treatments in the patient’s home.

A service delivery protocol was implemented – outpatients and carers could have a course of up to six treatments. We would evaluate the efficacy of treatments and whether referrals to other modes of assistance were necessary, such as counselling. We used the MYCaW (Measure Yourself Concerns and Wellbeing) method to evaluate the outcomes of complementary therapy treatments for three months. This gave us a useful snapshot of the efficacy of treatments. Patients and carers were also

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Palliative care | COMPLEMENTARY THERAPY

They would receive training in the 'M' Technique so they could be confident of providing a safe and effective treatment using an appropriate level of touch

“...”

encouraged to give feedback if appropriate. In certain circumstances, we continued to offer support after the six sessions. We gave advice on how to find a suitably qualified practitioner if they wished to continue to have complementary therapy after completing their course.

Attending meetings of the ACN’s complementary therapy steering group provided a valuable opportunity for networking with other experienced professionals to discuss the implementation of care in our respective units. I was very lucky to have this support, in combination with national guidelines, to ensure the safe delivery of complementary therapies in the SPC setting.

Following the 2010 proposals for the reorganisation of the NHS, the cancer networks were replaced by 12 strategic clinical networks, which included some cancer expertise. However, there was no provision for complementary therapy, so we had lost our clinical network of excellence which had developed the policy on which we based our own. Later, in 2015, when the NICE guidelines for SPC were being reviewed, the intention was to remove complementary therapy from the guidelines, again making our position feel more vulnerable. Thankfully, following an overwhelming response to their consultation, NICE U-turned and kept complementary therapy in the guidelines.

I visited units in East Anglia and Essex to meet other coordinators and find out how their services were run. Most had a complementary therapy service provided largely by volunteers. There were a few self-employed therapists and only one non-NHS unit that employed therapists. These all had many variations in service delivery, with some units providing home visits, and some therapists having access to patients’ notes and so on.

ACHIEVING MY GOALS

Part of my role was to develop a sustainable service, which was affordable and maintained all the standards required by clinical governance and provided the most effective service delivery. The support group did not want to continue to fund both the coordinator post and self-employed therapists, as this was an expensive option. Having looked at all the different variations, I presented the findings to a team of senior management. It was decided that the model which would provide the most cost-effective and efficient service was to have a coordinator and a team of Band 4 therapists who would provide complementary therapies five days a week, supported by a small number of volunteers. These volunteers would benefit by gaining experience in an SPC unit under the supervision of the employed therapists and the service would benefit from their support. They would receive training in the 'M' Technique so that they could be confident of providing a safe and effective treatment using an appropriate level of touch.

This decision by senior management to employ therapists brought about a huge change in the structure of the complementary therapy service. I had not anticipated the length of time that it can sometimes take to achieve such goals, but eventually the model was adopted where the therapists are still paid for by the support group but employed by the NHS, which means that they are fully integrated into the multidisciplinary team providing care for patients in this palliative care setting. It is quite unusual for therapists to be employed by the NHS, as most hospices have a complementary therapy service which is provided by volunteers and a coordinator. It was a huge step forward for them to be employed.

The therapists received the mandatory training received by all other clinicians in the NHS, including manual handling/musculoskeletal health, basic life support and resuscitation training, documentation and record-keeping, and infection control.

After achieving my goals, I left the NHS in 2016 to return to being a self-employed therapist, knowing the service was in safe hands. It continues to thrive and develop under its new leadership and is now firmly embedded in the fabric of the service. Having excellent supervision and building a network with other coordinators in the area are both essential, and I am very grateful for all the help and support I received.

The current coordinator, Sally Lawrence, MFHT, has plans to further develop the close working relationship between the complementary therapy service and the psychological support team and would like to develop a system to help support staff in the unit. There are also plans for a new SPC unit to be built where the complementary therapy service would have a more spacious area than at present.

Jane Sheehan, MFHT, is qualified in a wide range of complementary therapies. Since leaving the NHS, Jane uses therapies to support women with fertility and pregnancy, teaches baby reflexology and the 'M' Technique® and runs yoga and qi gong holidays.