Health and Social Care Board

Public Health Agency

Cancer Clinical Nurse Specialist (CNS) Workforce Plan

Introduction and background

The role of clinical nurse specialists (CNS) in contributing to high quality cancer care is now well acknowledged and understood. CNSs are at the front line of cancer care; they are the main point of contact for patients, significantly improve patient experience and deliver services for individual patients according to need and patient choice. They play a vital role in the coordination of care and successful implementation of initiatives to improve cancer services. To date CNS commissioning within Northern Ireland has been ad hoc and opportunistic, with provision significantly lower than the rest of the UK. This paper sets out a summary of the development of a risk based, prioritised and incremental cancer CNS workforce plan which has been progressed and endorsed by the HSCB and PHA cancer team in collaboration with Trusts.

Needs assessment

In NI, 11,000+ people are diagnosed with cancer *(taken from Macmillan census of the specialist adult cancer nursing workforce NI 2014, whereby incidence data was sourced from personal correspondence with the biostatisticians/researchers at the Northern Ireland Cancer Registry in August 2014.*
Driven by the ageing population, this number is expected to rise by 25% for men and by 24% for by 2020. By 2035 the number of cases per year is projected to be 7,181 male and 6,967 female cases, a 65% rise among men and a 63% rise in women. The prevalent population in 2014 was reported as 63,500+ people living with cancer, which is estimated to rise to 110,000 by 2030. CNSs are at the front line of cancer care; they are the main point of contact for patients, significantly improve patient experience and help to deliver services for individual patients according to need and patient choice. They play a vital role in the coordination of care and successful implementation of initiatives to improve NHS cancer services.

The 2015 NI Cancer Patient Experience Survey (CPES) reported 72% of patients having access to a CNS, much lower than England (2014) 89% and Wales (2013) 88%. Key driver analysis demonstrates the support of a CNS is the most important contributing factor to people reporting a positive experience of care. The April 2014 Macmillan Adult Cancer CNS census of the specialist adult cancer nurse workforce reported 57.4 WTE with majority area of practice was breast (33.8%) with minimal provision in skin and urology, significantly lower that other UK countries when incidence rates are compared to whole time equivalent posts.

This is further compounded by results from years 1 and 2 of the NI cancer peer review programme of multi-disciplinary teams (local and specialist). Lack of access and single handed CNS service provision were found as immediate risks or serious concerns in 17 out of the 30 MDTs peer reviewed to date. Year

3 is scheduled for 2016 and is expected to find similar access issues. The 2014 Macmillan Adult Cancer CNS census of the specialist adult cancer nurse workforce[2] reported 2% growth from 2011 (57.4 WTE from 56.07 WTE) compared to 10% in UK.
The transforming cancer follow-up evaluation (2015)[7] has provided a strong evidence base for the effectiveness of risk stratified models of follow-up within breast and prostate cancer. Risk stratification has the potential to improve patients experience, health and wellbeing and improve resource utilisation. Pivotal to the success of risk stratified models of follow-up is the involvement and availability of CNSs.

Six step methodology for workforce planning

The Skills for Health Six Steps Methodology to Integrated Workforce Planning (2009) has been employed to support the development of this workforce plan.

Step 1: Defining the Plan

The plan takes account of the demographics and health and care needs of the patient population in Northern Ireland and the services for which there is expressed demand for the profile and dynamics of a CNS workforce. The extent to which a balance of supply and demand can be achieved will be an integral part of the timeframes for completion of the plan.

The assurance of safety quality and experience through appropriate performance measures will be integral to the development of the workforce plan. The monitoring and evaluation of the plan will be led by the PHA/HSCB with key workforce metrics agreed with nursing workforce leads in PHA and HSCTs.

Step 2: Mapping the service change

In developing a vision and model for Cancer CNS teams, a workshop with key stakeholders was held in March 2015. The aim was to develop a shared understanding of the issues pertaining to the cancer CNS workforce, agree core principles underpinning a cancer specialist nursing workforce plan and agree a standardised approach to identifying and prioritising the CNS workforce gaps. A Scottish model predicated on partnership working, resilient services and maximising skill mix was shared. The outcome of the workshop was an agreed set of principles (listed below) for the development of specialist cancer nursing services.

- Overarching coordination of the totality of specialist nursing services must take a standardised approach

- Resilient services with cross cover where appropriate within and across MDTs
- Making the most of skill mix and teamwork
- Enabling workforce capability

Work to redesign clinical nursing teams should have the main aim of maintaining person centred cancer care in line with the DHSSPSNI Nursing and Midwifery Strategy (2015)[8], whilst ensuring cost effective use of resources and any future investment in specialist nursing services will reflect these principles.

Step 3 Defining the required workforce

There are currently 76.2 WTE cancer CNSs across Northern Ireland, of which 11 WTE are charitably funded posts with no identified exit strategy.

Workforce requirements

A benchmarking exercise of the 2014 Macmillan Adult Cancer CNS workforce census demonstrates that the average cancer incidence per WTE CNS in Northern Ireland is significantly higher than the rest of the UK (see table 1).

Table 1: UK Benchmarking – WTE Cancer CNS : Cancer Incidence

	Cancer Incidence (2013)	WTE Adult Cancer CNS	Average CNS caseload / WTE
Wales	19,026	184.3	103
Scotland	31,013	265.0	117
England	280,000	3088.0	91
N Ireland	11,000	76.2*	144

**2015/16 position and includes 11 WTE charitably funded posts with no exit strategy.*

Recommended caseload sizes for CNSs are available for three specialties (lung, breast and colorectal). In order to bring average caseloads to the recommended caseload sizes, and comparable with Wales, an average caseload of 100-105 per WTE was applied which identifies that a total of 108.5 WTE CNSs are required for Northern Ireland.

As outlined above, the current workforce is 76.2 WTE therefore to ensure NI CNSs have an average caseload of new incidence cases of 100-105 per WTE there is a **shortfall of 32.3 WTE.**

The current and future CNS workforce is required to network at regional, Trust, team and individual level, whilst maintaining person centred care across the patient pathway. Utilising the knowledge and skills framework, combined with work undertaken by Macmillan in partnership with Skills for Health the competencies required to fulfil the roles at bands 7 and 6 are outlined.

Combined with the development and regional agreement of a generic cancer CNS commissioning specification (see annex 2), these steps will provide assurances for the commissioning of the cancer CNS workforce to equitably meet the needs of the NI population.

The appropriate use of support workers has been shown in UK and NI to maximise the capacity of CNSs. Oliver and Leary's (2012) research found 20-30% of CNS interventions were non clinical administrative duties which could be performed by a clerical worker allowing more effective use of nursing time. The inclusion of support worker roles within the CNS workforce plan will support skill mix by assisting in the delivery and co-ordination of care, education and support, under the supervision of Clinical Nurse Specialists, for patients with cancer.

The job summary for band 3 support worker is provided below

- Assist in the delivery and co-ordination of care, education and support, under the supervision of Clinical Nurse Specialists, for patients with Cancer.
- Obtaining and collating data for reports, governance, patients care from a number of systems as appropriate.
- Maintain high standards of practice and adhere to quality procedures
- Maintain good communication with patients/clients, relatives and carers and report issues to line manager and other members of the multidisciplinary team
- The post holder will be responsible for the co-ordination of their workload to meet the demands of the post.

The support worker role is set at 0.25 per WTE CNS.

In order to develop a risk based, incremental plan, it was necessary to determine which tumour sites were of highest priority for CNS provision. A prioritisation methodology was developed and agreed through engagement with cancer managers and lead nurses which enabled Trusts to prioritise areas for commissioners to assess and consider for investment. Criteria utilised within this methodology are listed below with full detail outlined in annex 1:

- WTE against incidence in tumour sites*
- WTE against 2 year prevalence in tumour sites (Benchmarked against 2014 Macmillan Adult Cancer CNS census of the specialist adult cancer nurse workforce)[2]
- Peer Review findings where immediate concerns or serious risks are identified (Year 1 and 2) or potentially identified (Year 3 (2016)) for those not yet peer reviewed but anticipated to fall below national measures
- Single handed practice

- Charitable funding with no exit strategy
- Acceptance of referrals to regional centre for treatment(s)
- Implementation of nurse led risk stratified follow-up

*Information on first presentation to Trusts was obtained through PMSID red flag analysis and compared with Trust information on incidence obtained through CaPPs system.

Trusts submissions were collated and prioritised into a regional phased plan outlined in table 2.

Table 2: Regional prioritised plan for tumour sites for cancer CNS provision

	Phase 1	Phase 2	Phase 3	Phase 4	Phase 5
BHSCT	Skin	Colorectal	Urology	Lung	Thyroid
	Urology (testicular)		Head and neck	Brain & Central Nervous system	Breast
	Hepato-pancreatobilary		Sarcoma	Haematology	Teenage Young Adult
				Upper GI	
				Gynae	
NHSCT	Haematology	Colorectal	Breast	Lung	
	Skin (commissioned through LCG)				
	Gynae (commissioned through LCG)				
	Oncology Nurse practitioner				
SEHSCT	Skin	Gynae	Upper GI	Colorectal	Breast
		Urology (commissioned through LCG)	Lung (pick up)	Haematology	
		Lung			
		Head & neck			
SHSCT	Skin	Head and neck	Colorectal	Upper GI	Breast
		Haematology	Urology	Gynae	
			Lung		
WHSCT	Skin	Colorectal	Urology	Gynae	Haematology
	Urology (NW)	Urology (NW)		Head and Neck	Upper GI
					Breast
					Lung

Step 4 Understanding the workforce availability

Data from the 2014 Macmillan Adult Cancer CNS census of the specialist adult cancer nurse workforce[2] on the age profile of posts in NI highlighted that 30% of

the total specialist cancer nursing workforce in Northern Ireland were reported as being over 50 years of age. It is likely that the majority of these will retire in the next 5 -10 years. This equates to 2-3 per annum.

The education and training agenda for CNS is focused on the knowledge, skills, values and behaviours required, incorporating recommendations from "The Advanced Nursing Practice Framework" (NIPEC). Training for CNS roles is available through a number of providers and details are outlined in annex 3. Commissioning educational courses to enable the workforce availability is carried out yearly through the education commissioning group processes and the Director of Nursing in PHA. Based on the development plan, the PHA and HSCB, working with Trusts will identify and commission the relevant course / education requirements to ensure the workforce availability for the posts. This submission will also incorporate the retirements and natural wastage for CNS services.

Step 5 Development of an action plan

Trusts submitted plans detailing requirements which totalled 67.3WTE CNSs band 6/7 and 27 WTE Band 3 support workers. Utilising the agreed cancer needs methodology, HSCB and PHA applied scrutiny and the resultant need was identified 43.3 WTE CNSs band 6/7 and 19.6 WTE Band 3 support worker.

Using this methodology, the PHA and HSCB applied scrutiny worked with to develop a regional workforce plan (and associated support workers) that allows for the prioritised recruitment of 32.3 WTE CNS over a 5 year period. Funding for the 11 WTE charitably funded posts included in the current workforce (whose funding ceases at different points over the next 3 years) are included in the workforce plan. The represents a total of 43.3WTE (i.e. 32.3 + 11.0).

The workforce plan proposes a phasing of these posts over a five year period (see table 2 below). A full breakdown of phasing by speciality and Trust is outlined in appendix 1.

Table 3: Phased cancer CNS workforce plan

	Phase 1	Phase 2	Phase 3	Phase 4	Phase 5	Totals
Band 7	8.2	5.6	3	6.3	1	24.1
Band 6	3	3.8	6.5	4.9	1	19.2
Band 3	3.5	3.5	2.85	5.75	4	19.6

Overall total workforce 62.9WTE

Table 4: Breakdown of phased plan per Trust

		CNS workforce plan					
		WTE					
		Phase 1	Phase 2	Phase 3	Phase 4	Phase 5	Total WTE
BHSCT	Band 7	2	1	1	4.8	1	9.8
	Band 6	2	0.5	3	3.3	1	9.8
	Band 3	1.25	0.5	1.1	3.75	1	7.6
NHSCT	Band 7	3.2	2	0	0.5	0	5.7
	Band 6	0	0.5	0	0	0	0.5
	Band 3	1.25	0.75	0.25	0.5	0	2.75
SEHSCT	Band 7	0	1	2	0	0	3
	Band 6	1	1	0	1.1	0	3.1
	Band 3	0.25	0.5	0.5	1	0.5	2.75
SHSCT	Band 7	1	0.6	0	1	0	2.6
	Band 6	0	1	3	0	0	4
	Band 3	0.25	0.5	0.75	0.5	0.5	2.5
WHSCT	Band 7	2	1	0	0	0	3
	Band 6	0	0.8	0.5	0.5	0	1.8
	Band 3	0.5	0.75	0.25	0.50	2	4

A more detailed breakdown of the phased workforce plan with the rationale is available in annex 4.

Funding arrangements

The funding model is based on a 6 year tapered model in partnership with Macmillan Cancer Support and Friends of the Cancer Centre. The total cost of this investment to HSCB is £2,522,882 over 11 years, phasing the CNSs in over 5 years. Costing is at mid-point +1 (including goods and services) based on HSCB general costings 2016/17. The charitable funding will be managed directly by Trusts but in tandem with HSCB contributions. A full breakdown of the finance investment is provided in annex 5.

A breakdown of partner and HSCB contributions is outlined below.

Year 1 (10% contribution in year 1, charitable contribution 90% Year 1)
Year 2 (additional 10% contribution in year 2, charitable contribution 80% Year 2)
Year 3 (additional 10% contribution in year 3, charitable contribution 70% Year 3)
Year 4 (additional 10% contribution in year 4, charitable contribution 60% Year 4)
Year 5 (additional 10% contribution in year 5, charitable contribution 50% Year 5)
Year 6 (additional 30% contribution in year 6, charitable contribution 20% Year 6)
Year 7 (additional 20% contribution in year 7, charitable contribution 0% Year 7)

It must be noted that of the 43.3 posts identified, within the workforce plan, 11 WTE require pick up funding which cannot utilise the 6 year tapered funding model. An additional 50K non recurrent funding has been offered for 10 posts (1 post has already received maximum funding) per post to facilitate phasing over 2 years when the 100% funding ceases. Further detail is provided in table 5.

Table 5: Posts requiring pick up funding where the tapered model is not applicable

Trust	Post	Phase	Charitable Funder	Date when funding ceases	Additional funding offered (non recurrent)
Belfast	Sarcoma 1 WTE B7	Phase 3 (2018/19)	Macmillan	Apr-16	50K
	Gynae 1 WTE B7	Phase 4 (2019/20)	Macmillan	Apr-17	50K
	Haematology 1 WTE Band 7	Phase 4 (2019/20)	Macmillan	Sep-17	No additional funding
	Haematology 1 WTE Band 7	Phase 4 (2019/20)	Friends of Cancer Centre	Apr-18	50K (TBC)
	Breast oncology 1 WTE Band 7	Phase 5 (2020/21)	Friends of Cancer Centre	Apr-18	50K (TBC)
Northern	Urology 1 WTE B7	Phase 1 (2016/17)	Macmillan	3 year 100% funding secured (post-holder not in post)	50K
	Colorectal 1 WTE B6	Phase 2 (2017/18)	Macmillan	Nov-17	50K
	Colorectal 1 WTE B7	Phase 2 (2017/18)	Macmillan	Dec-17	50K
South Eastern	Gynae 1 WTE B7	Phase 2 (2017/18)	Macmillan	Aug-14	50K
	Upper GI 1 WTE B7	Phase 3 (2018/19)	Macmillan	Sep-17	50K
	Lung 1 WTE B7	Phase 3 (2018/19)	Macmillan	Sep-17	50K

Step 6 Implementation and monitoring

It has been demonstrated that the cancer clinical nurse specialist workforce, if suitably trained and funded, with independent work plans from consultants, can play an integral part in any organisations ability to improve patient experience and improve productivity within a cost effective timely manner. It is important that any clinical nurse specialist has a clear and concise job plan identified prior to taking up post with a view to maximising their ability to deliver services in the most efficient cost effective way possible. Success will be monitored though the KPIs developed in the generic commissioning specification (annex 2), and any unintended consequences of the changes identified so that corrective action can be taken. The PHA / HSCB will undertake yearly review of the incremental plan and adjust as required.

The overall aim of this workforce plan for CNS is to ensure that NI HSC services have a healthy, productive workforce, who are appropriately skilled trained, and provide the highest quality healthcare services at the right time in the right place. The plan will require the commitment from HSCT/ Nurse leaders across HSC system/commissioners, education providers, professional and union organisations and other key professionals, particularly medical staff. The steps outlined in this plan can support informed decision-making and prioritisation at a local and regional level. Further work will be required with CNSs once gaps are filled to further assess effectiveness, new ways of working and skill mix.

References

1. NI Cancer Registry (2013) Living with and Beyond Cancer
2. Macmillan Cancer Support Specialist Adult Cancer Nurses in NI: A Census of the specialist adult cancer nurse workforce 2014
3. National Peer Review Report: Northern Ireland 2014 An overview of the findings from the 2014 National Peer Review of Cancer Services in Northern Ireland
4. NI Cancer Patient Experience Survey (2015) PHA/Macmillan Cancer Support
5. NHS England, Cancer Patient Experience Survey. 2014, Quality Health
6. NHS Wales, Cancer Patient Experience Survey. 2013, Quality Health
7. Macmillan Cancer Support - Evaluation of the Transforming Cancer Follow-up Programme in Northern Ireland Final Report (2015)
8. DHSSPSNI (2015) Strategy for Nursing and Midwifery in Northern Ireland (draft)
9. Oliver,S., Leary,A (2012) Return on investment: workload, complexity and value of the CNS British Journal of Nursing: 21(1)
10. NMC (2015) Professional Code of Conduct for Nurses and Midwives
11. Macmillan Cancer Support Specialist Adult Cancer Nurses in England: A Census of the specialist adult cancer nurse workforce 2014
12. Achieving World Class Cancer Outcomes: A Strategy for England 2015-2020

Annex 1: Risk scoring matrix - Seven criteria were developed and regionally agreed to facilitate the prioritisation for phasing of the plan can be seen below

Key - Concern based on WTE ratio (incidence)		
0-100	Low	1
101-199	Medium	2
200+	High	3
No CNS	Very High	4

Key - Peer Review	
No concern	1
Concern	2
Serious Concern	3
Immediate Risk	4

Key - Concern based on WTE ratio (prevalence)		
0-100	Low	1
101-199	Medium	2
200+	High	3
No CNS	Very High	4

Key - Risk Stratified to nurse led care	
Self -directed care	1
Shared care (potential)	2
Shared care established	3

Key - Concern based single handed practice (incidence)		
0-100	Low	1
101-199	Medium	2
200+	High	3
No CNS	Very High	4

Key - No recurrent funding	
Score as tables above dependent on year charitable funding ends	
Funding ended	3
Funding ends in 1 year	2
Funding ends in 2 years	1

Key – Acceptance of referrals to regional centre for treatment(s) eg: specialist gynae (BCH) or plastics (UHD)	
No specialist treatment	0
One specialist treatment only (i.e. XRT, chemo or surgery)	1
Two specialist treatments	2
Three specialist treatment (i.e. XRT, chemo and surgery (transplant for haematology))	3

Annex 2: HSCB/PHA Commissioner Specification: July 2014
Clinical Nurse Specialist - Cancer

1. Overview

In Northern Ireland over 11,000 people are diagnosed with cancer and the prevalent population is over 63,500 people living with cancer[1]. This figure is estimated to rise to 110,000 by 2030, with this rise attributed to improvements in treatments and a growing and ageing population.

The cancer journey is complex involving care interventions from various multi-site professionals such as oncologists, surgeons and counsellors which can often lead to disjointed care. Cancer clinical nurse specialists (CNSs) play an important role in the coordination and successful implementation of initiatives to improve NHS cancer services. CNSs are at the front line of cancer care; they are the main point of contact for patients and as a result help to shape services for each patient according to need and patient choice, which contributes to wider cancer priorities.

In 2015 the first NI Cancer Patient Experience Survey (CPES)[2] was conducted and the overall findings for patients having access to a CNS was 72% with ranges from 94% in breast to 42% in skin. This is significantly lower than the CPES findings from England[3] (2014) which reported 89% and Wales[4] (2013) which reported 88%. Key driver analysis of CPES findings; demonstrate the support of a CNS is the most important contributing factor to people's positive experience of care.

Nurses' practice is underpinned by the Nursing and Midwifery Council Code of Professional Practice (2015)[5] which provides clear guidance on development, responsibilities and accountability. Clinical nurse specialists should demonstrate clear understanding of the medico-legal implications of their role.

2. Model and Vision for CNS

A workshop was held in March 2015, to develop a shared understanding of the current issues pertaining to the Cancer CNS workforce, agree core principles underpinning a Cancer Specialist nursing workforce plan and agree a standardised approach to identifying and prioritising the CNS workforce gaps. A Scottish model predicated on partnership working, resilient services and maximising skill mix was shared. The outcome of the workshop was an agreed a set of principles for the development of specialist cancer nursing services.

- Overarching coordination of the totality of specialist nursing services must take a standardised approach
- Resilient services with cross cover where appropriate
- Make the most of skill mix and teamwork
- Enabling workforce capability

Work to redesign clinical nursing teams should have the main aim of maintaining person centred cancer care in line with the DHSSPSNI Nursing and

Midwifery Strategy (2015)[6]. The current and future CNS workforce is required to network at regional, Trust, team and individual level, whilst maintaining person centred care across the patient pathway. The value of support worker roles has been shown in a number of sites across the UK and NI to release significant capacity for CNSs to concentrate on other activities[7]. Oliver and Leary[8] (2012) found 21% of CNS interventions were non clinical administrative duties which could be performed by a clerical worker allowing more effective use of nursing time.

3. Aim and scope

The aim of this commissioner specification is to ensure that, regardless of the employing organisation all clinical nurse specialists in cancer teams should adhere to the job-plan outlined in appendix 1, and pathway in appendix 3 and deliver on the 5 functions outlined below:

(i) Key worker function
(ii) Act as core member of the tumour specific multidisciplinary team
(iii) Nurse-led activity to include nurse led clinics and telephone work
(iv) Education / Training / Audit
(v) Identify and contribute to service development and policy development.

(i) Key worker function

The Manual of Cancer Services (2004)[9] stipulates that all multidisciplinary teams should ensure that all patients have a designated keyworker. The role of the key worker (one which a typical CNS would commonly hold) should be embedded in practice. The current and future workforce needs to be developed with specific skills and specialist knowledge in cancer, for example understanding and supporting the management of consequences of cancer treatment. The keyworker acts as a point of contact for patients, ensuring that patients have access to information and support services and provides ongoing holistic assessments. The CNSs skills and expertise provide physical, emotional, psychological and spiritual support to patients and carers and coordination of care services leading to positive patient outcomes.

The Cancer Reform Strategy (2007)[10] identified the vital role that clinical nurse specialists play in improving the experience of people living with and surviving cancer. Nurse specialists play a hugely valuable role across many different elements of cancer patient management and support, carrying out a range of technical, informational, emotional and coordination functions.

(ii) Act as a core member of the multi-disciplinary team

Clinical nurse specialists should be a core member of the multi-disciplinary team[7]. Many cancer CNSs work as part of a tumour specific team, whereas others may work across more than one service or setting. Although many are based within acute Trusts, post-holders can also be located in primary care and community settings, and voluntary sector organisations. They may be responsible for whole client groups, or for episodes of care.

NICE quality standards should be adhered to across primary and secondary care. They provide concise sets of prioritised statements designed to drive measurable quality improvements within the area of cancer care.

Psychological support is a core element of the CNSs role with 18% of all clinical events reported as psychological in nature[11]. Most of these psychological interventions were around management of the anxiety and distress.

(iii) Nurse-led activity to include nurse led clinics and telephone work

Nurse-led activity can be direct or indirect, inpatient and outpatient and provided within an acute, community or primary care setting. The CNS will play a key role with the multi-professional teams across organisational boundaries, in order to ensure a seamless coordinated approach to care, appropriate interventions, advice and support and/or timely onward referral to other professionals and agencies as appropriate.

CNS interventions provide differing levels of intervention which recognise the varying complexity of patient need. Four levels of intervention ranging from Level 1 - 4 have been identified[12] and are outlined below:

Level 1 - Simplest level of intervention
Level 2 - Single patient contact to resolve a specific problem
Level 3 - Short-term involvement for multiple problems
Level 4 - Interventions when patients require ongoing specialist advice and support for complex problems

National studies of CNSs have found that a significant amount of their work is performed in the outpatient setting or on the telephone[11]. The average outpatient workload of the cancer nurse specialist will differ across tumour sites dependent on the service model in place within the team.

Telephone consultations are an integral aspect of the clinical nurse specialists' role for rapid access, advice, information and support, many of which result in the avoidance of hospital admission or outpatient appointments.

(iv) Education / Training / Audit

Education, training and audit are inherent aspects of the cancer CNS role and should permeate all aspects of their work. The clinical nurse specialist should contribute to advancing the body of knowledge through education, research and audit as well as developing practice in others. Patient education is fundamental in promoting patient empowerment and self-efficacy.

The CNS should provide informal education on an ongoing basis and maximise opportunities to up-skill others in daily practice.

For example:

- Enable critical reflection with nursing staff
- Mini caseload review of the clinical input with other staff.

The CNS role involves the provision of formal sessions both in the clinical setting and through educational institutions where appropriate.

The CNS will self-assess their skills and competencies against a suitable competency framework to identify their specific development needs and take measures to address these.

For example:

- NIPEC Competency Framework (2006)[13]
- Macmillan (2014) A Competence Framework for Nurses[14]

(v) Contribute to service improvement and policy development

Each CNS should have reflected in their job plans a dedicated session every week for service development and policy development. The Donaldson report (2014)[15] stated that traditionally, doctors, nurses and other health professionals have seen their duty to the patient in front of them. Whilst, this remains the important primary requirement for establishing a culture of good clinical practice, healthcare professionals should ensure that the service for all their patients reaches a consistently high standard and that opportunities for improvement are identified and taken. Utilisation of a network approach should be utilised.

4. Monitoring and Outcome Measures for CNS activity

Parameters for key performance indicators (KPIs) are outlined in appendix 2 to be agreed through HSCB and PHA professionals on the basis of initial monitoring of data.

5. Conclusion

It has been proven that the cancer clinical nurse specialist workforce, if suitably trained and funded, with independent work plans from Consultants, can play an integral part in any organisations ability to improve patient experience, improve productivity within a cost effective timely manner. It is important that any clinical nurse specialist has a clear and concise job plan identified prior to taking up post with a view to maximising their ability to deliver services in the most efficient cost effective way possible.

References

1. NI Cancer Registry (2013) Living with and Beyond Cancer
2. NI Cancer Patient Experience Survey (2015) PHA / Macmillan Cancer Support
3. NHS England, Cancer Patient Experience Survey. 2014, Quality Health
4. NHS Wales, Cancer Patient Experience Survey. 2013, Quality Health
5. NMC (2015) Professional Code of Conduct for Nurses and Midwives
6. DHSSPSNI (2015) Strategy for Nursing and Midwifery in Northern Ireland
7. Achieving World-class Cancer Outcomes A Strategy for England 2015-2020 Report of the Independent Cancer Taskforce
8. Oliver,S., Leary, A (2012) Return on investment: workload, complexity and value of the CNS British Journal of Nursing, 2012, Vol 21, No 1
9. Department of Health, *Manual for Cancer Services*, 2004
10. Department of Health, Cancer Reform Strategy, December 2007
11. Leary A, Crouch H, Lezard A, Boden L, Richardson A (2008). Dimensions of clinical nurse specialist work in the UK. Nursing Standard 23: 15–17; 40–4410
12. Webber J. The Evolving Role of the Macmillan Nurse. 1997. Macmillan Cancer Relief, London
13. NIPEC (2006) Competency Profile Foundation Paper
14. Macmillan (2014) A Competence Framework for Nurses
15. Donaldson, L (2014) The Right Time, The Right Place. DHSSPS NI

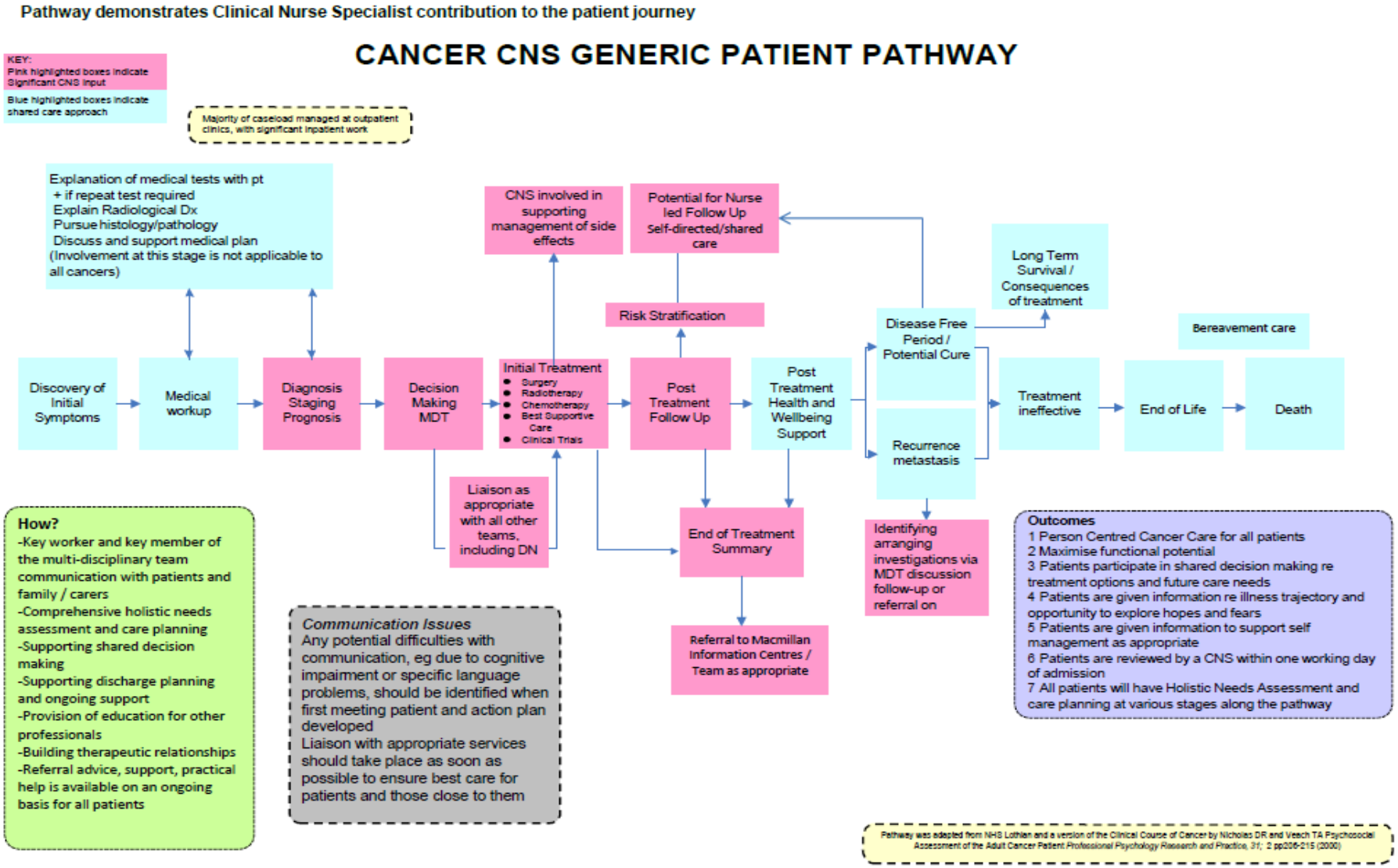
APPENDIX 1: Clinical Nurse Specialist – Cancer Job Plan

		Proposed Norm
1.1	Independent Nurse led clinics	
	• Number of clinics per week	**1-2**
	• Average number of patients per clinic (New and Review)	*6-10*
	• Indicate the location (H - hospital C-community)	H
1.2	Multidisciplinary Clinics	
	• Number of clinics per week	**1**
	• Indicate the location (H- hospital C-community)	H
1.3	Multidisciplinary Ward Rounds	
	• Number per week	
1.4	Multidisciplinary Case Management discussions	
	• Number per week	**1**
1.5	Provision of Direct Care	
	• Average time spent per week in wards	**2**
	• Average time spent per week in community	
1.6	Patient Education	**As part of 1.1/1.2/1.5**
1.7	Home visits (not applicable to all roles)	
	• Average number per week (3-4)	**1**
	• Average time spent per week	
1.8	Telephone Consultations	
	• Average time spent per week	**1**
1.9	Tele-health	
	• Average time spent per week	
1.10	Clinical Administration	**0.5**
	Sub Total	**8.5 Sessions**
		Proposed Norm
2.1	Teaching	
2.2	Clinical governance activities including audit & research	
2.3	Administration; organisational requirement	
2.4	Contribution to service planning and policy development	
2.5	Professional development / CPD	
	Sub Total	**1.5 Sessions**
	Total	**10 Sessions**

Appendix 2: Monitoring information to be provided by Trusts

Core Component of Clinical Nurse Specialist – Cancer service	Local commissioning context where relevant	Performance Metrics
(i) Key worker function	Number of patients referred to service Number of patients who know the name of their key worker	**KPI:** Provide assurance that patient satisfaction surveys are core component of service evaluation. **Baseline:** Based on incidence / prevalence data in specialist cancer nursing development plan and NI CPES 2015 comparative data
(ii) Act as core member of the tumour specific multidisciplinary team		**KPI:** % attendance at MDT meetings must meet National Peer review measures standard **Baseline: 66%**
(iii) Nurse-led activity to include nurse led clinics and telephone work	To deliver Independent Nurse led clinics (x sessions per week for fully trained full time posts) 42 weeks a year. Nurse led activity must be coded on patient administration system to CNS.	**KPI:** Numbers of appointments with specific clinical code for CNS and telephone activity **Baseline:** SBA (if developed)
(iv) Education / Training	Provide assurances of formal and informal education for staff through annual KSF reviews and/or annual report	**KPI:** Provide assurance that formal and informal education for staff and continuing professional development (CPD) needs are met.
(v) Identify and contribute to service improvement and policy development.	Provide assurance of contribution to service improvement and policy development through annual KSF reviews and/or annual report	**KPI:** Provide assurance of contribution to service improvement and policy development.

Appendix 3: Cancer CNS Generic Patient Pathway



Annex 3: Development courses to prepare for a CNS Role

Academic / Professional courses / Experience

- Degree / Masters
- NMC recordable qualification in specialist practice or equivalent
- Evidence of clinical experience in chosen area
- Stand alone modules or course in their chosen speciality – see examples below (not an exhaustive list)
- Non-Medical Prescribing (not necessarily prior to appointment)
- Advanced Communication Skills Training

Colorectal	A Stoma Care Course at Level 6 (Dansac Academy- Advanced Approach to Stoma Care Management, accredited by Birmingham City University or Salts Stoma Care Course).
Head and Neck	Short course (4-days) facilitated by Clinical Education Centre (PHA).
Urology	Short courses in Urology which are 3 stand alone modules that students can study as part of their BSc or MSc and the course consists of the following modules:
Lung	Lung Cancer Stand Alone Module at QUB European Certificate in Essential Palliative Care (Princess Alice)
Skin	The Skin Cancer Management Study facilitated by HSC Clinical Education Centre, Knockbracken (incorporating the role of dermatology, dermoscopy, radiology, pathology, prosthetics, plastic surgery, oncology and psychology in the care of patients with skin cancers). Dermatology short course, Dermatology surgical course for nurses
Oncology	Acute Oncology Course, MDCS 156 or MDSC 199, University of Liverpool (fully online course, Masters level) Introduction to acute oncology- Macmillan Learn-zone
Haematology	Haematology Course Specialist Practice Health Assessment (not necessarily prior to appointment) Bone Marrow Transfusion of blood products
Breast	No local breast specific courses, however incorporated into Cancer Care - Oncology and Supportive and End of Life Care options. Royal Marsden and University of Manchester -Breast Care Nursing module. The University of Manchester - Principles and Practice of Breast Care The Royal Marsden School of Cancer Nursing and Rehabilitation - Principles of Breast Cancer Care