Urology Services Inquiry

UROLOGY SERVICES INQUIRY

USI Refs: Section 21 Notices Number 24 of 2022 and Number 7 of 2023
Dates of Notices: 29th April 2022 and 5th May 2023

Addendum Witness Statement of: Martina Corrigan

I, Martina Corrigan, will say as follows:-

I wish to make the following amendments and/or additions to my existing responses of 6th July 2022 (to s.21 Notice No.24 of 2022 dated 29th April 2022) and of 12th May 2023 (to s.21 Notice No.7 of 2023 dated 5th May 2023) and, beyond this, to provide some further information regarding the chronology of events surrounding the recruitment of Clinical Nurse Specialists for Urology in the decade from approximately 2010 to 2020 as I have become aware that this is an issue in respect of which the Inquiry would welcome further information:

Section 21 Notice No.24 of 2022 dated 29th April 2022

1. I wish to make the following amendments and/or additions to my existing response dated 6th July 2022:

1.1 WIT-26198 - Para 16.3 (b) v – The existing paragraph below should be replaced by that in red:

Existing para 16.3 (b) v

'The funding for this proposal was going to go 'at risk' but I presented that these were needed to assist in tackling the increasing waiting times for outpatient appointments. Mrs Burns agreed to go 'at risk' for these posts and we temporarily appointed 2 members of staff who were substantive Band 5s to these and then we backfilled their posts in the unit. To note, both of these Band 6s eventually have taken up permanent Band 7 Clinical Nurse Specialist roles

(Leanne McCourt and Jason Young). Furthermore, in 2020 the Clinical Specialist Nurses have increased to 5 members of staff. However, the key issue here is that it took from 2009, when the recommendation was made, until 2020 when there were finally 5 Clinical Nurse Specialists in post.'

Replacement para 16.3 (b) v

The funding for this proposal was going to go 'at risk' but I presented that these were needed to assist in tackling the increasing waiting times for outpatient appointments. Mrs Burns agreed to go 'at risk' for these posts and we temporarily appointed 2 members of staff who were substantive Band 5s: Mrs Dolores Campbell (who was already working in the Thorndale Unit and whose post there we were ultimately unable to backfill) and Mrs Janice Holloway (who came from the Ward and whose post there we were able to backfill). In 2017 we recruited these posts permanently: Jason Young and Leanne McCourt were both successful and both have since been successful in securing permanent Band 7 Clinical Nurse Specialist roles (Leanne McCourt in 2019 and Jason Young in 2020). Furthermore, in 2020 the Clinical Nurse Specialists increased to 5 members of staff. However, the key issue here is that it took from 2009, when the original recommendation for increased numbers was made, until 2020 when there were finally 5 Clinical Nurse Specialists in post. All of this is addressed in more detail in my addendum witness statement of 23 June 2023.

1.2 WIT-26205 - Para 20.1 (f) – Having read and accepted the correction made at para 7 of the witness statement of Kate O'Neill at WIT-94682, I now believe that the paragraph below in my 6th July 2022 witness statement should be replaced by that in red:

Existing para 20.1 (f)

'From 1 September 2017 Clinical Nurse Specialists K O'Neill and J McMahon were re-banded from Band 7 Clinical Nurse Specialist to Band 8A and they came out of day to day management and concentrated on clinical work only.'

Replacement para 20.1 (f)

Urology Services Inquiry

From June 2019 Clinical Nurse Specialists K O'Neill and J McMahon were re-banded from Band 7 Clinical Nurse Specialist to Band 8A and they came out of day to day management and concentrated on clinical work only.

Section 21 Notice No.7 of 2023 dated 5th May 2023

2. I can confirm that I have now seen the email exchange and attachments exhibited to Patricia Kingsnorth's addendum witness statement of 2nd June 2023 (WIT-96809 – WIT-96827). In light of this, I would offer the following additional evidence:

2.1 I had not recalled this email exchange when preparing, at relatively short notice, my statement of 12th May 2023 in response to s.21 Notice No.7 of 2023.

2.2 I have no reason to doubt that this exchange occurred and I accept that I must have added to the draft typed minute of the 18 January 2021 meeting (prepared by Mrs Kingsnorth and sent to me on 24th January.

2.3 I believe that I made the additions to the typed minute without access to Mrs Kingsnorth's handwritten meeting notes (which I only saw for the first time after 5th May 2023, when preparing my 12th May 2023 statement) and without any notes of my own from the 18 January 2021 meeting.

2.4 I believe that all of these events (i.e., the 18th January 2021 meeting and the 24th-25th January 2021 email exchange) occurred at a time when I was particularly busy with my day to day work, it being the middle of the Winter of 2021/2022 COVID-19 lockdown and I having been asked to cover the Patient Flow Team in order to release the nurses to work on the wards. This regularly involved 13-hour shifts with the result that meetings such as that of 18 January 2021 and attention to emails such as that of 24th January 2021 occurred during breaks.

2.5 Where there is any conflict or discrepancy between Patricia's handwritten note of the 18th January 2021 meeting and the final typed note of the meeting (of 25th January 2021), I would place more reliance upon the handwritten note.

Recruitment of Clinical Nurse Specialists for Urology

3. I have become aware, in preparing for my evidence next week, that the Inquiry would welcome further information on the chronology of events surrounding the recruitment of Clinical Nurse Specialists for Urology in the decade from approximately 2010 to approximately 2020 and that it would assist if this were provided ahead of my oral evidence. In the circumstances, I have attempted to provide a summary of my involvement in, and knowledge of, relevant events in chronological form. I have set this out in the table attached to this addendum witness statement and have also provided copies of the documents referenced in the right-hand column of the table and numbered [1] to [26].

Statement of Truth

I believe that the facts stated in this witness statement are true.

Signed: Personal information redacted by USI

Date: 23rd June 2023

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Timeline and supporting documentation for recruitment of Urology Clinical Nurse Specialists

Year	Event	Supporting Documents
2009	The March 2009 *'Review of Adult Urology Services in Northern Ireland'* addressed nurse staffing in urology regionally at paras 8.17 to 8.24. These were followed by Recommendation 23 which recommended as follows: 'At least 5 Clinical Nurse Specialists (cancer) should be appointed (and trained). The deployment of these staff within particular teams will need to be decided and Trusts will be required to develop detailed job plans with caseload, activity and measurable outcomes agreed prior to implementation. A further review and benchmarking of cancer CNS's should be undertaken in mid-2010.' It was agreed that two of these should be in the Southern Trust. This is documented on the 3rd page of Appendix 2 to the letter from Hugh Mullen of HSCB to Trust Directors of Acute Services dated 27 April 2010.	[1] 20090301- Review of Adult Urology Services in Northern Ireland [2] 20100427- HM700-ltr to Trust Dir Acute re Urology review implementation
2010	Job plans were agreed for current Clinical Nurse Specialists. Jenny McMahon and Kate O'Neill. In respect of the second part of Recommendation 23 above ('*A further review and benchmarking of cancer CNS's should be undertaken in mid-2010*'), it is my recollection that this would have sat with Cancer and Clinical Services under Ronan Carroll or Alison Porter, that discussions commenced regarding the cancer CNS but that no funding had yet been made available for the 2 cancer CNS that had been identified in the 2009 Regional Review.	[3] 20100618 – Jobplan Template for CNS
2014	In October 2014 I prepared a paper for Mrs Burns, Director of Acute Services, requesting more staffing for the Thorndale Unit and it was agreed, after discussion, that the Trust would go 'at risk' for two Band 6's and 2 Band 3's.	[4] 20141002 – E paper for staffing TDU [5] 20141002 – E paper for staffing TDU a1 [6] 20141003 - E paper for staffing TDU DB – MC [7] 20141114 - E EOI Band 6 TDU [8] 20141114 - E EOI Band 6 TDU a1 [9] 20141101 - job description band 6

	Job Descriptions were prepared (with a focus on providing support to the Specialist Nurses) and interviews were held after an 'expression of interest' process. Janice Holloway (Band 5 Nurse from 3 South) and Dolores Campbell (from the Thorndale Unit) were successful. SN Holloway came from 3 South ward and was replaced there. SN Campbell was a Band 5 in the Thorndale Unit and, whilst we tried to get her replaced, we were unsuccessful in recruitment. However, she did take on Band 6 duties, for example, deputising for Kate O'Neill at MDT, taking on some of the staff management duties (rotas/training etc.), and so on.	
2016	It was agreed that, although the Trust was still waiting on identification of funding from HSCB for the 2 cancer CNS posts recommended in 2009/2010, we would go out 'at risk' for two permanent band 6 specialist nurse posts. A Job Description was agreed for these posts between myself as Head of Urology, Brigeen Kelly as Head of Trauma & Orthopaedics (with responsibility for nursing), and Dorothy Sharpe as Lead Nurse for Urology. These posts were advertised on 23 August 2016 and the deadline for applications was 8 September 2016. 7 persons applied for the posts. It should be noted that the funding for these posts came from the Surgical and Elective Care Divisional funding and was not part of the funding discussed regionally at cancer forums, so we would not have consulted with the Clinical and Cancer Team when we agreed recruitment.	[10] 20170505 - JD B6 Specialist nurse urology
2017	Interviews for the two Band 6 specialist nurse posts were due to be held on 19 January 2017 and the interview Panel was Mr Anthony Glackin, Mrs Brigeen Kelly and Mrs Dorothy Sharpe.	[11] 20170106 - E interviews [12] 20170113 - E CNS interviews [13] 20170113 - E CNS interviews A1 [14] 20170505 - JD B6 Sister Charge Nurse changed

		On 6 January Mrs Sharpe contacted Mrs Fiona Reddick to ask for some sample interview questions and this prompted Fiona to request a copy of the Job Description, which was forwarded to her. Mrs Reddick then emailed Mrs Kelly on 13 January 2017 expressing a concern that there was no requirement to hold or be working towards completion of a specialist course on the job description. After Mrs Reddick and Mrs Kelly had spoken Mrs Kelly advised me that the job could not go ahead as advertised and asked if we still wanted the process to go ahead. I advised that we did as it had been a long process and that I was content to appoint, that we would advise the candidates of the error at interview and let them know that the plan would be that we would start a new process to recruit with the correct job description and criteria in the future. All candidates were advised at the interview stage of the problem that had emerged and the plan going forward. Leanne McCourt and Jason Young were successful and both took up post after the error had been discussed with them. Their revised Job Description was as 'Sister/Charge Nurse Band 6' but it retained the key role to support the Specialist Nurses. As mentioned above, the view was that we would start a new process to recruit with the correct job description and criteria but I was advised (after the nurses had been recruited) that, because these were Cancer Nurse Specialists, this needed to go through Cancer and Clinical Services (Mrs Reddick) so it was taken out of my control at this stage, as Mrs Reddick was working with the Region and Macmillan to secure funding for the identified gap of CNS. During some of the Cancer Performance Meetings, Mrs Reddick would have updated all the Heads of Service for the various tumour sites on progress towards securing funding and I was aware verbally that funding	

	was being sought for a Band 6 Nurse for Urology and I remember that I would have made Mrs Reddick aware that I preferred this to be a Band 7. I can confirm that, until the Inquiry process, I do not believe I had ever seen the April 2016 CNS funding document produced to the Inquiry by Mrs Reddick and contained at WIT-94649.	
2018 to 2019	Mrs Reddick, as Head of Cancer Services, contacted me in April 2018 via email with two documents attached (reference [16] and [17] to advise that the partnership form had been completed by herself and Macmillan and that we needed to move on this to work up and progress recruitment of a Band 7 Urology Nurse Specialist and that she would be happy to advise on the Job Description. Mrs Reddick shared 2 relevant documents with me on 6 April 2018. The first (Document [16]) was the Macmillan Partnership Application. I did not have any input into this application as it was completed by Mrs Reddick along with Ms Ruth Thompson from Macmillan. I understand that Mrs Reddick would have done this for the other Tumour sites' CNS applications. This application identified funding stream (although this was for a band 6 and I moved funding to bring it up to a band 7). It also included information on the background to the need for this, what the CNS role would entail, the postholder outcomes and measurable targets, governance, how the post would link with Macmillan, risks, project plan, and sustainability. The second (Document [17]) was the Macmillan Urology Clinical Nurse Specialist Post, Operational Policy. As with Document [16], I did not have any input to this. The document included a description of the service and who it was for, staffing, governance structures, and Macmillan profile. I now see, although I do not believe I noticed it at the time, that in section 3 of this document the CNS post was identified as sitting under the Head of Cancer Services. It surprises me as I had been asked to identify the additional funding to make this post a Band 7 and to do the recruitment of this post as Head of Urology and it was never discussed with me that it	[15] 20180406 - E partnership form for Urology [16] 20180406 - E partnership form for Urology a1 [17] 20180406 - E partnership form for Urology a2 [18] 20180517 - E about macmillan funding [19] 20180924 - E final paperwork for B7 macmillan CNS [20] 20180924 - E final paperwork for B7 macmillan CNS a1 [21] 20180924 - E final paperwork for B7 macmillan CNS a2 [22] 20180924 - E final paperwork for B7 macmillan CNS a3 [23] 20180924 - E final paperwork for B7 macmillan CNS a4

	wouldn't sit within my structure. I duly did these things and included my Lead Nurses Dorothy Sharpe/Gillian Henry in this. Ultimately, I understood that the post once recruited (see further below) did sit under me and not under the Head of Cancer Services. In May 2018 I emailed Mrs Mary Haughey, Cancer Service Improvement Lead, about the process as it would appear that Mrs Reddick was off long-term at that point. I spoke with Ruth Thompson in Macmillan to advise that I wanted this to be a Band 7 and Ms Thompson confirmed Band 7 funding (for one year). Paperwork was completed and the job advertised and Leanne McCourt was appointed in February 2019 and this funding has now been mainstreamed into the Urology budget and is no longer funded by Macmillan.	
2019 to 2020	The Trust, having completed a business case to request permanent funding for an additional 2 x Urology CNS (note: this sat with Surgical Division to make the case and was additional to the Macmillan post) in September 2018, received an allocation letter from HSCB advising of funding for a further 2 x CNS on 18 September 2019. Job descriptions were agreed, a recruitment process followed, and 2 additional CNS were appointed – Jason Young (who had been previously been employed in 2017 [see above] but who had left in in February 2019 to take up a post in Belfast Trust) took up post August 2020 and Patricia Thompson took up post September 2020.	[24] 201890801 - Final Business case for CNS nurse expansion [25] 20190918 Allocation letter Southern Urology CNS [26] 20191101 job description CNS x 2

Health and Social Care Board

Review of Adult Urology Services in Northern Ireland

A modernisation and investment plan

March 2009

Ministerial Foreword

The health service in Northern Ireland has been able to make remarkable progress in improving access to services and sustaining the quality of those services. That work, as part of the current programme of modernisation and reform of health and social care services is ensuring that many more patients are gaining timely access to the services they need than was the case only a few short years ago. I am determined that this progress should continue.

However, whilst reducing waiting times generally there have been some concerns about the capability of our urology services as they are currently arranged, to continue to deliver care of the highest standard while striving to meet increasing demand. The capacity within the HSC to deal with an increasing demand for urology services was the principal reason why this review was commissioned.

The review considers workforce planning, training and development needs and future resourcing and proposes a model of service delivery which I am confident will produce a reformed service fit for purpose, with high quality services provided in the right place at the right time by appropriately trained and skilled staff.

Ensuring that the patients who need our health and social care services remain at the centre of everything we do is of course a fundamental step of developing and improving service provision. I hope that many of you, especially those with experience of the service, will respond with comments and suggestions which will inform the future development of this important
Speciality.

Michael McGimpsey
Minister for Health, Social Services and Public Safety

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Tables

Figures

1. SUMMARY OF RECOMMENDATIONS

Section 2 – Introduction and Context

For the purposes of this review all Urology services and Urological related procedures should be taken in the context of Adult Urology only.

1. Unless Urological procedures (particularly operative 'M' code) constitute a substantial proportion of a surgeon's practice, (s)he should cease undertaking any such procedures. Any Surgeon continuing to provide such Urology services should do so within a formal link to a Urology Unit/Team.

2. Trusts should plan and consider the implications of any impending retirements in General Surgery, particularly with regard to the transfer of "N" Code work and the associated resources to the Urology Team.

3. A separate review of urinary continence services should be undertaken, with a view to developing an integrated service model in line with NICE Guidance.

Section 3 – Current Service Profile

4. Trusts must review the process for internal Consultant to Consultant referrals to Urology to ensure that there are no undue delays in the system.

5. Northern Ireland Cancer Network (NICaN) Urology Group in conjunction with Urology Teams and Primary Care should develop and implement (by September 2009) agreed referral guidelines and pathways for suspected Urological Cancers.

6. Deployment of new Consultant posts (both vacancies and additional posts arising from this review) should take into account areas of special interest that are deemed to be required in the service configuration model.

7. Urologists, in collaboration with General Surgery and A&E colleagues, should develop and implement clear protocols and care pathways for Urology patients requiring admission to an acute hospital which does not have an acute Urology Unit.

8. Urologists, in collaboration with A&E colleagues, should develop and implement protocols/care pathways for those patients requiring direct transfer and admission to an acute Urology Unit.

9. Trusts should ensure arrangements are in place to proactively manage and provide equitable care to those patients admitted under General Surgery in hospitals without Urology Units (e.g. Antrim, Daisy Hill, Erne). Arrangements should include 7 day week notification of admissions to the appropriate Urology Unit and provision of urology advice/care by telephone, electronically or in person, also 7 days a week.

10. In undertaking the ICATS review, there must be full engagement with secondary care Urology teams, current ICATS teams, as well as General Practitioners and LCGs. In considering areas of Urology suitable for further development they should look towards erectile dysfunction, benign prostatic disease, LUTS and continence services. The review should also take into account developments elsewhere within

the UK and in particular developments within PCTs in relation to shifting care closer to home.

Section 4 – Capacity, Demand and Activity

11. Trusts (Urology departments) will be required to evidence (in their implementation plans) delivery of the key elements of the Elective Reform Programme.

Section 5 – Performance Measures

12. Trust Urology Teams must as a matter of urgency redesign and enhance capacity to provide single visit outpatient and assessment (diagnostic) services for suspected urological cancer patients.

13. Trusts should implement the key elements of the elective reform programme with regard to admission on the day of surgery, pre-operative assessment and increasing day surgery rates.

14. Trusts should participate in a benchmarking exercise of a set number of elective (procedure codes) and non-elective (diagnostic codes) patients by Consultant and by hospital with a view to agreeing a target length of stay for these groups of patients.

15. Trusts will be required to include in their implementation plans, an action plan for increasing the percentage of elective operations undertaken as day surgery, redesigning their day surgery theatre facilities and should work with Urology Team in other Trusts to agree procedures for which day care will be the norm for elective surgery.

16. Trusts should review their outpatient review practice, redesign other methods/staff (telephone follow-up/nurse) where appropriate and subject to casemix/complexity issues reduce new:review ratios to the level of peer colleagues.

17. Trusts must modernise and redesign outpatient clinic templates and admin/booking processes to ensure they maximise their capacity for new and review patients and to prevent backlogs occurring in the future.

Section 7 – Urological Cancers

18. The NICaN Group in conjunction with each Trust and Commissioners should develop and implement a clear action plan with timelines for the implementation of the new arrangements/enhanced services in working towards compliance with IOG.

19. By March 2010, at the latest, all radical pelvic surgery should be undertaken on a single site, in BCH, by a specialist team of surgeons. The transfer of this work should be phased to enable BCH to appoint appropriate staff and ensure infrastructure and systems are in place. A phased implementation plan should be agreed with all parties.

20. Trusts should ensure that surgeons carrying out small numbers (<5 per annum) of either radical pelvic operation, make arrangements to pass this work on to more

specialised colleagues, as soon as is practicably possible, (whilst a single site service is being established).

Section 8 – Clinical Workforce Requirements

21. To deliver the level of activity from 2008/09 and address the issues around casemix and complexity it is recommended that the number of Consultant Urologists is increased to 23 wte.

22. Urology Teams must ensure that current capacity is optimised to deliver the number FCEs by Consultant as per BAUS guidelines (subject to casemix and complexity). This may require access to additional operating sessions up to at least 4 per week (42 weeks per year) and an amendment to job plans.

23. At least 5 Clinical Nurse Specialists (cancer) should be appointed (and trained). The deployment of these staff within particular teams will need to be decided and Trusts will be required to develop detailed job plans with caseload, activity and measurable outcomes agreed prior to implementation. A further review and benchmarking of cancer CNS's should be undertaken in mid 2010.

Section 9 – Service Configuration Model

24. Urology services in Northern Ireland should be reconfigured into a 3 team model, to achieve long term stability and viability.

25. Teams North and East (Northern, Western, Belfast and South Eastern Trusts) should ensure that prior to the creation of the new Teams, there are clear, unambiguous and agreed arrangements in place with regard to Consultant on-call and out of hours arrangements.

26. Each Trust must work in partnership with the other Trust/s within the new team structure to determine and agree the new arrangements for service delivery, including inter alia, governance, employment and contractual arrangements for clinical staff, locations, frequency and prioritisation of outreach services, areas of Consultant specialist interest based on capacity and expertise required and catchment populations to be served.

2. INTRODUCTION AND CONTEXT

Introduction

2.1 A regional review of Adult Urology Services was undertaken in response to service concerns regarding the ability to manage growing demand, meet Cancer and elective waiting times, maintain quality standards and provide high quality elective and emergency services.

2.2 A multi-disciplinary and multi-organisational Steering Group was established under the Chairmanship of Mr H. Mullen, Director of Performance and Provider Development and this group met on five occasions between September 2008-March 2009. Membership of the group is included in Appendix 1.

2.3 An External Advisor, Mr Mark Fordham, a Consultant Urologist, Royal Liverpool and Broadgreen University Hospital Trust, was appointed and attended all Steering Group meetings and a number of other sub group sessions.

2.4 Terms of Reference were agreed (Appendix 2), with the overall purpose of the review being to;

Develop a modern, fit for purpose in 21century, reformed service model for Adult Urology Services which takes account of relevant guidelines (NICE, Good Practice, Royal College, BAUS, BAUN). The future model should ensure quality services are provided in the right place, at the right time by the most appropriate clinician through the entire pathway from primary care to intermediate to secondary and tertiary care.

2.5 A literature search of guidance and policy documents was undertaken. This included consideration of reports on previous reviews in Northern Ireland. A list of the key documents considered during this review is included as Appendix 3. Sections in italics within this report are direct quotes from these documents.

2.6 During the course of the review, a significant number of discussion papers, detailed information and datasets were collated, copies of which are not included in this report but are available on request.

Context

2.7 The speciality of Urology predominately covers the assessment, diagnosis and treatment of Urogenital Conditions involving diseases of the Kidney, Bladder, Prostate, Penis, Testis and Scrotum. Bladder dysfunction, Male and Female Continence Surgery and Paediatric Peno-Scrotal Conditions make up the rest.

2.8 Thirty years ago the field of Urology was one of the many that was the province of the General Surgeon. Since that time, Urology has developed and evolved as a separate surgical specialty. Higher specialist training in General Surgery no longer covers Urology, which now has its own training programme.

2.9 Prior to 1992, fully trained dedicated Urologists were based only at the Belfast City (BCH) and Royal Victoria (RVH) Hospitals providing a unified service to these two sites and a referral service for the rest of Northern Ireland. In 1992, Urologists were

appointed at Craigavon, Mater and Altnagelvin Hospitals. By 1999 there were ten full time Urologists in post, providing services on the above sites along with Lagan Valley and Coleraine Hospitals. In addition to these ten Urologists, there were two Consultant General Surgeons (one based in Mater, one based in Ulster) who were accredited as Urologists and whose workload was increasingly in the field of Urology. Since 2002, further appointments were made in the Belfast Hospitals, Altnagelvin and Craigavon Hospitals, along with the development of a Urology Service based in Causeway Hospital. At the time of this review 2008/2009, there is a funded establishment of 17 wte Consultant Urologists, which is in line with the recommendations of the 2000 Northern Ireland Review. However, the 2000 Review envisaged the Northern Board area Urology Services being based in Antrim Area Hospital rather than at Causeway Hospital.

2.10 Urology work can be divided into two categories;

- Medical and surgical treatment of the urinary tract, (kidneys, bladder, ureters, urethra, prostate), with these surgical procedures known as 'M'code (OPCS 4.4)
- Medical and surgical treatment of the genital and reproductive system (peno-scrotal), with these surgical procedures known as 'N'code (OPCS 4.4)

2.11 Both categories comprise elective and non-elective and cancer and non-cancer elements, albeit there are much fewer non elective and cancer cases in the 'N' code category.

2.12 In recent years, with the retirement of General Surgeons who historically undertook a substantial amount of Urology work, the number of General Surgeons who undertake urinary tract operative procedures (M Code) has significantly reduced. A small number continue to undertake diagnostic cystoscopies, which to varying degrees represents a substantial proportion of their workload. Should any subsequent treatment be required, the patient is referred into the Urology Team. A General Surgeon in the Northern Trust continues to undertake Inpatient and Day Case "M" code work in the Mid-Ulster Hospital.

Recommendation

1.	Unless Urological procedures (particularly operative 'M' code) constitute a substantial proportion of a surgeon's practice, (s)he should cease undertaking any such procedures. Any Surgeon continuing to provide such Urology services should do so within a formal link to a Urology Unit/Team.

2.13 Peno-scrotal operative procedures ('N' Code) continue to be undertaken by many General Surgeons predominately based outside of Belfast. This position is not surprising given the current number of urologists in the Southern, Western and Northern Trust areas.

2.14 Table 1 below identifies the type, volume and surgical speciality for N Code work.

Table 1 - Analysis of 'N' Code (Male Genital) Surgical Operations and Procedures Undertaken by Urologists and General Surgeons (2007/08)

Trust	Total Activity	General Surgeons	Urologists	% of 'N' Code undertaken by Urologists	Number / % undertaken as day case		V	C	H
NHSCT	807	767	40	5%	701	87%	517	129	35
SHSCT	612	521	91	15%	493	81%	314	135	36
WHSCT	614	544	70	11%	528	86%	318	143	38
SEHSCT	1244	650	594	48%	1148	92%	860	147	45
BHSCT	674	103	571	85%	407	60%	209	164	49
Total	**3951**	**2585**	**1366**	**35%**	**3277**	**83%**	**2218**	**718**	**203**

V Vasectomy
C Circumcision
H Hydrocele

2.15 Consultant General Surgeons have gained substantial experience and expertise in these procedures over the years and it is not envisaged that Trust's should make any immediate plans to pass this work onto Urologists. However, it is likely that future appointees to Consultant General Surgeon Posts, will have had little experience in undertaking such procedures and therefore Trust's will need to plan and consider the implications of impending retirements in General Surgery.

Recommendation

2. Trusts should plan and consider the implications of any impending retirements in General Surgery, particularly with regard to the transfer of "N" Code work and the associated resources to the Urology Team.

2.16 Gynaecology is another specialty which undertakes urinary tract diagnostic and operative 'M' code procedures and medical treatments for female bladder dysfunction (non cancer) and incontinence. The surgical specialty of Uro-Gynaecology has developed in the last decade, with most Trusts now having trained surgeons in post, for whom, such surgical procedures, represent a significant proportion of their surgical workload.

2.17 More complex surgical procedures are referred to Urologists and this aspect of Urology is termed as female/functional Urology. The demand for these specialist surgical services is increasing and there is a need, in some cases, to have joint working e.g. complex cancer Gynaecological Surgery and complex Urological Surgery.

2.18 Female continence (stress and urge incontinence) services (non surgical) are provided in Primary Care, Community Services and in Gynaecology Secondary Care. However, *there is evidence of large undeclared demand for continence services which is held in check by the embarrassment factor* (Action On Urology). Current services in NI are fragmented, disparate and are not managed in accordance with NICE Guidelines –Urinary Incontinence: The Management of Urinary Incontinence in Women (2006).

2.19 The referral review exercise undertaken as part of the review demonstrated that GP's are not generally referring these patients into urology and as 80-90% of such patients will not require surgical intervention, it was agreed that this service would not be considered as part of this review. However, it is clear from developments

elsewhere in the UK, that continence services can be significantly enhanced and redesigned within a multidisciplinary team model (GP's, Urologists, Gynaecologists, Physiotherapists and Nurse Practitioners) and is very suitable for development in a non secondary care environment.

Recommendation

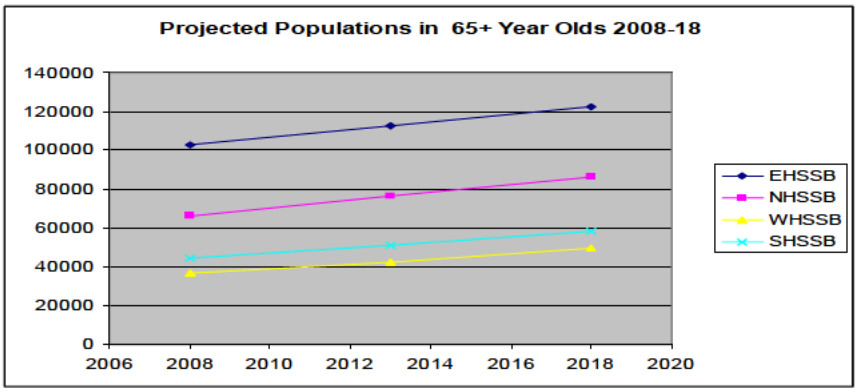
3.	A separate review of urinary continence services should be undertaken, with a view to developing an integrated service model in line with NICE Guidance.

Demography

2.20 The current population in Northern Ireland is 1.76 million with a projected rise to 1.89 million by 2018. The greatest increase will be seen in the 65+ year age group from 249,663 in 2008 to 316,548 (+27%) in 2018. This is particularly relevant for Urology as it is the ageing population that makes the heaviest demands upon Urology care (cancer and non cancer).

Figure 1

Demography 65+ years (Health and Social Services Boards)



Source NISRA

Total	249,663	282,877	316,548

3. CURRENT SERVICE PROFILE

Location of Urology Services

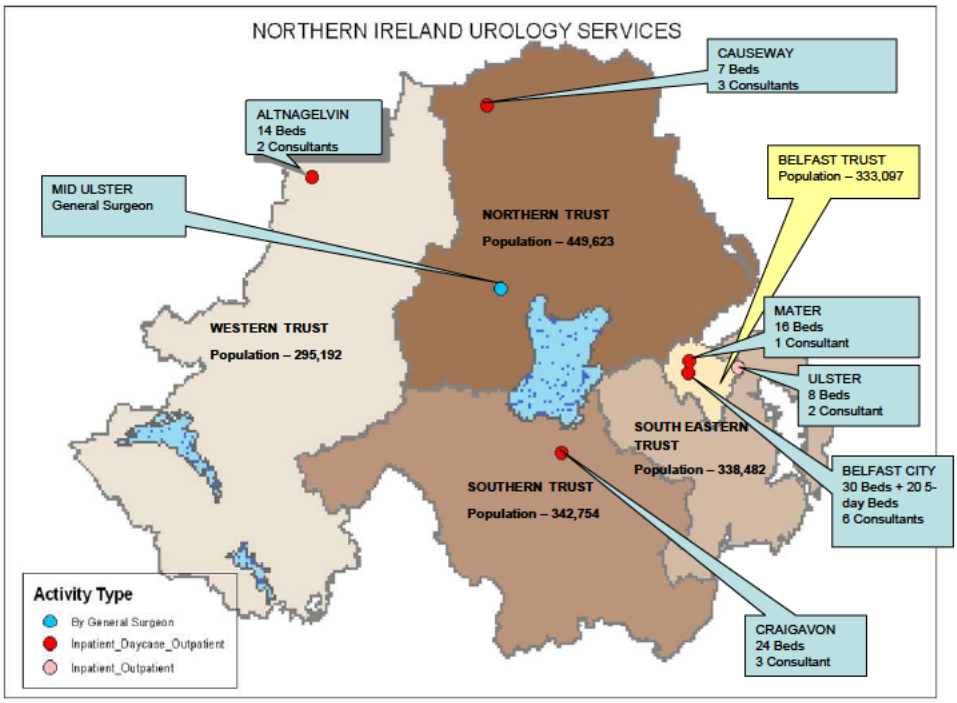
3.1 Consultant led Adult Urology Services are provided in each of the five Trusts. Table 2 below outlines the number of Consultants, Specialist Nurses and Main Hospital bases.

Table 2 – Consultant/Nurse Staffing and Inpatient Units

	Northern	Southern	South Eastern	Western	Belfast	Total
Consultants	3	3	2	2	7	17
Specialist Nurses	3	2	1	3 (2.6 WTE)	3	12 (11.6 WTE)
Hospital Base	Causeway	Craigavon	Ulster	Altnagelvin	BCH/ Mater	

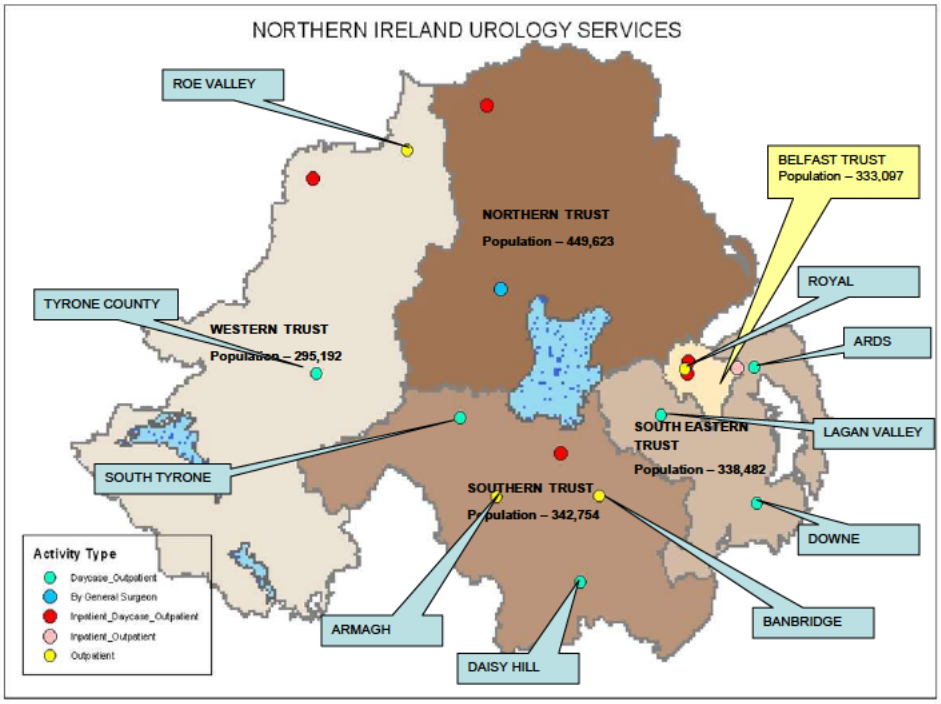
3.2 Figure 2 depicts the five Trusts, their respective resident population, and location and number of Inpatient beds.

Figure 2 – Urology Services – Inpatient Services



3.3 Figure 3 layers on the additional sites within each Trust which provide a range of Outpatient, and Day Surgical Services.

Figure 3 – Urology Services – Outpatients, Day Surgery



3.4 Figures 2 and 3 identified the resident populations for each of the 5 Trusts, however, the actual catchment populations significantly differ when adult only services and patient flows are considered. Table 3 indentifies the inpatient and day case population served by each Trust/Consultant.

Table 3 – Catchment populations served by each Trust

	Consultant urological surgeons number	Inpatient catchment population	Inpatient catchment population per consultant	Daycase catchment population	Daycase catchment population per consultant
BHSCT	7	873,000	124,700	646,000	92,300
NHSCT	3	218,000	72,700	245,000	82,000
SEHSCT	2	130,000	65,000	321,000	160,000
SHSCT	3	305,000	102,000	287,000	96,000
WHSCT	2	236,000	118,000	262,000	131,000
Total	**17**	**1,762,000**	**103,000**	**1,762,000**	**103,000**

3.5 This analysis demonstrates a significant flow of inpatient/day case work (and therefore outpatient/assessment and diagnostic workup) from the Northern Trust area to Belfast. It also demonstrates that although South Eastern Trust services a significant catchment population for day case work (and outpatient, assessment and diagnostics) it serves a smaller proportion of its population with inpatient care. This is due to the fact that a significant volume of outpatients, diagnostics and day surgery is undertaken in the Lagan Valley Hospital by a Consultant Urologist outreached from Belfast. Any subsequent inpatient treatment is then carried out in BCH.

Outpatient (new) Services

3.6 A referral review exercise was held in December 2008, at which a number of primary and secondary care clinicians (5 General Practitioners and 5 Consultant Urologists) and Trust Managers undertook a quantitative and qualitative analysis of all new outpatient referrals received (368) in Urology for a full week in November 2008.

Table 4 - Analysis of Urology Referral Letters

Gender	Belfast	Northern	Western	Southern	SE	Regional
Male	111	39	34	42	55	**281**
Female	33	13	10	11	18	**85**
Blank	0	1	1	0	0	**2**
Total	**144**	**53**	**45**	**53**	**73**	**368**

Age Range	Belfast	Northern	Western	Southern	SE	Regional
0-14	2	0	0	1	0	**3**
15-30	17	4	5	3	7	**36**
31-40	19	4	5	8	4	**40**
41-50	29	9	4	7	5	**54**
51-60	18	13	9	6	4	**50**
60+	59	22	22	28	9	**140**
Blank	0	1	0	0	44*	**45**
Total	**144**	**53**	**45**	**53**	**73**	**368**

Urgency	Belfast	Northern	Western	Southern	SE	Regional
Red Flag	6	2	3	3	4	**18**
Urgent	30	11	10	10	12	**73**
Routine	108	40	32	40	57	**277**
Blank	0	0	0	0	0	**0**
Total	**144**	**53**	**45**	**53**	**73**	**368**

Named Cons	Belfast	Northern	Western	Southern	SE	Regional
Y	35	13	6	12	15	**81**
N	109	40	39	41	58	**287**
Total	**144**	**53**	**45**	**53**	**73**	**368**

Ref Source	Belfast	Northern	Western	Southern	SE	Regional
Non-GP ref's	15	12	1	5	14	**47**
GP Ref's	129	41	43	48	59	**320**
Blank	0	0	1	0	0	**1**
Total	**144**	**53**	**45**	**53**	**73**	**368**

* 44 out of 73 referrals in SET had DOB deleted-therefore not possible to record age range.

** Data on percentages is **Appendix 4**

3.7 Regionally 76% of the referrals were male, which was to be expected. 87% of the referrals were from GPs with the remaining 13% spread across Consultant to Consultant (internal and external), A&E referrals and other sources. 78% of the referrals were referred into Urology as a specialty, with only 22% having a named Consultant. Regionally (excluding SET) 63% of the referrals related to the over 50's age range. Referrals marked by GPs as red flag or urgent represents 25%.

3.8 A breakdown of the referrals by presenting symptoms/conditions is in Table 5 below. Data on percentages is included in Appendix 5. Clinicians have indicated that this outcome is fairly representative of the nature and type of referrals they receive.

Table 5 - Analysis of presenting symptoms/conditions

Presenting Symptom/Condition		Belfast		Northern		Western		Southern		SE		Regional	
Haematuria (ALL)		**19**		**10**		**10**		**5**		**12**		**56**	
	frank		*11*		*3*		*4*		*2*		*6*		*26*
	microscopic		*6*		*5*		*6*		*2*		*6*		*25*
	blank		*2*		*2*		*0*		*1*		*0*		*5*
Prostate/raised PSA		**14**		**7**		**8**		**9**		**12**		**50**	
Other		**21**		**4**		**5**		**8**		**8**		**46**	
Ncode procedure (All)		**21**		**2**		**1**		**3**		**14**		**41**	
	vasectomy		*11*		*0*		*1*		*1*		*4*		*17*
	foreskin		*1*		*0*		*0*		*2*		*7*		*10*
	epididymal cyst		*3*		*2*		*0*		*0*		*3*		*8*
	hydrocele		*4*		*0*		*0*		*0*		*0*		*4*
	varicocele		*1*		*0*		*0*		*0*		*0*		*1*
	blank		*1*		*0*		*0*		*0*		*0*		*1*
Recurrent UTI's		**17**		**9**		**4**		**6**		**4**		**40**	
LUTS		**11**		**7**		**2**		**5**		**7**		**32**	
Prostate/BPH/prostatitis		**11**		**5**		**4**		**6**		**2**		**28**	
Renal stones/colic/loin pain		**11**		**5**		**1**		**2**		**4**		**23**	
Testicular/ Scrotal lumps or swelling		**8**		**0**		**5**		**0**		**8**		**21**	
Andrology (ALL)		**7**		**2**		**3**		**6**		**2**		**20**	
	erectile dysfunction		*2*		*2*		*0*		*3*		*1*		*8*
	Peyronie's disease		*2*		*0*		*2*		*0*		*0*		*4*
	blood in ejaculate		*3*		*0*		*0*		*0*		*0*		*3*
	ulcer/lesion on gland		*0*		*0*		*1*		*1*		*0*		*2*
	balanitis/discharge		*0*		*0*		*0*		*2*		*0*		*2*
	Blank		*0*		*0*		*0*		*0*		*1*		*1*
Unknown		**3**		**1**		**1**		**2**		**0**		**7**	
Ca Bladder/Kidney		**1**		**1**		**0**		**1**		**0**		**3**	
Blank		**0**		**0**		**1**		**0**		**0**		**1**	
Total		**144**		**53**		**45**		**53**		**73**		**368**	

3.9 The categorisation of patients by presenting symptoms/condition is a useful process and the outcomes of this exercise should assist Urology teams in determining the nature and frequency of assessment and diagnostic clinics. There was an overlap in symptoms for some patients e.g. many patients with enlarged prostate, known benign prostatic hyperplasia (BPH) or prostatitis have a range of lower urinary tract symptoms (LUTS). However, for the purposes of this exercise, if prostatic disease was identified on the referral letter, these patients were recorded as such, whereas patients presenting with just LUTS were categorised as such. Where LUTS

services are in place, both of these groups of patients are seen and treated within the same pathway.

3.10 General comments;

- A small number of the referrals (<10) were not for a new outpatient appointment but were asking for a review appointment, which was overdue, to be expedited. In addition, a small number of referrals (<10) were for patients who had been discharged from outpatients due to not responding to a booking letter or had DNA'd and who had subsequently visited their GP and asked for another referral to be processed.

- In overall terms, the quality and appropriateness of the referrals was deemed to be good. Internal referrals (A&E, inpatient etc) were often handwritten and were not as structured as GP referral letters.

- The exercise included looking at the time between the date recorded on the referral letter and the hospital date stamp indicating receipt. A significant variance between these two dates was noted in internal referrals (Consultant to Consultant). There did not appear to be any significant delays with regard to GP referrals.

Recommendation

4.	Trusts must review the process for internal Consultant to Consultant referrals to Urology to ensure that there are no undue delays in the system.

- Consultants indicated that they would routinely upgrade a significant number of routine and urgent referrals (GP) to urgent or red flag. This is particularly relevant when considering the service capacity requirements to assess and investigate potential cancers within cancer standard timescales. This has been confirmed in a recent Cancer Registry, full year analysis of the cancer waiting times database, with a total of 700 red flag GP referrals and 875 referrals which Consultants upgraded to red flag at triage recorded.

- It has been noted that the development of agreed referral guidelines/criteria for suspected Urological cancers is a priority piece of work for the recently formed NICaN Group and this should work should be advanced as soon as possible.

Recommendation

5.	NICaN Urology Group in conjunction with Urology Teams and Primary Care should develop and implement (by September 2009) agreed referral guidelines and pathways for suspected Urological Cancers.

Areas of Urology

3.11 As a specialty, Urology can be sub-divided into a number of special interest areas, most of which also comprise elements of general or 'core' Urology work.

3.12 **Core Urology** includes the assessment, diagnosis, medical treatment and (non complex and/or endoscopic) surgical treatment of diseases/conditions of the kidney,

bladder, prostate, penis and scrotum. LUTS, BPH, haematuria, simple stones, erectile dysfunction (ED) and 'N' code work are considered to be core Urology. Urologists in NI, regardless of special interest area, all provide core Urology services. Over 80% of all 'M' and 'N' code inpatient and daycase procedures are peno-scrotal, cystoscopy, TURBT (trans urethral resection of bladder tumour), TURP (trans urethral resection of prostate) and urethral catheterisation.

3.13 **Uro-Oncology.** Around 40% of Urology work is cancer related and most of the assessment, diagnostics and medical/ simple surgical treatments are appropriately undertaken at local level. Less than 10% of Urological cancers require radical/complex surgery. (see section 7).Specialist cancer services are based in BCH, where there are three designated 'cancer' Urologists. One Urologist in Altnagelvin and one/two in Craigavon would also be considered to have a special interest in cancer.

3.14 **Stones/Endourology** includes the management and treatment of renal and ureteric calculi. This involves open surgery, endoscopic intervention or stone fragmentation using multimodal techniques such as laser, lithoclast with or without US (ultrasound) and ESWL (Extracorporeal shock wave lithotripsy). Craigavon has the only fixed-site lithotripter, with BCH and Causeway serviced by a mobile facility on a sessional basis. With regard to special interest Urologists, there are currently two in Belfast Trust and one in each of the other four Trusts.

3.15 **Andrology** includes the treatment of erectile dysfunction, particularly post prostate surgery, penile curvatures and deformities (Peyronie's disease) and other conditions of the male reproductive organs. Currently all Consultants provide andrology services within their commitment to core Urology. The service would benefit from having a specialist Urologist to manage and treat the more complex cases, including penile prostheses work.

3.16 **Reconstruction,** which is often combined with the functional side of Urology, includes reconstruction of urinary continence in men, bladder reconstruction after oncological surgery and in a neuropathic bladder, e.g. spina bifida, spinal cord injury, bladder reconstruction in congenital and developmental LUT pathology (adolescent), urethral reconstruction for strictures and reconstruction prior to transplantation. There are currently two Consultants (one on long term sick leave) in Belfast who specialise in this area, working closely with the Uro-oncology team and with supra regional support provided by University College Hospital London.

3.17 **Female/functional** relates to the management and treatment of incontinence and bladder dysfunction in women, which on some occasions overlaps with reconstruction surgery. Some of this work is undertaken by Urologists however, the majority is undertaken by Uro-Gynaecologists as outlined in section 2. There is a shared view among Urologists that each Urology team should have at least one Urologist with a special interest in female/ functional Urology, and who for this aspect of their work, should work within a multidisciplinary team of Gynaecologists, physiotherapists and nurse practitioners in providing care for urinary incontinence, prolapse and fistula repair.

Recommendation

6.	Deployment of new Consultant posts (both vacancies and additional posts arising from this review) should take into account areas of special interest that are deemed to be required in the service configuration model

Non-Elective Services

3.18 There are approximately 2,500 non-elective FCE's (coded as Urology on admission or discharge) per annum (approximately 7 a day) with little variation in these numbers from year to year.

3.19 In broad terms, non-elective admissions fall into the following categories;

- Testicular torsion/infections
- Renal colic/Acute kidney obstruction
- Infection—recurrent UTI's/ pyelonephritis
- Urinary retention /haematuria

3.20 The majority of admissions fall into urinary retention and renal colic which do not usually require an immediate surgical operation, neither does treatment of infections. Testicular torsion and acute kidney obstruction require emergency (often surgical) intervention.

3.21 There are currently 15 hospitals in NI with A&E Departments (varying opening times) and acute medical and surgical facilities. With the implementation of DBS (Developing Better Services) this position will change in future years. However, for the purposes of this review the profile of services and location of non-elective Urology patients is assumed to be as is at present.

3.22 The majority of non-elective admissions are admitted to the 'presenting' acute hospital and unless it is BCH or CAH are admitted (out of hours) under General Surgery, until transfer to the care/specialty of Urology, if appropriate, on the next working day.

3.23 Even in a redesigned Urology service it is not envisaged that these arrangements will change for the foreseeable future, as it would not be viable to provide 24/7 onsite Urology cover in all 15 hospitals. However, the requirement to have clearly defined protocols and pathways in place for the management of these admissions has been identified.

Recommendations

7.	Urologists, in collaboration with General Surgery and A&E colleagues, should develop and implement clear protocols and care pathways for Urology patients requiring admission to an acute hospital which does not have an acute Urology Unit.

8.	Urologists, in collaboration with A&E colleagues, should develop and implement protocols/care pathways for those patients requiring direct transfer and admission to an acute Urology Unit.

9.	Trusts should ensure arrangements are in place to proactively manage and provide equitable care to those patients admitted under General Surgery in hospitals without Urology Units (e.g. Antrim, Daisy Hill, Erne). Arrangements should include 7 day week notification of admissions to the appropriate Urology Unit and provision of Urology advice/care by telephone, electronically or in person, also 7 days a week.

ICATS (Integrated Clinical Assessment and Treatment Services)

3.24 ICATS was launched in NI in 2005/06, as one element of the Department's Outpatient Reform Programme and in response to very lengthy waiting times for first outpatient appointments.

3.25 ICATS were designed to provide services, in a variety of primary and secondary care settings by integrated multidisciplinary teams of health service professionals, including GPs with a special interest, specialist nurses and allied health professionals. One of the fundamental elements was that many patients didn't need to be seen or assessed by a hospital Consultant at an outpatient clinic and that quick triage of referral letters and assessment and diagnostics by the most appropriate health care professional within ICATS teams, with onward referral to secondary care, only if required, would divert large numbers of outpatient referrals from hospital consultants. Another fundamental design principle was that non urgent referrals would, in the first instance, go to ICATS to be triaged and that all subsequent flows to secondary care consultants would be from the ICATS team.

3.26 It was agreed that, to begin with, ICATS would be implemented in a small number of core specialities (4) and these were identified based on those specialities with the highest volumes and longest waiting times in 2005/06. Urology was one of the 4 initial specialties identified. Across all ICATS specialties £2m was allocated in 2006/07, increasing to £9m recurrently from 2007/08.

3.27 The design of ICATS included 5 possible next steps/pathways for patients referred into the service-

- to diagnostics,
- for direct treatment on an inpatient/day case list,
- for return to primary care with advice on further management,
- to tier 2 outpatient services (non Consultant assessment and treatment) or
- to hospital (Consultant) outpatients.

3.28 For a variety of reasons, the development of Urology ICATS has been difficult, slower than planned and somewhat fragmented with regard to service model design, which differs significantly in each of the Board areas.

3.29 Table 6 below outlines the progress to date in Urology ICATS.

Table 6 - Urology ICATS - Current Position

Board Area	Current Position	Ring fenced funding/ Investment Made	Comments
NHSSB	Hospital based (Causeway) Nurse specialists undertaking mostly cystoscopies. Consultant led referral triage.	£642K	Original intention to expand nurse service to LUTS/haematuria/prostate clinics and review/follow-up clinics.
SHSSB	GPSI and specialist nurse Tier 2 clinics for haematuria, prostate, LUTS, stones, andrology. ICATS in separate building on Craigavon Area Hospital site. Consultant led referral triage.	£240K	Oncology review and urodynamics clinics being established.
WHSSB	Nurse led clinics (LUTS, prostate) and single visit haematuria clinics with nurse specialists/staff grade in place for some years. Predominately hospital based (Altnagelvin). Consultant led referral triage.	£211K	ICATS plan now approved – expanding diagnostic, LUTS services and involving GPSI'S in referral triage process in order to improve links with primary care and improve referral information and patterns.
EHSSB	SET – plan approved by EHSSB late 2008. Nurse specialist undertaking cystoscopies for some time outwith any ICATS model. BELFAST – no progress but nurse led services in place for some time and single visit haematuria clinic established late 2008. Consultant led referral triage in both SET +Belfast	£350K	GPSI'S appointed some time ago but posts not yet activated.

3.30 It is clear that Urology services have been developing non Consultant delivered outpatient, assessment and diagnostic services, such as haematuria, LUTS, ED, prostate, stones etc for some years prior to the launch of ICATS. These services were/are largely provided by nurse specialists, staff grades and radiology staff in a hospital environment.

3.31 Consultant Urologists unanimously consider that referral triage should be led by Consultants. With over 40% of referrals being cancer related (and with many not red flagged or marked urgent) they believe that they are best placed and skilled to undertake the triage process. They also believe that despite the volume of referrals, this is not a particularly time consuming process.

3.32 They indicate that they are fully committed to developing further non Consultant assessment, diagnostic and some treatment services and supportive of *providing appropriate, safe and sustainable, cost effective care closer to home, so that urology services are delivered in the right setting, with the right equipment, performed by the appropriate skilled person* (NHS, Providing Care for Patients with Urology Conditions- Guidance).

3.33 This approach was evident during the referral review exercise in December 2008, with Consultants readily indicating that patients should be booked straight into diagnostics or nurse led clinics such as LUTS, prostate, haematuria.

3.34 Consultant Urologists are very clear that the need to ensure that whoever the specialist practitioner is and wherever they work, they should be part of, or affiliated to, the local Urology team, led by a Consultant Urologist.

3.35 In light of the already changing shape of Urology services and the further developments that will arise out of this review, it is appropriate and timely to take stock of ICATS, its design principles and future development and investment. A review of all ICATS Services is planned for the first quarter of 2009/10 year and the outcomes of this review should guide the future direction of travel for ICATS services within Urology .

Recommendation

10.	In undertaking the ICATS review, there must be full engagement with secondary care Urology teams, current ICATS teams, as well as General Practitioners and LCGs. In considering areas of Urology suitable for further development they should look towards erectile dysfunction, benign prostatic disease, LUTS and continence services. The review should also take into account developments elsewhere within the UK and in particular developments within PCTs in relation to shifting care closer to home.

Links with Renal Transplantation

3.36 Renal transplantation is the definitive preferred treatment for end-stage renal failure. Kidneys for transplantation become available from either deceased or live donors. In 2006 the DOH commissioned a Taskforce to investigate and make recommendations to increase the level of organ donation. In 2008/09 the DHSSPS set a target for access to live renal transplantation and investment has been made to increase the live donor programme at Belfast City Hospital.

3.37 There are currently two wte transplant surgeons in post, a long-term locum transplant surgeon and in addition there is 0.2 wte input from an Urologist. The Urologist only undertakes live donor kidney retrieval using laparoscopic techniques, which is an essential quality component for the live donor programme.

3.38 Taskforce recommendations would suggest that cadaveric retrievals and transplantations should be increased to 50 per year (currently approximately 30) and within Priorities for Action there is a target for an additional 20 live donor retrievals and transplantations per year by March 2011. With the increase in laparoscopic live donor retrieval, additional input from Urologists may be needed and the current review of the renal transplantation service will need to take account of this requirement, along with the Urology input required if any reconstruction of the urinary drainage system is needed before transplantation.

4. CAPACITY, DEMAND AND ACTIVITY

4.1 Urology is a specialty that is categorised by high numbers of referrals for relatively simple initial diagnostics (often to exclude pathology) or surgical procedures. In addition, around 40% of Urology is cancer related and as more elderly patients are referred and treated, there is a need for follow-up services and patient surveillance.

4.2 The increasing demand for Urology services in Northern Ireland is similar to that being experienced in the rest of the UK.

4.3 The Action On Urology Team (March 2005) reported that:

Demand for Urology services is rising rapidly and the pattern of disease is changing.

- *There is an overall rise in demand from an ageing population especially the over 50's who make the heaviest demands upon Urology care.*
- *Prostate disease incidence is rising rapidly and PSA requests are generating further demand.*
- *Haematuria/bladder disease demand is also rising, stimulated by the combined availability of dipsticks and flexible cystoscopes.*
- *Work is shifting away from surgery towards diagnostics and medical treatment.*

4.4 In addition, there has been an increased "medicalisation" of Urology as the pharmacology of the urinary tract has become better understood and the increasing availability and ever improving range of drugs.

Activity/Demand/Capacity Analysis

4.5 During the review detailed analysis was undertaken by SDU and the Boards, and the following represents the most accurate information available at this time.

Outpatients

4.6 New outpatient referrals and attendances (activity) have been increasing year on year. Not all referrals result in attendance as many are removed for "reasons other than treatment" (ROTT) and are appropriately discharged from the system without having been seen.

4.7 The most recent analysis undertaken is estimating an 18% increase in predicted (GP) demand from 2007 to 2008 (2008 ROTT rates applied). This does not however represent a 'true' picture as during this period two Trusts changed their recording/management of activity from General Surgery to Urology. It has been difficult to quantify, with a degree of accuracy, the impact of these changes on the information, as increases, (albeit smaller), in General Surgery are also being estimated. Notwithstanding the above difficulty, it has been accepted that there is a significant increase in demand, which is likely to be between 10 and 15%. It has also been concluded that this increase is likely to be as a result of those factors outlined at the beginning of this section i.e. ageing population, patient expectation and demand with the increased emphasis on men's health, changing pattern of disease, availability of assessment and diagnostic modalities to exclude pathology, along with decreasing waiting times and previously unmet need.

4.8 A regional referrals management review, led by SDU Primary Care advisors is due to commence in April 2009.

Table 7 - Urology – Service and Budget Agreement Levels and Activity

	SBA (1)	07/08 Outturn(2+4)	Projected 08/09 Outturn (3+4)
Elective Inpatients	4,155	4,937 + 295(IS)	5,823+606(IS)
Non-elective Inpatients	2,109	2,369	2,496
Daycases	8,715	12,416 + 462 (IS)	13,252+1028(IS)
New Outpatients	5,824	7,593 + 571 (IS)	9,984 +519(IS)
Review Outpatients	12,566	15,967	19,224

(1) Information from 4 Boards SBAs
(2) 2007/08 outturn from PAS (includes in-house additional activity)
(3) Projected 2008/09 outturn (including in-house additional activity) based on November 2008 position
(4) IS information provided by EHSSB

4.9 In 2008, the Boards completed a detailed capacity and demand model across a number of specialities, inclusive of Urology. A number of assumptions/estimates were applied and both the recurrent gap against SBA and non-recurrent (backlog) was identified. The recurrent gap does not take account of growth in demand. The backlog (non-recurrent) gap relates to the in-year activity required due to the need to reduce waiting times for inpatient/day cases and outpatients to 13 and 9 weeks respectively by March 2009.

4.10 It has been agreed that the maximum elective access waiting times for 2009/10 will remain at 13 and 9 weeks and with a year of steady state, Trusts and Commissioners will therefore be better placed to assess both the 'real' demand and capacity to treat.

4.11 As part of this review EHSSB undertook further analysis of demand and capacity within urology and identified a significant recurrent gap, against SBA volumes.

Conclusion

4.12 Both the demand and activity in Urology is significantly greater than the current SBA volumes. Some of this is non-recurrent backlog created by the reducing waiting times since 2005/06 and the remainder is recurrent based on 2007/08 demand. Significant non-recurrent funding has been allocated in recent years to ensure Trusts were able to undertake this activity and to meet the elective access waiting times and cancer access standards. Within Trusts large numbers of additional clinics and theatre sessions have been funded non-recurrently and there has also been significant use of the independent sector.

4.13 Both increased and additional capacity to assess and treat patients is urgently required in Urology. However, additional recurrent investment in capacity (resources-human and physical) which is required in this speciality and is detailed later in this report is not the only solution. Trusts will also be required to ensure optimum use and efficiency of their existing capacity and will need to be creative in developing new ways of working and re-designing and modernising services to increase the capacity already in the system and to manage the increasing demand into secondary care.

4.14 The IEAP (Integrated Elective Access Protocol) provides detailed guidance on tried and tested systems and processes which ensure effective and efficient delivery of elective services, along with improvements to the patient experience. The Scheduled Care Reform Programme (2008-10) includes significant developments such as, pre-op assessment, admission on day of surgery, increasing day surgery rates, reducing cancelled operations, optimising the use and productivity of theatres, booking systems and a management of referral demand exercise. All of these will build/create additional capacity within the system.

Recommendation

11.	Trusts (Urology departments) will be required to evidence (in their implementation plans) delivery of the key elements of the Elective Reform Programme.

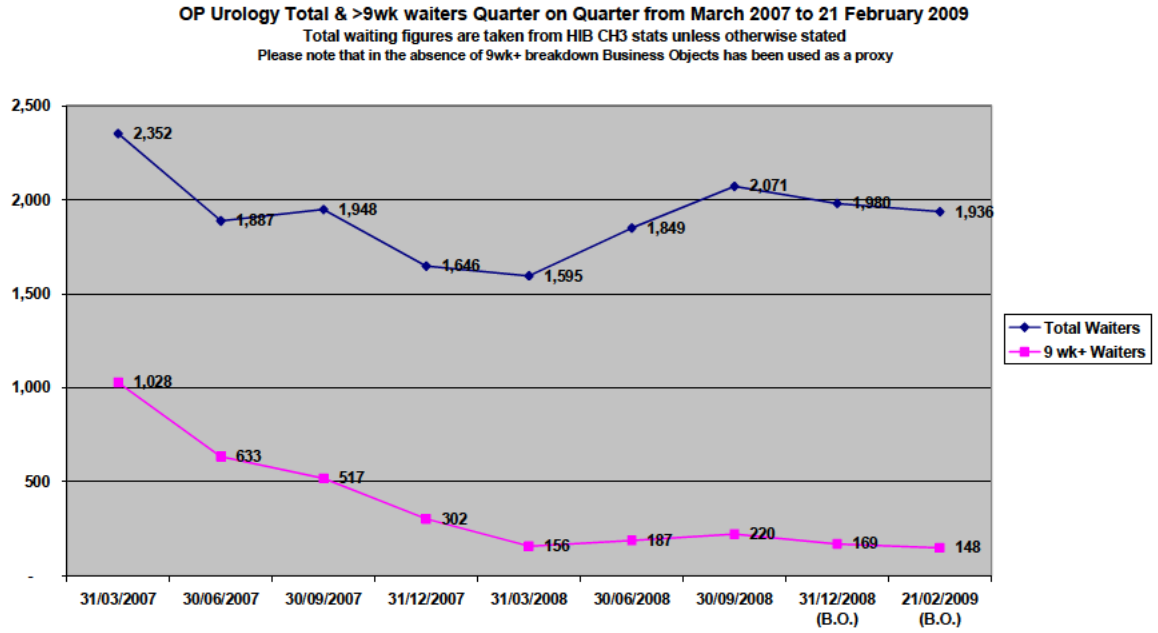
5. PERFORMANCE MEASURES

Elective access waiting times

5.1 There have been significant reductions in waiting times since 2005, in line with PFA (Priorities for action) targets and as a result of the elective reform and modernisation programme.

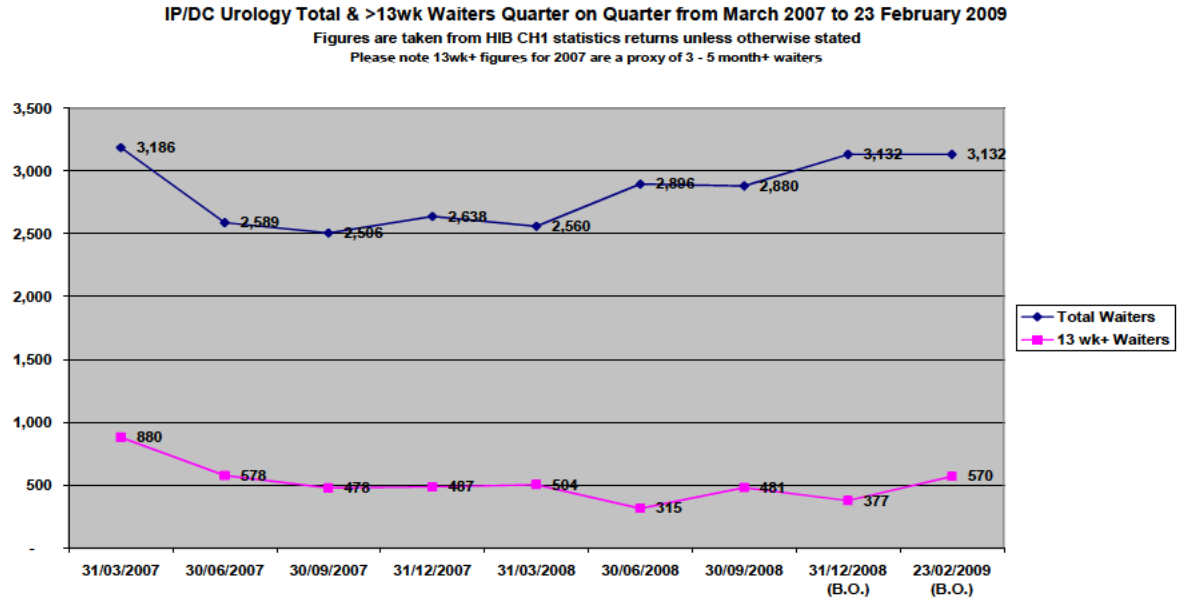
PFA 2008/2009: By March 2009, no patient should wait longer than 9 weeks for first outpatient appointment and/or diagnostics
By March 2009, no patient should wait longer than 13 weeks for Inpatient or daycase treatment.

Figure 4



(B.O. – refers to Business Objects)

Figure 5



5.2 As at February 2009, all Trusts, with the exception of Belfast, are indicating that they will meet the target waiting times for outpatients, diagnostics, Inpatients and daycases. Belfast Trust is reporting in excess of 100 anticipated breaches in Inpatient/daycase work.

Urology Cancer Performance

5.3 The Cancer Access Standards were introduced from April 2007. These introduced waiting times standards for suspected cancer patients both urgently referred by the General Practitioner or those referrals triaged by the Consultant as suspected cancer. It also set standards for those patients diagnosed with cancer and how long they should wait for treatment.

5.4 The 2008/09 Cancer Access Standards were defined as below:

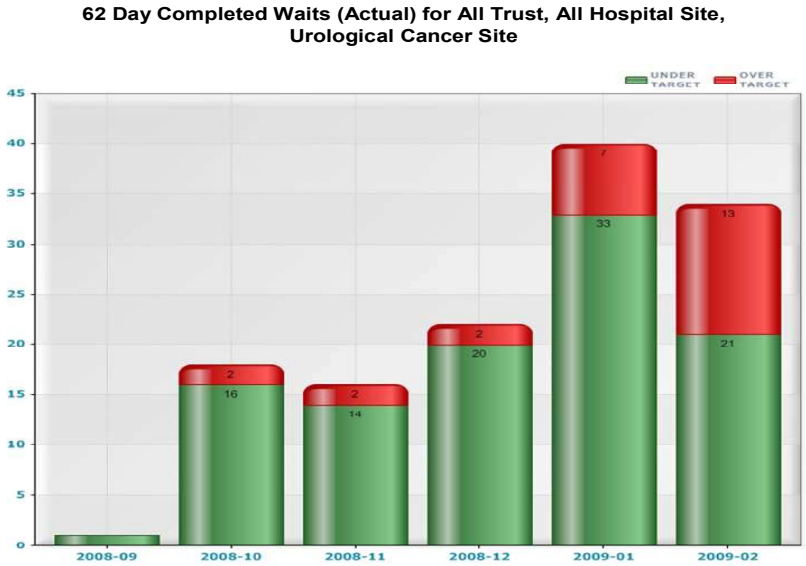
- 98% of patients diagnosed with cancer from decision to treat, should begin their treatment within a maximum of 31 days
- 95% of patients urgently referred with a suspected cancer should begin their first definitive treatment within a maximum of 62 days.

* decision to treat is the date on which the patient and clinician agree the treatment plan.

5.5 It is recognised that a considerable amount of the actions required to achieve the cancer access standards are associated with service improvement. These include the identification and agreement of the suspected cancer patient pathway, the introduction of robust administrative systems or processes and the proactive management of patients.

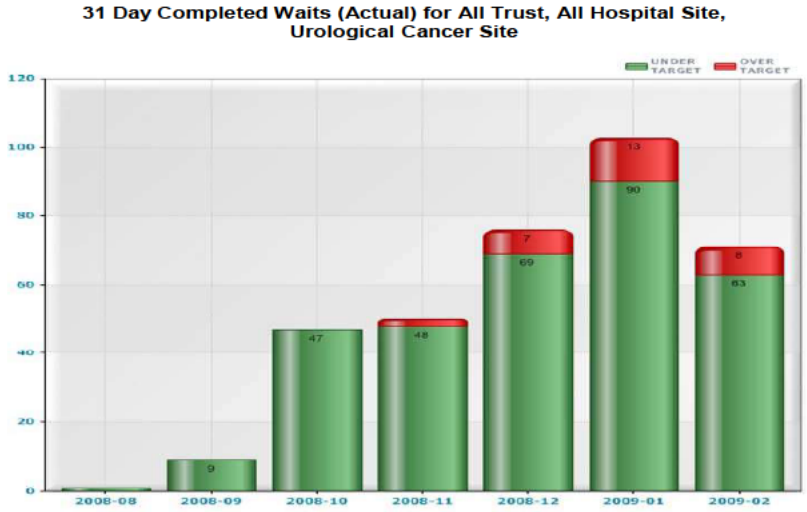
5.6 The recent cancer access standard performance in relation to the 62 day standard shows that up to 24 February 2009, across all Trusts, the number of Urological cancer patients achieving the 62 day standard is at 62%. This shows that of the 34 confirmed cancers treated up to this date, 13 of these had not been treated within 62 days.

Figure 6



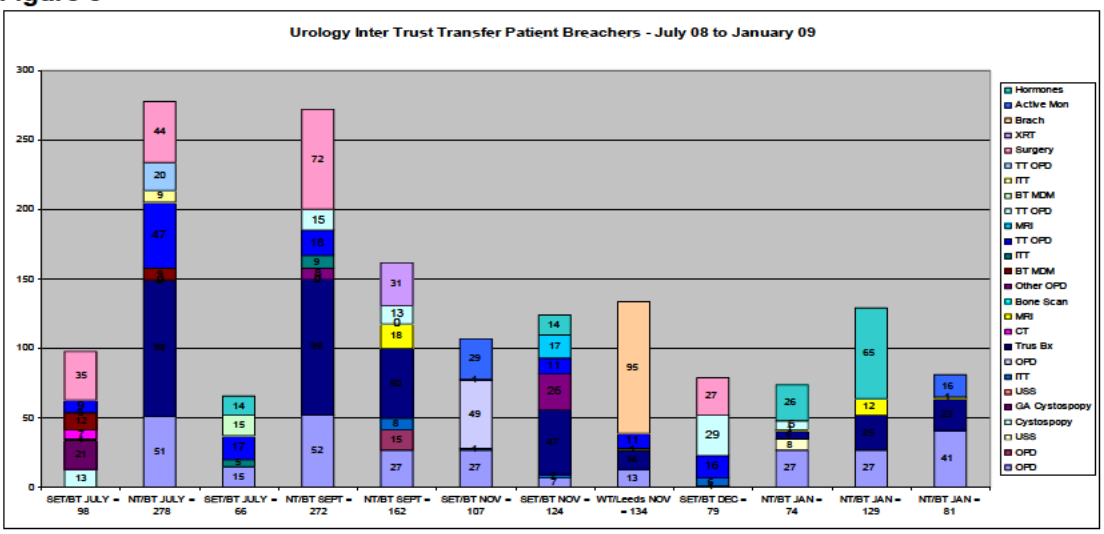
5.7 For the same period in February, the performance in relation to the 31 day standard shows that, only 87% of those Urological cancer patients (63 of 71 patients) were treated within 31 days of the decision to treat. From a sample of 9 patients that breached the 31 day standard in January 2009, they waited on average 50 days from their decision to treat to their first treatment.

Figure 7



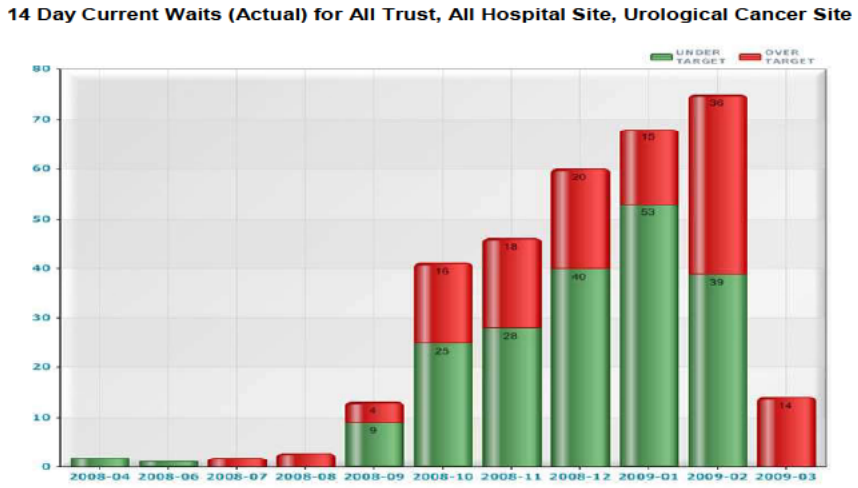
5.8 It is accepted that those patients who transfer from one Trust to another for treatment are more likely to breach the target, than those who remain within the one Trust for their complete pathway. These patients are referred to as Inter Trust Transfer (ITT) patients. These ITT patients that breach the target are analysed in more detail. The detail for the period July 2008 to January 2009 is shown on Figure 8 below. This shows that of the suspected 'red flag' cancer patients referred who breached the 62 day target, 12 of these were ITT patients and they waited from 66 to 278 days from referral to their first treatment. It is accepted as a regional standard, for all tumour sites that if the patient is to be transferred for treatment, all diagnostic investigations should be completed and the patient should be ready for transfer by day 28 of the 62 day pathway. From this evidence it shows that this is not happening in the majority of cases.

Figure 8



5.9 Whilst this analysis only refers to ITT patients, it is probably representative of the pathway for those patients that breach the target and remain only within the one Trust. For example, for the 'front end' of the patient pathway, the number of days the patient can wait for their initial outpatient appointment and subsequent investigation can be over 150 days. This has improved in recent months, but to achieve the 28 day standard this should be completed within approximately 21 days. This is further evidenced by the analysis of the 14 day waiting times for suspected Urological cancers referrals; this showed that of the referrals seen in February only 52% were seen within 14 days. As highlighted any delay at the front end of the pathway will have an impact on the Trusts ability to achieve the treatment times and the 62 day standard.

Figure 9



5.10 Whilst it is clear that some element of redesign of the pathway is required, the evidence appears to indicate that for the number of suspected 'red flag' cancer referrals received or triaged by the Consultants, additional capacity at the front end to complete timely investigations is required. For example, the introduction of one-stop clinics for investigations such as haematuria can have an impact and reduce the number of days the patient waits for investigations as well as reducing the number of times that the patient has to attend the hospital. This needs to be matched with sufficient Consultant capacity for treatments, including theatre capacity, Oncologists for oncology and radiotherapy.

5.11 All Trusts have reported that Urology is the key tumour site which they are at most risk with and their achievement of the cancer access standards by March 2009. In addition, at a recent ITT Executive Directors Services Steering Group the Belfast Trust reported they estimate 15 to 20 urological patients will breach the cancer access standards. Some of this is due to the late transfer of patients, but also due to a lack of available Consultants and theatre capacity. If the number of patients forecasted breach the target, this will mean that as a region NI will not achieve the cancer access standard.

Recommendation

12.	Trust Urology Teams must as a matter of urgency redesign and enhance capacity to provide single visit outpatient and assessment (diagnostic) services for suspected urological cancer patients.

NHS Better Care, Better Value Indicators

5.12 A number of better care, better value Indicators are useful performance measures to apply to Urology in assessing levels of efficiency, productivity and patient experience.

5.13 Length of stay (LOS) is one of the greatest variables between Trusts, hospitals and individual Consultants. By reviewing and improving admission and discharge processes, Trusts can improve the patient experience by reducing the number of days spent in hospital, and save bed days thus increasing capacity and saving money.

5.14 Some hospitals would expect to have longer than average LOS if they undertake more complex operations, treat patients with greater co-morbidity and patients with higher levels of social deprivation.

Table 8
Urology Episodic Average Length of Stay (06/07, 07/08, 08/09 - Apr 08 to Nov 08)

	Elective			Non Elective		
	FY2006/2007	FY2007/2008	FY2008/2009*	FY2006/2007	FY2007/2008	FY2008/2009*
Regional average LOS in days	3.7	3.4	3.2	4.8	4.7	4.6

	Elective			Non Elective		
Trust	FY2006/2007	FY2007/2008	FY2008/2009*	FY2006/2007	FY2007/2008	FY2008/2009*
Belfast Health and Social Care Trust	3.9	3.4	3.3	5.5	4.9	5.0
Northern Health and Social Care Trust	2.3	2.9	2.5	4.3	5.4	5.6
South Eastern Health and Social Care Trust	3.8	3.9	3.3	3.9	4.4	3.4
Southern Health and Social Care Trust	3.7	4.0	3.5	4.5	4.8	4.9
Western Health and Social Care Trust	3.6	2.8	3.1	3.9	3.8	3.7
Average LOS in days	**3.7**	**3.4**	**3.2**	**4.8**	**4.7**	**4.6**

	Elective			Non Elective		
Site	FY2006/2007	FY2007/2008	FY2008/2009*	FY2006/2007	FY2007/2008	FY2008/2009*
Altnagelvin Hospitals	3.6	2.8	3.1	3.9	3.8	3.7
Belfast City Hospital	4.1	3.5	3.4	5.5	4.7	5.0
Causeway	2.3	2.9	2.5	4.3	5.4	5.6
Craigavon Area Hospital	3.7	4.0	3.5	4.5	4.8	4.9
Down and Lisburn	1.0	0.0	1.2	0.0	0.0	0.0
Mater Infirmorum Hospital	3.2	2.7	2.5	5.9	6.4	5.0
The Royal Group of Hospitals	0.0	0.0	0.0	0.0	0.0	0.0
Ulster Community and Hospitals	3.8	4.0	3.5	3.9	4.4	3.4
Average LOS in days	**3.7**	**3.4**	**3.2**	**4.8**	**4.7**	**4.6**

***Information for 08/09 is cumulative from 01/04/08 to 30/11/08**

5.15 All Trusts have longer average LOS for non elective patients than elective. The Southern Trust has the longest average LOS for elective patients and for elective and non-elective combined. Northern Trust has the shortest elective LOS which reflects their lower levels of major surgery.

5.16 Hospital Episode Statistics (HES) data, which combines elective and non-elective LOS, indicates a reduction in England over a three year period from an average of 3.8 days in 2005/2006 to 3.3 days in 2007/2008. Only South Eastern and Western Trusts have an average (combined) LOS of less than 4 days.

Recommendations

13.	Trusts should implement the key elements of the elective reform programme with regard to admission on the day of surgery, pre-operative assessment and increasing day surgery rates.

14.	Trusts should participate in a benchmarking exercise of a set number of elective (procedure codes) and non-elective (diagnostic codes) patients by Consultant and by hospital with a view to agreeing a target length of stay for these groups of patients.

Day Surgery

5.17 For any surgical operation there is a large variation in performance throughout the UK with regard to time spent in hospital. Some units favour certain procedures to be performed on a day case basis while others, for the same procedure may regard an overnight stay as the norm. (BADS Directory of Procedures 2007)

5.18 Hospitals are increasingly focussing on the short stay elective pathway. Carrying out elective procedures as day cases, where clinical circumstances and specialist equipment and training allows, saves money on bed occupancy and nursing care, as well as improving patient experience and outcomes.

5.19 The Audit Commission has identified 25 operations across a number of surgical specialties which could be carried out as day cases and has set a target of an average day case rate of 75% across the 25 procedures. This target has now been adopted within Priorities for Action, to be achieved by March 2011. Three of the procedures specifically relate to Urology (orchidopexy, circumcision, transurethral resection of bladder tumour). BADS (British Association of Day Surgery) identifies another 28 Urology operations (M and N code) which could be done as day surgery. The BADS Directory also suggests a % rate that can be achieved, which is 90% for the majority of the operations.

5.20 Table 9 below identifies the day case rates (% of all elective work undertaken as day case) in Urology by Trust and by hospital. It excludes Independent Sector activity and cystoscopies (M45) and prostrate TRUS, +/- biopsy (M70), both of which are not considered to be 'true' surgical operations and could equally be treated and coded as an outpatient with procedure case.

Table 9 Urology Day Case Rates excluding M45 and M70.3 & Y53.2 (06/07, 07/08, 08/09 - Apr 08 to Nov 08)
Independent Sector Activity has been excluded

	FY2006/2007	FY2007/2008	FY2008/2009*
Regional Total	50.0	48.4	48.7

Trust	FY2006/2007	FY2007/2008	FY2008/2009*
Belfast Health and Social Care Trust	47.1	42.9	46.4
Northern Health and Social Care Trust	31.1	32.6	27.9
South Eastern Health and Social Care Trust	78.0	74.0	69.9
Southern Health and Social Care Trust	43.7	45.4	49.1
Western Health and Social Care Trust	47.1	51.3	42.2

Site	FY2006/2007	FY2007/2008	FY2008/2009*
Altnagelvin Hospitals	47.1	51.3	42.2
Belfast City Hospital	49.9	45.5	48.9
Causeway	31.1	32.6	27.9
Craigavon Area Hospital	43.7	45.4	49.1
Down and Lisburn	98.8	100.0	89.3
Mater Infirmorum Hospital	4.9	4.2	6.9
The Royal Group of Hospitals	100.0	100.0	100.0
Ulster Community and Hospitals	76.6	71.2	66.3

5.21 There is a significant variation in day case rates across the Trusts/hospitals, ranging from 30% in Northern to 70% in South Eastern. Some of this can be explained due to the variation in 'N' code work undertaken by Urologists as opposed to General Surgeons (see Chapter 2). Trusts have also reported that on some sites access to dedicated day surgery facilities is limited and that this hampers the development of short stay elective pathways.

5.22 The CSR (Comprehensive Spending Review) is driving Trusts to reduce inpatient costs and to redesign/remodel their bed stock. This along with day surgery targets in Priorities for Action and the HSC Board's Elective Reform Programme will require Urology services to be creative in the development of day and short stay surgery, ensuring the provision of a safe model of care that provides a quality service to patients.

5.23 Trusts will need to consider procedures currently undertaken using theatre/day surgery facilities and the appropriateness of transferring this work to procedure/treatment rooms, thereby freeing up valuable theatre space to accommodate increased day surgery. Some operations will require specialised equipment and training for clinicians and some require longer recovery or observation times and so are only possible as a true day case if performed on morning sessions. Therefore, the development and expansion of day surgery may require reconfiguration of day surgery/main theatre lists, redesign of clinical pathways and investment in appropriate equipment/technology.

Recommendation

15. Trusts will be required to include in their implementation plans, an action plan for increasing the percentage of elective operations undertaken as day surgery, redesigning their day surgery theatre facilities and should work with Urology Team in other Trusts to agree procedures for which day care will be the norm for elective surgery.

Outpatients

Table 10

Urology Outpatient Attendances - Consultant Led (06/07, 07/08, 08/09 - Apr 08 to Nov 08) - New : Review ratios

Independent Sector has been excluded

	FY2006/2007	FY2007/2008	FY2008/2009*
Regional new to review ratio	1.93	2.04	1.93

Trust	FY2006/2007	FY2007/2008	FY2008/2009*
Belfast Health and Social Care Trust	1.68	2.14	1.97
Northern Health and Social Care Trust	1.97	1.74	1.46
South Eastern Health and Social Care Trust	1.15	1.10	1.09
Southern Health and Social Care Trust	4.04	3.27	3.85
Western Health and Social Care Trust	2.34	2.21	2.78
Average new to review ratio	**1.93**	**2.04**	**1.93**

Site	FY2006/2007	FY2007/2008	FY2008/2009*
Altnagelvin Hospitals	2.34	2.21	2.78
Belfast City Hospital	1.84	2.90	2.44
Causeway	1.97	1.74	1.46
Craigavon Area Hospital	4.04	3.27	3.84
Down and Lisburn	1.06	1.18	1.24
Mater Infirmorum Hospital	1.63	1.11	1.47
The Royal Group of Hospitals	0.83	0.91	0.88
Ulster Community and Hospitals	1.19	1.07	1.01
Average new to review ratio	**1.93**	**2.04**	**1.93**

***Information for 08/09 is cumulative from 01/04/08 to 30/11/08**

5.24 Regionally, there is an average new: review ratio of 1:2, with little variation from year to year. English HES data for 2006/07 reports a 1:2.4 new: review ratio. Variations are to be expected between hospitals and individual Consultants when case mix and complexity are taken into account e.g. BCH, due to a more complex case mix and Lagan Valley/RGH due to the fact that only day surgery is undertaken on these sites.

5.25 Craigavon Hospital is an outlier with regard to review ratios, with Altnagelvin Hospital having the second highest ratio.

5.26 It is disappointing to note that at the time of this review Trusts have reported a total of 9,386 patients for whom the (intended) date of their review has past (some by many months). This is referred to as a review backlog and if most of these patients had been seen within the same 2008/09 timeframe for the data above, then the new: review ratios would have been higher, particularly in Belfast and Southern Trusts. (Backlog; Belfast 5,599, Southern 2,309, Northern 668, South Eastern 431, Western 379). All Trusts have submitted action plans to address the review backlog that has arisen across a number of specialties.

Recommendations

16.	Trusts should review their outpatient review practice, redesign other methods/staff where appropriate and subject to casemix/complexity issues reduce new:review ratios to the level of peer colleagues.

17.	Trusts must modernise and redesign outpatient clinic templates and admin/booking processes to ensure they maximise their capacity for new and review patients and to prevent backlogs occurring in the future.

6. CHALLENGES AND OPPORTUNITIES

6.1 At an early stage in the Review, an extensive round of meetings/discussion sessions were held with the various stakeholder organisations and staff to scope the challenges and opportunities of service delivery.

Challenges

6.2 A number of key themes were articulated and are summarised below:

- Increasing demand and workload pressures which were understood to be as a result of an ageing population along with people living longer, increased cancer detection and shorter waiting times arising from the elective access targets and cancer access standards, which is generating a previously unmet need in assessment and diagnostics.

- Capacity pressures (staffing), with a workforce struggling to cope with the increasing workload and meet the current targets and quality/clinical standards. This has resulted in significant reliance on independent sector and large numbers of additional clinics and theatre sessions being held internally. Both of these have been funded non-recurrently, year on year and are not sustainable in the future.

- Capacity pressures (infrastructure), on some sites, with regard to access to theatres and day surgery sessions which again results in transfer of work to independent sector. Access to elective Urology beds, in times of emergency admissions pressures, was also an issue for some sites.

- The challenges presented by the operation of 2 to 3 person Consultant teams outside of Belfast and the impact this has on on-call/cross cover arrangements, attraction and retention of clinical staff and the opportunity to develop sub specially interests and expertise. The size of the team is directly linked to its catchment population and the viability and sustainability of Urology services is dependent on a critical mass of work, of sufficient variety of conditions and treatments, to attract both training and substantive posts. The arrangements for the management and admission of acute Urological patients, particularly out of hours, in some Trusts, and the impact that the lack of such a service has on other sites was also raised as an issue.

- Impact of junior doctors hours, EWTD (European Working Time Directive) and in particular, changes to the training programme have resulted in a reduction in "the medical workforce", a shift from Consultant led services to Consultant delivered services and additional requirements on Consultants to directly provide and supervise training opportunities.

- Challenges around the cancer agenda and in particular, compliance with IOG (Improving Outcomes Guidance) and preparing for the Peer Review Exercise in 2010.

- Concerns were expressed about how service development tends to take place within and is restricted by Trust/Organisational boundaries. Also about inconsistent access/pathways for patients.

Opportunities

6.3 Within the various service and staff groups there was a strong desire and commitment to making significant improvements to Urology services in Northern Ireland.

6.4 There was general acceptance that additional investment was not the only solution: Making better use of the existing resources was also necessary and that the review of Urology services created significant opportunities to develop and re-design services, provide high quality, timely and cost effective services to patients and the community and to support and develop the individual and teams within this important specialty.

6.5 There was also a strong sense of wanting to do things differently and of the need to change and adapt to a changing landscape in terms of public expectations, targets and standards, changing pattern of disease and treatment, new technologies and techniques and employment and training legislation and entitlement.

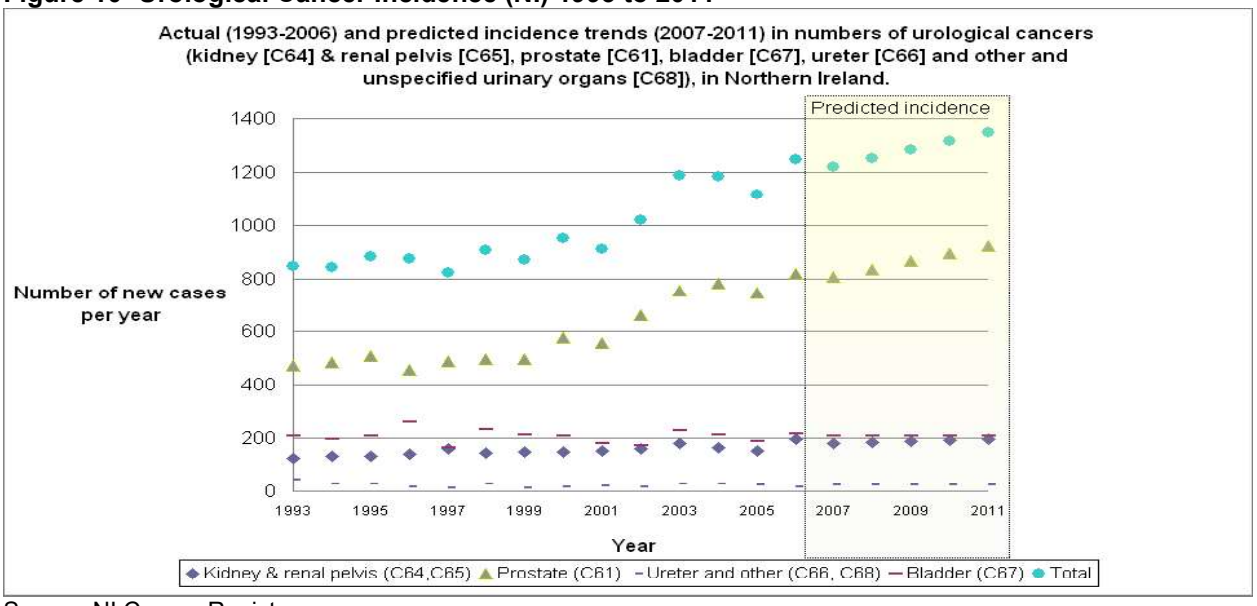
7. UROLOGICAL CANCERS

7.1 Around 40% of Urology work is cancer related and in addition to intensive assessment, diagnostics and treatment requirements, there is also a requirement for considerable patient follow-up, support and surveillance services. Cancer becomes more common with increasing age with almost 2 out of every 3 cancers diagnosed in people aged 65 and over.

7.2 Cancer of the prostate, testis, penis, kidney and bladder as a group has the highest volume of cancer incidence than any other specialty, with 1,246 incidence recorded on the cancer registry for 2007. The next highest is breast, followed by colorectal and lung.

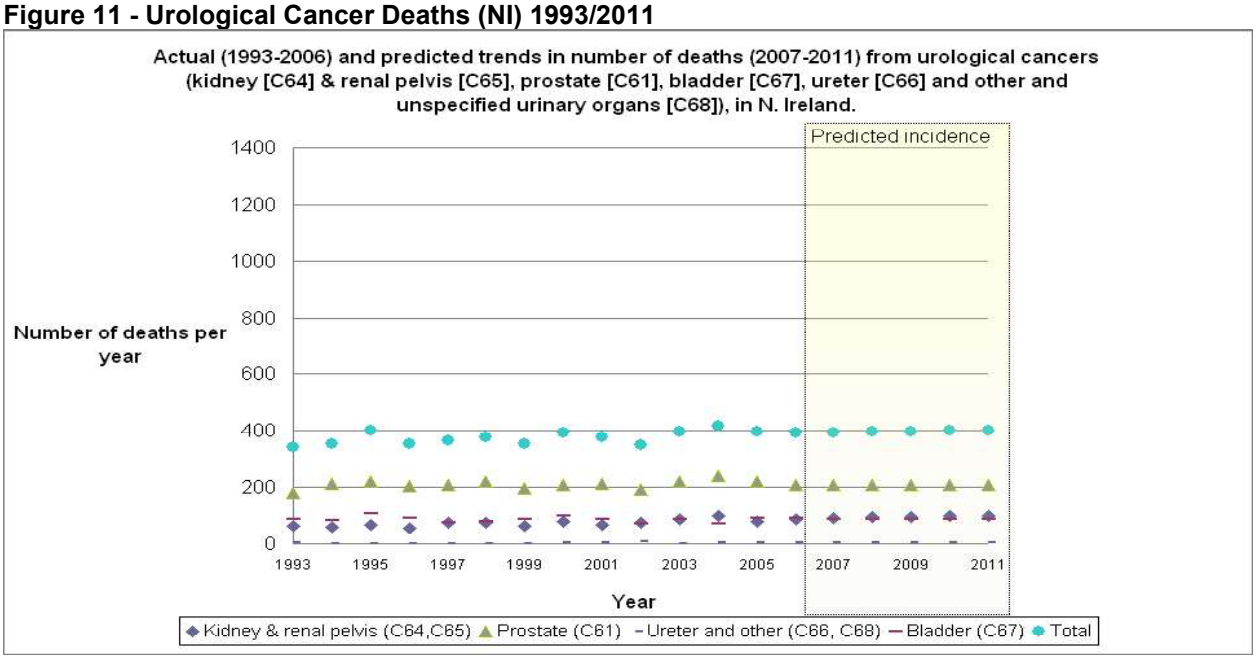
Cancer Incidence and Mortality

Figure 10- Urological Cancer Incidence (NI) 1993 to 2011



Source: NI Cancer Registry

Figure 11 - Urological Cancer Deaths (NI) 1993/2011



Source: NI Cancer Registry

7.3 Bladder and ureter incidence has been and is likely to remain stable (approximately 230).

7.4 Kidney cancer incidence has increased by almost 50% between 1993 and 2006 (196 in 2006), with a corresponding rise in deaths. By 2011, there could be further slight increases.

7.5 Prostate cancer incidence increased by 70% between 1993 and 2006 (817 in 2006). By 2011, it is predicted to increase by a further 20% compared with current incidence, but the number of deaths remains stable.

7.6 Prostate cancer is the second most frequently diagnosed cancer among men of all ages; testicular cancer, although relatively infrequent, is nevertheless the most common cancer in men under 45 years of age. Cancer of the penis, by contrast, is rare. Cancers of the kidney and bladder are roughly twice as common among men.

7.7 The main presenting symptoms of primary urological tumours fall into 3 groups:

- Lower urinary tract symptoms
- Haematuria and
- Suspicious lumps.

7.8 Haematuria is the most common symptom of both bladder and kidney cancer, although kidney cancer is often asymptomatic until it reaches a later stage.

7.9 Early, asymptomatic prostate cancer is being diagnosed more in recent years due to increase use of PSA testing and men's health awareness programmes.

Guidance and Standards

7.10 The NI Report "Cancer Services: Investing in the Future" (The Campbell Report) published in 1996 recommended that delivery of cancer services should be at three levels: Primary Care, Cancer Units and the Cancer Centre. The 2000 Review of Urological Services in Northern Ireland endorsed the principles of the Campbell Report and took account of them in their recommendations.

7.11 In 2002, NICE published guidance on cancer services-"Improving Outcomes in Urological Cancers-The Manual" (IOG).

7.12 The key recommendations from IOG are in Appendix 6. The recommendations relate to the requirement to have dedicated, specialist, multidisciplinary Urological cancer teams, making major improvements in information and support for patients and carers, with nurse specialist having a key role in these services, and having specific arrangements in place to undertake radical surgery for prostate and bladder cancer.

7.13 In 2008, under the auspices of NICaN (Northern Ireland Cancer Network) a new Urological tumour group was set up and has to date met on three occasions. Mr H Mullen chairs this group with Mr P Keane, Consultant Urologist, Belfast Trust, serving as the lead clinician. Mr Keane is also a member of the Review Steering

Group (as a NICAN lead) along with Dr D Hughes, NICaN Medical Director and Mrs B Tourish, NICaN, Clinical Network Co-ordinator.

7.14 The NICaN Group has agreed priority areas of work, based on IOG, including the development and implementation of formal dedicated MDTs / MDMs, implementing referral guidelines and agreed pathways for diagnostics and treatment of each of the cancers, developing patient information and guidance and ensuring suitable arrangements are in place prior to the Peer Review planned for 2010.

Recommendation

18.	The NICaN Group in conjunction with each Trust and Commissioners should develop and implement a clear action plan with timelines for the implementation of the new arrangements/enhanced services in working towards compliance with IOG.

7.15 A key element of IOG is the requirement to undertake radical pelvic surgery on a single site, serving a population of 1 million or more, in which a specialist team carries out a cumulative total of at least 50 such operations (prostatectomy (M61)and cystectomy (M34) per annum.

7.16 Tables 11 and 12 outline the number of radical pelvic operations carried out in 2006/07 and 2007/08 by Trust and Consultant.

Table 11 – Radical Pelvic Surgery 2006/07

Trust	Consultant	M34 Bladder	M61 Prostate	Total
BHSCT	Cons A	3	11	*14*
	Cons B	8	14	*22*
	Cons C	9	11	*20*
	Cons D	5	0	*5*
Total		**25**	**36**	***61***
SHSCT	Cons A	3	1	*4*
	Cons B	8	5	*13*
	Cons C	2	5	*7*
Total		**13**	**11**	***24***
WHSCT	Cons A	3	17	*20*
Total		**3**	**17**	***17***
Grand Total		**41**	**64**	***105***

Table 12 – Radical Pelvic Surgery 2007/08

Trust	Consultant	M34 Bladder	M61 Prostate	Total
BHSCT	Cons A	6	12	*18*
	Cons B	7	18	*25*
	Cons C	20	12	*32*
	Cons D	3	0	*3*
	Cons E	1	0	*1*
Total		**37**	**42**	***79***
SHSCT	Cons A	0	1	*1*
	Cons B	3	1	*4*
	Cons C	5	3	*8*
	Cons D	0	3	*3*
Total		**8**	**8**	***16***
WHSCT	Cons A	0	7	*7*
Total		**0**	**7**	***7***
Grand Total		**45**	**57**	***102***

7.17 The Northern and South Eastern Trust do not undertake such operations and patients requiring/choosing radical surgery are referred to BCH.

7.18 In 2007/08 77% of radical pelvic operations were undertaken in Belfast Trust (BCH). Neither the Southern or Western Trust (separately or together) undertake the required number (50) of such operations. Four of the existing Consultants undertake small (<5) numbers of each of the procedures. With a total of just over 100 procedures a year, a population less than 2 million and, with the potential for this activity to reduce with the implementation of a brachytherapy service in the next year, a single site for radical pelvic surgery is considered to be the appropriate way forward if IOG compliance is to be achieved.

Recommendations

19.	By March 2010, at the latest, all radical pelvic surgery should be undertaken on a single site, in BCH, by a specialist team of surgeons. The transfer of this work should be phased to enable BCH to appoint appropriate staff and ensure infrastructure and systems are in place. A phased implementation plan should be agreed with all parties.

20.	Trusts should ensure that surgeons carrying out small numbers (<5 per annum) of either radical pelvic operation, make arrangements to pass this work on to more specialised colleagues, as soon as is practicably possible, (whilst a single site service is being established).

8. CLINICAL WORKFORCE REQUIREMENTS

Consultant staffing

8.1 In 1996, BAUS (British Association of Urological Surgeons) recommended a Consultant: Population ratio of 1:80,000 by 2007. In 1999 the ratio in Northern Ireland was 1:167,000 population reducing to 1:103,000 population at the time of the review in 2009, with a funded establishment of 17 wte Consultants.

8.2 In the 2000 "Report of a working group on Urological Services in Northern Ireland" a ratio of 1:100,000 population was recommended due to Northern Ireland's younger age profile. BAUS had indicated that the demand for Urological Services is related to the age structure of the population and specifically with the proportion of 65 years.

8.3 In 1996, the percentage of those aged 65 years and over in Northern Ireland was 12.85% and at this time was considerably lower than in England (15.8%) and Wales (15.2%). By 2007 Northern Ireland's percentage of over 65 had risen to 14.1% and is predicted to rise further to 16.7% by 2018.

8.4 A total population of 1.76 million in 2008 and a Consultant to population ratio of 1:80,000, would equate to a funded establishment of 22 wte Consultant Urologists.

8.5 The NI Urology SAC (Specialist Advisory Committee), in estimating the number of higher specialist trainees required by 2018, have used a Consultant Urologist workforce of 38 wte by 2018. In projecting future staffing, SAC took account of "Developing a Modern Surgical Workforce" published by the Royal College of Surgeons in England (2005) and subsequent interim review of October 2006. The Royal College suggests that for a population of 1 million the requirement will be 8-9 specialist surgeons and 8-10 generalists.

8.6 Based on an average age of retirement of 60 years of age, the anticipated retirements in Urology between 2009 - 2018 is four. Taking this into account along with the Royal Colleges projected future staffing requirements, SAC have recommended an increase in the number of higher specialist trainees from the current 8 at ST3+ (year 3 and above) to up to 15 by 2018.

8.7 SAC have confirmed that they are content, at this time, with the Consultant to population ratio proposals within this review i.e. 1:80,000.

Consultant Programme

8.8 Guidelines for a Consultant job plan (agreed by the Royal College of Surgeons and adopted by the Association of Surgeons of Great Britain and Ireland) are based on a commitment of 10 notional half days.

8.9 The traditional Consultant contract has 6 + 1 (special interest) fixed sessions with 3 flexible sessions. BAUS Council recommend a 5 + 1 fixed session contract with 4 flexible sessions for Consultant Urologists.

"A Quality Urologist Service for Patients in the New Millennium - Guidelines on Workload, Manpower and Standards of Care" (BAUS 2000) recommends a typical job plan as outlined below:

Operating Theatre	3 NHD
Outpatient Clinics	2 NHD
Specialist Interest	1 NHD
Ward Round plus on-call	1 NHD
Post Graduate Education:	1NHD

To Include:

- Audit, teaching
- Pathology and X-ray meetings
- Clinical Governance
- Quality Assurance
- Mortality and Morbidity meetings

Flexible commitment	2 NHD

On-call rota 1:5

- *Special interest sessions may be used to provide additional operating, specific outpatient clinics, uro dynamics, lithotripsy or to supervise the research activities of the Department.*
- *Involvement in clinical management, audit and clinical governance will occupy significant clinical time and provision must be made for these activities within the job plan, as should participation in MDM's for all Urologists.*
- *Flexible sessions cover duties, which may be performed at different times, over different weeks and even sometimes outside standard working hours. These will include clinic administration, travel, inter-departmental referral and continuing clinical responsibility. They will also include time spent after operating sessions and clinics "tidying the desk", talking to patients relatives, visiting patients on the ward prior to operation, reviewing patient notes, results and ensuring that these are made known to patients and to the relevant medical practitioners.*

Workloads

8.10 Both BAUS and The Royal College of Surgeons outline similar workloads/activity that can be expected from a Consultant's working week, based on a 42 week working year.

8.11 **Outpatients (new and review) -** A Consultant working alone should see between 1176 and 1680 patients per annum. *Consultants with a major sub specialty interest e.g. oncology, will see significantly fewer patients due to case complexity and a need to allocate more time to each patient. Teaching, particularly under graduates and house officers, will also reduce the number of cases per clinic.*

8.12 To allow sufficient time for proper assessment and counselling, it is accepted practice to allow approximately 20 minutes for a new patient consultation and 10 minutes for a follow-up consultation. Therefore in a standard clinic an Urologist, working on his own should see 7 new patients and 7 follow-up patients. This can be

adjusted locally depending on case complexity up to a maximum of 20 patients (new and review) per clinic.

8.13 **In patient/day case activity -** *The average Consultant Urological Surgeon, and his team, should be performing between a 1000 and 1250 inpatient and day patient FCEs per annum. The exact number will depend on sub specialty interest, case mix, the number of operating sessions in the job plan and whether the Urologist has an obligation to train a specialist registrar. For example, some specialists in oncology, who perform lengthy complex procedures, would be expected to have fewer FCEs than their generalist counterparts.*

8.14 The activity analysis outlined in section 4 of the report outlines projected activity of 21,571 episodes in 2008/09. This figures includes in-house additional activity provided by Trusts but excludes activity sent out to the Independent Sector. With no further reduction in elective waiting times in 2009/10, it will be possible to make a more robust assessment of recurrent demand during the year.

8.15 The activity delivered by Trusts in 2008/09 equates to 21.5 wte consultant staff, taking account of the average workload figures above. However, due to complexity/casemix issues not all Consultants will perform the average number of FCEs. For example, with the creation of single site for radical pelvic surgery there will be a requirement for an additional Uro-oncology Consultant at the BCH.

Recommendation

21.	To deliver the level of activity from 2008/09 and address the issues around casemix and complexity it is recommended that the number of Consultant Urologists is increased to 23 wte.

8.16 This level of investment in staffing infrastructure will allow Urology services to be recurrently provided at 2008/09 outturn levels. In terms of future proofing, Trusts will be required to look at further efficiencies within existing capacity with a view to increasing the average workload per Consultant to the higher level in the context of changing demographics with an older population which will place additional demands on Urology services over the coming years. This is particularly relevant to the Northern and Southern Trusts where Consultant workloads are significantly below their peer colleagues and BAUS guidelines.

Recommendation

22.	Urology Teams must ensure that current capacity is optimised to deliver the number FCEs by Consultant as per BAUS guidelines (subject to casemix and complexity). This may require access to additional operating sessions up to at least 4 per week (42 weeks per year) and an amendment to job plans.

Nurse Staffing

8.17 The additional nursing and support staff requirements to support the additional clinics and theatre sessions that will be implemented with the appointment of new Consultants are included in the estimated costing in Appendix 7.

8.18 To ensure high quality nursing services and effective and efficient use of highly specialised equipment and instruments it is essential that nurses working in Urology wards, theatres and other departments are fully trained and competent in the field of Urology.

8.19 Specialist nurses and practitioners have a key and expanding role to play in a modern Urology Service. There are many examples of nurses, within and outwith ICATS teams, undertaking assessment, diagnostic, treatment and follow-up of areas of Urology such as erectile dysfunction, LUTS (Lower Urinary Tract Symptoms), haematuria clinics, stones etc.

8.20 Specialist (Uro-Oncology) nurses must be dedicated, fully participating members of any cancer MDT, actively represent the patient's interests at MDM's and have a key role to play in carrying out detailed assessment of patients needs in order to provide, or coordinate good care. They have a particular role to play at "results" clinics and in assisting patients and carers in making informed decisions and choices regarding treatment options, the management of and living with the symptoms and consequences of their cancer and the treatments/interventions.

8.21 Under the auspices of NICaN, in collaboration with the senior nurses for cancer services across the Northern Ireland and English networks, a number of cancer site specific, clinical nurse specialist benchmarking censuses have been completed. There are a total of 12 specialist nurses in Urology in Northern Ireland at this time. However, few of these staff are solely dedicated to cancer care and therefore an estimate of the wte (whole time equivalent) has been made. In November 2008 there were estimated to be 4 wte oncology nurse specialists -1.5 in BCH, 2 in Altnagelvin and .5 in the Ulster.

8.22 Table 13 below outlines the results of a benchmarking exercise completed in November 2008, in which each of the cancer networks identified the incidence of cancer and calculated an average caseload per Clinical Nurse Specialist (CNS).

Table 13 - CNS caseload benchmarking data

	Lung	Breast	Urology	Colo-rectal	Gynae	Upper GI	Haem	Skin	Head & Neck	Brain
Cancer incidence	845	1,031	1,246	995	450	562	411	208	127	109
Total no CNS in post 2008	7.5	14	4	3	2	1	3	3	2	1
NI mean caseload	112	73	311	331	225	562	137		63	109
England mean caseload	122	81	131	89	77	98	70		66	81
Additional nos needed	3	2	5	4	4	3.5	5	1	2.5	1
Future NI mean caseload	80	64	138	142	75	125	52		51	54.5

8.23 There are higher numbers of Urological cancer incidences than in any other speciality and these CNSs have the third highest (upper GI is the highest at 562) mean caseload at 311, which is more than double the English mean caseload.

8.24 This shortfall will need to be addressed if significant improvements are to be made in the cancer pathways, waiting times, support and follow-up for Urology patients in Northern Ireland.

Recommendation

23.	At least 5 Clinical Nurse Specialists (cancer) should be appointed (and trained). The deployment of these staff within particular teams will need to be decided and Trusts will be required to develop detailed job plans with caseload, activity and measurable outcomes agreed prior to implementation. A further review and benchmarking of cancer CNSs should be undertaken in mid 2010.

Radiology Staffing

8.25 The assessment and diagnostics of Urological diseases/conditions involves intensive and high volumes of radiology services across a broad range of modalities-ultrasound (KUB, TRUS), IVP, CT and MRI scans, along with the provision of an interventional radiology service. As Urology services are redesigned and streamlined, radiology services will be required to respond and adapt to the new service models and pathways and in particular accommodate more single visit haematuria, LUTS, prostate and stones clinic.

8.26 In addition to any further investment, radiology services will be required to ensure optimum and enhanced use of current available capacity by modernising and reforming the systems and processes currently in place.

8.27 In recognition of the significant capacity gap in Urology to meet the growing demand, a number of additional Consultants will be appointed and a significant number of additional patients will need to be assessed and treated internally. Additional radiology staffing to support these appointments (included in the estimated costs in Appendix 7) has been calculated using the Adenbrookes formula of .3 wte Consultant Radiologist per wte Consultant Urologist and a ratio of 6 wte band 5 Radiographers per wte Radiologist.

Pathology and Radiotherapy Services

8.28 It is recognised with the volumes of Urological cancers, the Urology service is a high user of both pathology and radiotherapy services. However, given the work being undertaken by NICaN, within the Cancer Services Framework and the supporting cancer investment plan, and the Pathology Services Review, published in December 2007, it was agreed that the current Urology review would not include a detailed assessment of these services. Investment in an additional band 7, BMS is however included in the estimated costs in appendix 7, in recognition of the increased diagnostic workload associated with growing PSA work and the centralisation of radical pelvic surgery on the BCH site.

9. SERVICE CONFIGURATION MODEL

9.1 In section 6 the key challenges currently being faced by the service were outlined. In summary, these related to the capacity to deliver a modern, quality service and the ability to achieve and sustain long term stability and viability, with a stable workforce that can continue to attract the necessary expertise across all of the professions.

9.2 It has been recognised that investment in additional capacity and staff will not on its own resolve the challenges relating to long term service stability. This will require a reconfiguration of teams/services into more sustainable units thus enabling the service to make the best use of any investment made.

9.3 A number of models (6) for future service delivery were developed. These ranged from 5 teams in NI, with each Trust having its own discrete urology service and its staffing and workload based on its current catchment population, to 2 teams in NI.

9.4 A sub group of clinicians, Trust and Board Managers developed criteria and a weighted scoring system against which each of the models could be assessed. The 5 criteria (Appendix 8) were:

- Service stability/sustainability (population, team size, dedicated skilled radiology and nursing staff, rotas and EWTD.
- Feasibility (ease and speed of implementation).
- Compliance with DHSSPS policy/strategy, commissioner intent/support, compatibility with Trusts strategic development plans and impact on other services.
- Inpatient accessibility.
- Organisational complexity.

9.5 At the Steering Group meeting on 20 January 2009, each of the 6 models was evaluated against the agreed criteria. Model 3 (Appendix 9) was agreed as the preferred model and was deemed to be the most appropriate way forward for urology services.

Recommendation

24.	Urology services in Northern Ireland should be reconfigured into a 3 team model, to achieve long term stability and viability.

9.6 Model 3 comprises 3 teams, which for ease of description are called Team North, Team South and Team East. Table 14 below outlines the main elements of each of these teams.

Teams	Geographical Area/ Catchment Population	Consultant Staffing/Suggested Special Interest Areas**	Arrangements for Elective and Non Elective Services
Team North	Upper2/3rd of Northern* and Western integrate to form one Team/Network. Catchment population circa 480,000	Six wte All core Urology Uro-oncology – 2 Stones/endourology – 2* Functional/female Urology – 1 Andrology – 1	One on-call rota (1:6). One local MDT/MDM.*** Main acute elective and non elective inpatient unit in Altnagelvin Approximately 7 elective beds in Causeway(Selected minor/intermediate cases) Day surgery – Altnagelvin, Causeway, Tyrone County Outpatients – Altnagelvin, Causeway, Tyrone County, Roe Valley May wish to consider outreach outpatient and/or day case diagnostics in Mid-Ulster *Mobile ESWL (Lithotripter) on Causeway site
Team South	Lower 1/3rd Western (Fermanagh) and all of Southern integrate to form one Team/Network. Catchment population circa 410,000	Five wte All core Urology Uro-oncology – 2 Stones/endourology – 2* Functional/female Urology – 1	One on-call rota (1:5). One local MDT/MDM.*** Main acute elective and non elective inpatient unit in Craigavon Day surgery – Craigavon, South Tyrone, Daisy Hill Outpatients – Craigavon, South Tyrone, Daisy Hill, Banbridge, Armagh May wish to consider outreach outpatients and/or day case diagnostics in Erne/ Enniskillen *Static/fixed ESWL (lithotripter) on Craigavon site.
Team East	SET + Belfast integrate to form one Team/Network-continue to provide service to patients from Southern sector of Northern Trust (Newtownabbey, Carrickfergus, Larne, ?Antrim). Catchment population circa 870,000 Complex cancer catchment 1.76m	Twelve Wte All core Urology Uro-oncology/cancer centre – 4 Stones/endourology – 3* Functional/female Urology – 2 Reconstruction – 3	One on-call rota (1:12) (may wish to consider 2nd tier on-call). One local MDT/MDM plus regional/specialist MDM.*** Main acute elective and non elective unit in BCH, with elective also in Mater and Ulster Day surgery – BCH, Mater, Lagan Valley, Ards, Downe Outpatients – BCH, Ulster, Mater, Royal, MPH, Ards, Lagan Valley, Downe Should provide outreach outpatient, day case diagnostics and day surgery in Antrim and/or Whiteabbey/Larne *Mobile ESWL lithotripter on BCH site.

Table 14 Elements and Arrangements in Three Team Model

*Population estimates for local District Council areas in Appendix 10. Precise catchment 'lines' on map to be clarified.

** Suggested special interest areas derived from discussions with clinicians and from BAUS guidelines.

*** MDM reconfiguration has been approved by NICaN Group

9.7 In response to concerns expressed at the Steering Group Meeting in January 2009, Speciality Advisor (local and 'Island of Ireland') advice was sought around the issue of a single handed Consultant doing on-call from home covering elective and non elective patients on different sites. The advice has confirmed that such arrangements are possible and that a similar situation exists in other specialties e.g. Trauma and Orthopaedics.

9.8 Urologists have advised that there are very few occasions when a Consultant's presence is required, out of hours, to deal with an elective post operative complication/event. Equally, as described in the previous section of this report, the vast majority of non elective admissions, out of hours, do not require a Consultant's intervention. However, surgeons undertaking elective inpatient surgery on a site other than the main acute unit should use morning lists so as to further ameliorate the impact of out of hour's events. They can minimise the impact further through careful choice of the nature and type of surgery undertaken.

Recommendations

25.	Teams North and East (Northern, Western, Belfast and South Eastern Trusts) should ensure that prior to the creation of the new Teams, there are clear, unambiguous and agreed arrangements in place with regard to Consultant on-call and out of hours arrangements.

26	Each Trust must work in partnership with the other Trust/s within the new team structure to determine and agree the new arrangements for service delivery, including inter alia, governance, employment and contractual arrangements for clinical staff, locations, frequency and prioritisation of outreach services, areas of Consultant specialist interest based on capacity and expertise required and catchment populations to be served.

10. IMPLEMENTATION ISSUES

10.1 To implement the review recommendations a recurrent (full year) investment of £2.875m has been estimated (Appendix 7). Commissioners will need to consider the method of allocating funding to support the full implementation of the recommendations, particularly with regard to aligning the allocation to the additional Consultant distribution profile.

10.2 Trusts and Commissioners will need to take forward discussions with General Practitioners around referral pathways and patient flows in the context of the proposed three team model.

10.3 Trusts will be required to submit detailed business cases prior to funding being released.

10.4 Trusts and Commissioners will need to agree timescales and the measurable outcomes in terms of additional activity, improved performance, a phased reduction in Independent Sector usage and service reform and modernisation plans.

10.5 The implementation of the recommendations of the review may/ will require capital investment to put in place additional physical infrastructure such and to fund equipment associated with technologically driven sub-specialty areas. e.g. endo-urology, reconstruction, laser surgery. Where capital requirements are identified, Trusts should process these bids through their normal capital and business planning cycle.

10.6 The new Teams (Trust partnerships) will be required to submit project plans for implementation of the new arrangements which is envisaged to be on a phased and managed basis. The new Health and Social Care Board will establish an Implementation Board to oversee the process.

GLOSSARY OF TERMS/ABBREVIATIONS

BADS- British Association of Day Surgery

BPH – Benign Prostatic Hyperplasia
A non –cancerous condition in which an overgrowth of *prostate* tissue pushes against the *urethra* and the bladder, restricting or blocking the normal flow of urine. Also known as benign prostatic hypertrophy. This condition is increasingly common in older men.

Biopsy
Removal of a sample of tissue or cells from the body to assist in diagnosis of a disease.

Bladder reconstruction
A surgical procedure to form a storage place for urine following a *cystectomy*. Usually, a piece of bowel is removed and is formed into a balloon-shaped sac, which is stitched to the *ureters* and the top of the urethra. This allows urine to be passed in the usual way.

Brachytherapy
Radiotherapy delivered within an organ such as the prostate.

CNS
Clinical Nurse Specialist

Cystectomy
Surgery to remove all or part of the bladder.

Cystoscope
A thin, lighted instrument used to look inside the bladder and remove tissue samples or small tumours.

Cystoscopy
Examination of the bladder and *urethra* using a *cystoscope*.

ED
Erectile dysfunction

EWTD
European Working Time Directive

Genital
Referring to the external sex or reproductive organs.

Haematuria
The presence of blood in the urine. Macroscopic haematuria is visible to the naked eye, whilst microscopic haematuria is only visible with the aid of a microscope.

HES/Hospital Episode Statistics
HES is the national statistical data warehouse for England of the care provided by NHS hospitals and NHS hospital patients treated elsewhere.

Incontinence
Inability to control the flow of urine from the bladder (urinary) or the escape of stool from the rectum (faecal)

IVP – Intravenous Pyelogram
An x-ray examination of the kidneys, ureters and urinary bladder that uses iodinated contrast material injected into veins.

KUB
Kidney, Ureter, Bladder (Ultrasound)

Laparascopic surgery
Surgery performed using a laparascope; a special type of endoscope inserted through a small incision in the abdominal wall.

LUTS
Lower Urinary Tract Symptoms

MRI - Magnetic resonance imaging
A non-invasive method of imaging which allows the form and metabolism of tissues and organs to be visualised (also known as nuclear magnetic resonance).

MDMs
Mutli-disciplinary meetings

MDTs
Mutli-disciplinary teams

NICaN
Northern Ireland Cancer Network

Oncology
The study of the biology and physical and chemical features of cancers. Also the study of the causes and treatment of cancers.

Prostatectomy
Surgery to remove part, or all of the *prostate gland*. Radical prostatectomy is the removal of the entire *prostate gland* and some of the surrounding tissue.

Prostate gland
A small gland found only in men which surrounds part of the urethra. The prostate produces semen and a protein called *prostate specific antigen (PSA)* which turns the semen into liquid. The gland is surrounded by a sheet of muscle and a fibrous capsule. The growth of prostate cells and the way the prostate gland works is dependent on the male hormone *testosterone*.

PSA – Prostate Specific Antigen
A protein produced by the *prostate gland* which turns semen into liquid. Men with prostate cancer tend to have higher levels of PSA in their blood (although up to 30% of men with prostate cancer have normal PSA levels). However, PSA levels may also be increased by conditions other than cancer and levels tend to increase naturally with age.

Radical treatment
Treatment given with curative, rather than *palliative* intent.

Radiologist
A doctor who specialises in creating and interpreting pictures of areas inside the body. The pictures are produced with x-rays, sound waves, or other types of energy.

Radiotherapy
The use of radiation, usually x-rays or gamma rays, to kill tumour cells. Conventional external beam radiotherapy also affects some normal tissue outside the target area. Conformal radiotherapy aims to reduce the amount of normal tissue that is irradiated by shaping the x-ray beam more precisely. The beam can be altered by placing metal blocks in its path or by using a device called a multi-leaf collimator. This consists of a number of layers of metal sheets which are attached to the radiotherapy machine; each layer can be adjusted to alter the shape and intensity of the beam.

Renal
Of or pertaining to the Kidneys.

Resection
The surgical removal of all or part of an organ.

Scrotum
The external sac that contains the testicles.

Testicle or testis (plural testes)
Egg shaped glands found inside the scrotum which produce sperm and male hormones.

TRUS Tran-rectal ultrasound (TRUS)
An *ultrasound* examination of the prostate using a probe inserted into the rectum.

Trans-uretharal resection (TUR)
Surgery performed with a special instrument inserted through the urethra.

Trans-urethral resection of the prostate (TURP)
Surgery to remove tissue from the prostate using an instrument inserted through the urethra. Used to remove part of the tumour which is blocking the urethra.

Ultrasound
High-frequency sound waves used to create images of structures and organs within the body.

Ureters
Tubes which carry urine from the kidneys to the bladder.

Urethra
The tube leading from the bladder through which urine leaves the body.

Urogenital system
The organs concerned in the production and excretion of urine, together with the organs of reproduction.

Urologist
A doctor who specialises in diseases of the urinary organs in females and urinary and sex organs in males.

Urology
A branch of medicine concerned with the diagnosis and treatment of diseases of the urinary organs in females and the urogenital system in males.

Uro-oncologist
A doctor who specialises in the treatment of cancers of the urinary organs in females and urinary and sex organs in males.

Vasectomy
Surgery to cut or tie off the two tubes that carry sperm out of the *testicles*.

WTE
Whole Time Equivalent

APPENDICES

Appendix 1

Regional Urology Steering Group

Membership

Mr Hugh Mullen (Chair)	SDU, Director of Performance and Provider Development
Mr Mark Fordham	External Advisor, Consultant Urologist
Ms Catherine McNicholl	SDU, Programme Director (Project Manager)
Mr Paul Cunningham	SDU, Performance Manager
Dr Hubert Curran	SDU, Primary Care Advisor
Dr Windsor Murdock	SDU, Primary Care Advisor
Dr Miriam McCarthy	DHSS&PS, Director Secondary Care
Dr Dermot Hughes	NICaN, Medical Director
Mr Patrick Keane	Belfast Trust, Lead Clinician NICaN Urology Group
Dr Diane Corrigan	SHSSB, Consultant Public Health
Dr Janet Little	EHSSB, Acting Director Public Health
Dr Christine McMaster	EHSSB, Specialist Registrar, Public Health
Dr Adrian Mairs	NHSSB, Consultant Public Health
Mr Alan Marsden	NHSSB, Elective Care Commissioning Manager.
Dr Bill McConnell	WHSSB, Director Public Health
Mrs Rosa McCandless	WHSSB, Information Manager
Mrs Karen Hargan	Western Trust, Assistant Director Surgery/Acute Services
Mr Colin Mulholland	Western Trust, Consultant Urologist
Ms Carmel Leonard	Western Trust, Lead Nurse Surgery
Mr Paul Downey	Northern Trust, Consultant Urologist
Mr Martin Sloan	Northern Trust, Director Elective and

	Acute Services
Dr Brian Armstrong	Belfast Trust, Co-Director Specialist Services
Mr Chris Hagan	Belfast Trust, Consultant Urologist
Mr Brian Duggan	Belfast Trust, Consultant Urologist
Mr Brian Best	South Eastern Trust, Consultant Urologist
Mr John McKnight	South Eastern Trust, Consultant Urologist
Mrs Diane Keown	South Eastern Trust, Assistant Director Surgery.
Ms Joy Youart	Southern Trust, Acting Director Acute Services
Mr Michael Young	Southern Trust, Consultant Urologist
Mrs Jenny McMahon	Southern Trust, Nurse Specialist.

Appendix 2

Regional Review of Adult Urology Services

Terms of Reference

Overall Purpose

To develop a modern, fit for purpose in the 21st century, reformed service model for Adult Urology services which takes account of relevant Guidelines (NICE, Good Practice, Royal College, BAUS, BAUN). The future model should ensure quality services are provided in the right place, at the right time by the most appropriate clinician, through the entire pathway from Primary Care to Intermediate to Secondary and Tertiary Care.

It is anticipated that the Review Report will be available for submission to the Department in December 08, subject to Steering Group approval. A multi-disciplinary, key stakeholder Steering Group, chaired by Mr Hugh Mullen will meet to consider and approve the review findings and proposals.

The Review will include the following;

1. Baseline assessment of current service model identifying what is provided where, by whom, performance against access standards and the current profile of investment.

2. Expand on the current capacity/demand modelling exercise to take account of case mix with a view to identifying capacity gaps and informing future investment plans.

3. Develop a service model with agreed patient pathways which informs the distribution of services. The model will also outline proposals for optimising safe, effective and efficient Urology services which meet both access and quality standards/outcomes. The following aspects of the service will be considered;

    - Management of referrals and diagnostics including urodynamics.
    - Development and use of ICATS services
    - Management of acute urological admissions
    - Core Urology (secondary care) Services
    - Andrology Services
    - Interventional Uro-Radiology
    - Endourology/Stone Service
    - Uro-oncology Services
    - Relationship with Uro-gynaecology Services
    - Reconstruction and Neurourology Service
    - Acute Urological management of nephrology patient

4. Make recommendations, as appropriate, on the relationship with the Transplant service and waiting time targets for live donor transplantations.

5. Review workforce planning and training / development needs of the service group and ensure any proposals take account of the need to comply with EWTD (European Working Time Directive.

Appendix 3

UROLOGY REPORTS/ REVIEWS

Northern Ireland Review Reports

Report of the EHSSB Sub Group on Urological Cancer	Sept 1997
Report of the Working Group on Urology Services in Northern Ireland	May 2000
Update on Urology Cancer Services in the EHSSB	Oct 2001
External Review of Urology Services for Craigavon Area Hospital Group	Aug 2004
Draft Service Framework for Cancer Prevention, Treatment and Care – (Urology section)	Version 7 June 2008

National Reports

BAUS – A Quality Urological Service for Patients in the New Millennium	Oct 2000
BAUS – The Provision of Urology Services in the UK	Feb 2002
NICE – (Guidance on Cancer Services) Improving outcomes in Urological Cancers	Sept 2002
Modernisation Agency – Action on Urology – Good Practice Guide	Mar 2005
Providing Care for Patients with Urological Conditions: guidance and resources for commissioners (NHS)	2008
NICE – Urinary Incontinence: the management of urinary incontinence in women	2006
NICE – Prostate Cancer: diagnosis and treatment	2008
NICE – (Urological) Referral guidelines for suspected cancer	2005

Appendix 4

GP REFERRAL EXERCISE - PERCENTAGES

Gender	Belfast	Northern	Western	Southern	SE	Regional Average
Male	77	74	76	79	75	**76**
Female	23	25	22	21	25	**23**
Blank	0	2	2	0	0	**1**
Total	**100**	**100**	**100**	**100**	**100**	**100**
Age Range	**Belfast**	**Northern**	**Western**	**Southern**	**SE**	**Regional Average**
0-14	1	0	0	2	0	**1**
15-30	12	8	11	6	10	**10**
31-40	13	8	11	15	5	**11**
41-50	20	17	9	13	7	**15**
51-60	13	25	20	11	5	**14**
60+	41	42	49	53	12	**38**
Blank	0	2	0	0	60*	**12**
Total	**100**	**100**	**100**	**100**	**100**	**100**
Urgency	**Belfast**	**Northern**	**Western**	**Southern**	**SE**	**Regional Average**
Red Flag	4	4	7	6	5	**5**
Urgent	21	21	22	19	16	**20**
Routine	75	75	71	75	78	**75**
Blank	0	0	0	0	0	**0**
Total	**100**	**100**	**100**	**100**	**100**	**100**
Named Cons	**Belfast**	**Northern**	**Western**	**Southern**	**SE**	**Regional Average**
Y	24	25	13	23	21	22
N	76	75	87	77	79	78
Total	**100**	**100**	**100**	**100**	**100**	**100**
Ref Source	**Belfast**	**Northern**	**Western**	**Southern**	**SE**	**Regional Average**
Non-GP ref's	10	23	2	9	19	**13**
GP Ref's	90	77	96	91	81	**87**
Blank	0	0	2	0	0	**0**
Total	**100**	**100**	**100**	**100**	**100**	**100**

* 44 out of 73 referrals in SET had DOB deleted-therefore not possible to record age range.

Appendix 5

GP REFERRAL EXERCISE – PRESENTING SYMPTOMS (PERCENTAGES)

Presenting Symptom/Condition		Belfast		Northern		Western		Southern		SE		Regional	
Haematuria (ALL)		**13**		**19**		**22**		**9**		**16**		**15**	
	frank		*58*		*30*		*40*		*40*		*50*		*46*
	microscopic		*32*		*50*		*60*		*40*		*50*		*45*
	blank		*11*		*20*		*0*		*20*		*0*		*9*
Prostate/raised PSA		**10**		**13**		**18**		**17**		**16**		**14**	
Other		**15**		**8**		**11**		**15**		**11**		**13**	
Ncode procedure (All)		**15**		**4**		**2**		**6**		**19**		**11**	
	vasectomy		*52*		*0*		*100*		*33*		***29***		***41***
	foreskin		*5*		*0*		*0*		*67*		***50***		***24***
	epididymal cyst		*14*		*100*		*0*		*0*		***21***		***20***
	hydrocele		*19*		*0*		*0*		*0*		***0***		***10***
	varicocele		*5*		*0*		*0*		*0*		***0***		***2***
	blank		*5*		*0*		*0*		*0*		***0***		***2***
Recurrent UTI's		**12**		**17**		**9**		**11**		**5**		**11**	
LUTS		**8**		**13**		**4**		**9**		**10**		**9**	
Prostate/BPH/prostatitis		**8**		**9**		**9**		**11**		**3**		**8**	
Renal stones/colic/loin pain		**8**		**9**		**2**		**4**		**5**		**6**	
Testicular/ Scrotal lumps or swelling		**6**		**0**		**11**		**0**		**11**		**6**	
Andrology (ALL)		**5**		**4**		**7**		**11**		**3**		**5**	
	erectile dysfunction		*29*		*100*		*0*		*50*		*50*		*40*
	peyronie's disease		*29*		*0*		*67*		*0*		*0*		*20*
	blood in ejaculate		*43*		*0*		*0*		*0*		*0*		*15*
	ulcer/lesion on gland		*0*		*0*		*33*		*17*		*0*		*10*
	balanitis/discharge		*0*		*0*		*0*		*33*		*0*		*10*
	blank		*0*		*0*		*0*		*0*		*50*		*5*
Unknown		**2**		**2**		**2**		**4**		**0**		**2**	
Ca Bladder/Kidney		**1**		**2**		**0**		**2**		**0**		**1**	
Blank		**0**		**0**		**2**		**0**		**0**		**0**	
Total		**100**		**100**		**100**		**100**		**100**		**100**	

Appendix 6

NICE – Improving outcomes in Urological Cancers (IOG) – The Manual (2002)

Key Recommendations

The key recommendations highlight the main organisational issues specific to urological cancers that are central to implementing the guidance. As such, they may involve major changes to current practice.

- All patients with Urological cancers should be managed by multidisciplinary Urological cancer teams. These teams should function in the context of dedicated specialist services, with working arrangements and protocols agreed throughout each cancer network. Patients should be specifically assured of:
    - Streamlined services, designed to minimise delays;
    - Balanced information about management options for their condition;
    - Improved management for progressive and recurrent disease.
- Members of Urological cancer teams should have specialised skills appropriate for their roles at each level of the service. Within each network, multidisciplinary teams should be formed in local hospitals (cancer units); at cancer centres, with the possibility in larger networks of additional specialist teams serving populations of at least one million; and at supra-network level to provide specialist management for some male genital cancers.
- Radical surgery for prostate and bladder cancer should be provided by teams typically serving populations of one million or more and carrying out a cumulative total of at least 50 such operations per annum. Whilst these teams are being established, surgeons carrying out small numbers (five or fewer per annum) of either operation should make arrangements within their network to pass this work on to more specialist colleagues.
- Major improvements are required on information and support services for patients and carers. Nurse specialist members of urological cancer teams will have key roles in these services.
- There are many areas of uncertainty about the optimum form of treatment for patients with urological cancers. High-quality research studies should be supported, with encouragement of greater rates of participation in clinical trials.

Appendix 7

Estimated Cost of Implementation of Recommendations.

Staffing	Number	Band/Grade	Unit Cost	Total
Consultant Urologist	6	Consultant	£104,000	£624,000
Consultant Anaesthetist @ 0.6 wte per Con. Urologist	3.6	Consultant	£104,000	£374,400
Consultant Radiologist @ 0.3 wte per Con. Urologist	1.8	Consultant	£104,000	£187,200
Radiographer @ 6 per wte Con Radiologist	10.8	Band 5	£27,995	£302,346
Nursing @ 1.8 wte per Con. Urologist	10.8	Band 5	£27,995	£302,346
Nursing @ 0.46 wte per Con. Urologist	2.7	Band 3	£19,856	£53,611
Specialist Nursing	5	Band 7	£41,442	£207,210
Nursing @ 0.64 wte (day surgery)	0.64	Band 5	£27,995	£17,917
Pers. Secretary @ 0.5 wte per consultant urologists	3	Band 4	£23,265	£69,795
Admin support to radiologists at 0.5 wte per Radiologist	1	Band 3	£19,856	£19,856
Admin Support to Specialist Nurses @ 0.5 wte per Nurse	3	Band 3	£19,856	£59,568
Medical Records support 0.5 per unit	2.5	Band 4	£23,265	£58,162
MLSO – Bio-medical Science	1	Band 7	£41,442	£41,442
Support Costs				
Surgical G&S @ £94,500 per Con. Urologist	X 6		£95,400	£567,000
Theatre Goods/Disposables @ £50,000 per Con.Urologist	X 6		£50,000	£300,000
Radiology G&S per Con. Urologist	X 6		£2,500	£15,000
CSSD @ £32,000 per Con. Urologist	X 6		£32,000	£192,000
Outpatients Clinics @ 2 per Con. Urologist	X 12		£10,000	£120,000
Sub Total				**£3,511,853**
Less Consultant funded in 2008				**(£437,076)**
Sub Total				**£3,074,777**
Less 2008/09 Cancer Funds				**(£200,000)**
FINAL TOTAL				**£2,874,777**

Appendix 8

Evaluation Criteria

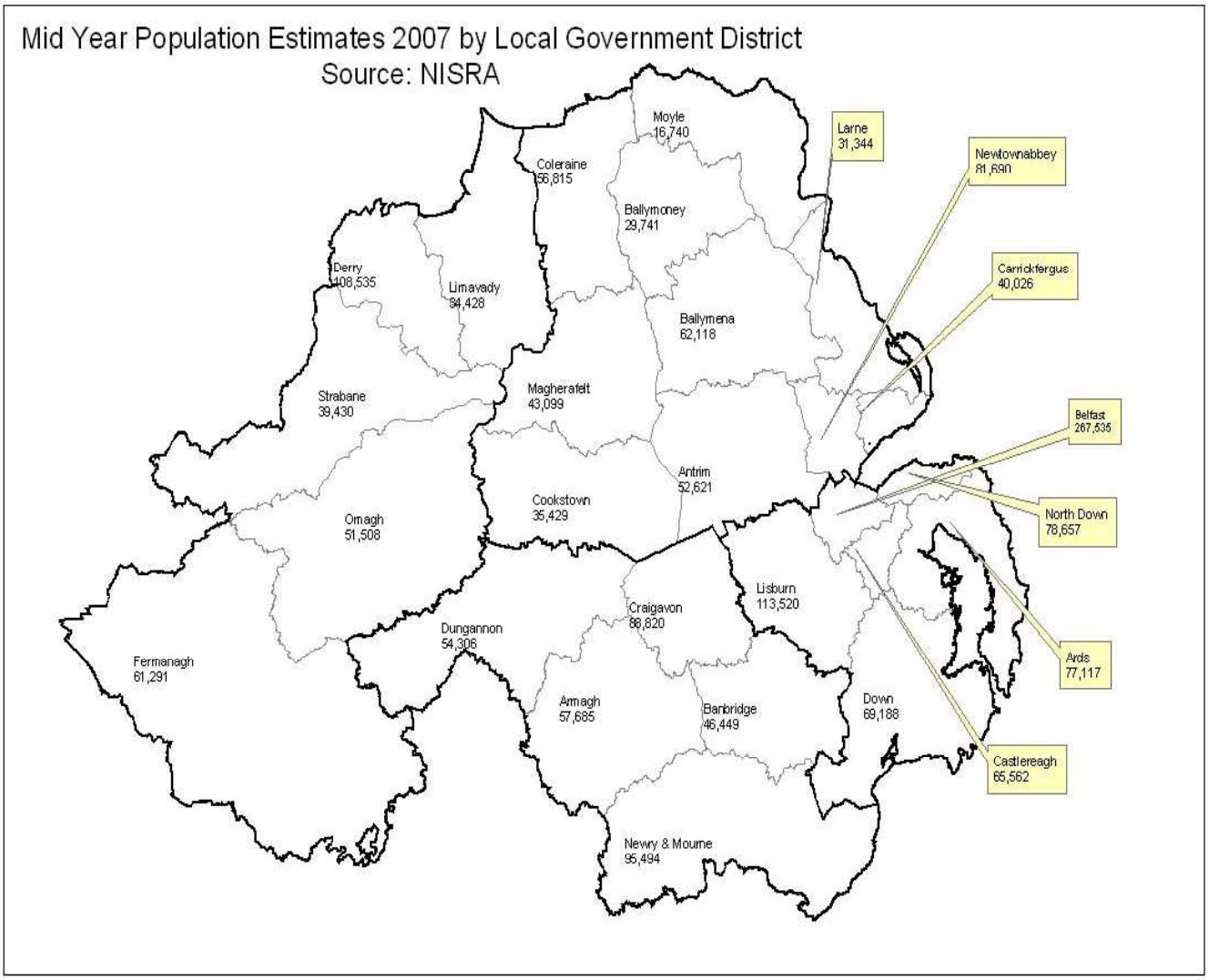
Criteria	Definitions
1. Service Stability / Sustainability	This is the criterion of the highest priority/value. The long term stability and hence viability and success of the service depends on a stable workforce – a workforce that can develop the service further and continue to attract the necessary expertise across all its professions. The criterion is sub-divided into four closely related sub-categories. a. Population – smaller catchment populations restrict the generation of a critical mass of work (cancer and non cancer). Using BAUS recommendations of 1 consultant per 80,000, each team should serve a catchment population of no less than 400,000. b. Team Size – A team of at least five to six consultants is preferred. This will improve long term attractiveness of each team in terms of recruitment and retention. It will also enable at least 2-3 to sub specialise, with dedicated sessions in the sub specialty e.g. uro-oncology, endourology/stones, female urology c. On site interventional radiology and trained urological nursing – These are key quality aspects. On site radiology to ensure timely access to interventions for emergency and urgent cases and sufficient total activity to justify 24 hour urology nursing experience in wards and theatres. This is to enhance multi-disciplinary working and support the development of nurse-led services. d. Commitment to Rotas and Working Time Directive – The service must be capable of sustaining adequate and acceptable on-call arrangements (elective and emergency), compliance with EWTD and equitable provision of emergency care.
2. Feasibility (ease and speed of implementation)	This criterion concerns the need to maximise the use of existing capital infrastructure (beds, theatres, equipment, clinic accommodation). The additional activity required and the appointment of additional Consultants and Nurse Specialists will require additional access to clinical facilities (as described above). It is assumed that the more new capital development is required, the longer the lead in time for starting new teams, and the longer the reliance on the independent sector. Preference will be given to those models that require the least capital resources and restructuring of premises. Consideration of the availability of trained staff will also be given. A particular model will lose points if it is unlikely that trained staff will be available in the numbers required to fill necessary posts.
3. Compliance with DHSSPS Strategy / Commissioner Support / Compatibility with Trust Strategic Plans/impact on other services	A model will lose points if it does not reflect specific regional health and wellbeing strategies/policies – DBS (the location of major hospitals with inpatient care), Cancer Framework (location of cancer units and Cancer Centre). Models should also attract commissioner support. Alignment with Trust Strategic Plans and impact on other services should also be considered.
4. Accessibility for Inpatient Elective Care	It is assumed that each model will be able to facilitate the flexible locating of outpatient and diagnostic service and will therefore be difficult to discriminate scores on this basis. Agreed pathways for emergency care is also assumed. Variation in local provision of elective inpatient care is more discriminatory. A model will lose points if it requires significantly greater travel time (from the do nothing case) for a substantial number of patients.
5. Organisational Complexity	A service should have unambiguous clinical and managerial leadership and accountability arrangements. Some potential models will need to transcend Trust organisational boundaries. This criterion concerns how complicated such arrangements are likely to be and weights each model accordingly – the more complicated the fewer the points awarded.

Appendix 9

Model 3: Three Teams/Networks

Team North and West:	• Upper 2/3rds of Northern and Western integrate to form one Team/Network
	• Main base Hospital - Altnagelvin
	• Potential for small number of inpatient beds in Causeway Hospital to be used for selected elective work subject to satisfactory arrangements for the post-operative management of these patients
Team South and West:	• Lower 1/3rd of Western (Fermanagh) and all of Southern integrate to form one Team/Network
	• Main base Hospital – Craigavon
Team East:	• SET and Belfast integrate to form one Team/Network
	• Continue to provide services to the southern sector of Northern population by outreach – Outpatient/Diagnostics/Day Surgery in Antrim and Whiteabbey hospitals with inpatients going to Belfast

Appendix 10



Health and Social Care Board

Performance Management and Service Improvement Directorate

HSC Board Headquarters
12-22 Linenhall Street
Belfast
BT2 8BS

Tel : Personal Information redacted by the USI
Fax : Personal Information redacted by the USI
Email: Personal Information redacted by the USI

Trust Directors of Acute Services

Our Ref: HM670
Date: 27 April 2010

Dear Colleagues

REGIONAL UROLOGY REVIEW

As you are aware, the Trust was represented on the Regional Urology Review which was completed in March 2009. The final report was presented to the Department in April 2009 and was endorsed by the Minister on 31 March 2010. I am aware an initial meeting of team East was held on 22 March and team North on the 1 April 2010 and team South is planned for the 13 May 2010.

Now that the Minister has endorsed the recommendations from the Review, it is imperative that the Trusts with lead responsibility for the development of the Business Case/Implementation Plan move quickly to develop the team model and agree the activity to be provided from the additional investment.

The Teams should base their implementation plan on each of the relevant Review recommendations; a full list of the recommendations is included in Appendix 1. I am aware that each of the teams has established project management arrangements to develop and agree the implementation plan for each team. It is also anticipated that these teams will agree the patient pathways, complete a baseline assessment of the current service, their current location and the activity available from the existing service model. The teams should aim to have completed the first draft of the Implementation Plan and submit this to the Board by Friday 11 June 2010.

It is planned that an overarching Implementation Project Board will be established comprising the Chair and Clinical Advisor from each of these project Teams, and key HSCB staff; to oversee the implementation of the Review. The first meeting of the Urology Project Implementation Board will be held on Thursday 1 July 2010 at 2.00pm in the Conference Room, Templeton House. The Project Team chair should send the team nominated representatives to Personal Information redacted by the USI by Friday 7 May 2010. I have asked Beth Malloy, Assistant Director, Scheduled Services, Performance Management and Service Improvement, to chair the Project Implementation Board.

The Review estimated the cost of implementing the recommendations to be £3.5m, of this £637k has already been allocated to Belfast Trust, and the remaining balance of £2.9m is

available. Please see Appendix 2 which has notionally allocated this budget to each of the teams, and it is on this basis the Teams should work collectively across Trusts to develop the Implementation Plans. The plan should also include a proposal for the use of the non-recurrent 'slippage' funding available from the teams share of the recurring £2.9m, this should include what additional in-house sessions will be provide to maintain the waiting times as at 31 March 2010 and to deal with any backlog of patients waiting for urological diagnostic investigations or outpatient review.

As per the details outlined in the Review, the initial assumption regarding the activity associated with each of the additional Consultant appointments is included in Appendix 3. To assist the teams in the further discussion, the figures outlined in the Urology Review have been updated and are attached in Appendix 4.

The Implementation plan, proposed patient pathways and the non-recurrent funding proposal should be sent to Beth Malloy Personal Information redacted by the USI by Friday 11 June 2010.

Yours sincerely

HUGH MULLEN
Director of Performance Management and Service Improvement

Enc

cc Trust Directors of Performance
John Compton
Paul Cummings
Beth Malloy
Michael Bloomfield
Iain Deboys
Lyn Donnelly
Paul Cavanagh
Paul Turley
Bride Harkin

Appendix 1

1. UROLOGY REVIEW SUMMARY OF RECOMMENDATIONS

Section 2 – Introduction and Context

1. Unless Urological procedures (particularly operative 'M' code) constitute a substantial proportion of a surgeon's practice, (s)he should cease undertaking any such procedures. Any Surgeon continuing to provide such Urology services should do so within a formal link to a Urology Unit/Team.

2. Trusts should plan and consider the implications of any impending retirements in General Surgery, particularly with regard to the transfer of "N" Code work and the associated resources to the Urology Team.

3. A separate review of urinary continence services should be undertaken, with a view to developing an integrated service model in line with NICE Guidance.

Section 3 – Current Service Profile

4. Trusts must review the process for internal Consultant to Consultant referrals to Urology to ensure that there are no undue delays in the system.

5. Northern Ireland Cancer Network (NICaN) Urology Group in conjunction with Urology Teams and Primary Care should develop and implement (by September 2009) agreed referral guidelines and pathways for suspected Urological Cancers.

6. Deployment of new Consultant posts (both vacancies and additional posts arising from this review) should take into account areas of special interest that are deemed to be required in the service configuration model.

7. Urologists, in collaboration with General Surgery and A&E colleagues, should develop and implement clear protocols and care pathways for Urology patients requiring admission to an acute hospital which does not have an acute Urology Unit.

8. Urologists, in collaboration with A&E colleagues, should develop and implement protocols/care pathways for those patients requiring direct transfer and admission to an acute Urology Unit.

9. Trusts should ensure arrangements are in place to proactively manage and provide equitable care to those patients admitted under General Surgery in hospitals without Urology Units (e.g. Antrim, Daisy Hill, Erne). Arrangements should include 7 day week notification of admissions to the appropriate Urology Unit and provision of urology advice/care by telephone, electronically or in person, also 7 days a week.

10. In undertaking the ICATS review, there must be full engagement with secondary care Urology teams, current ICATS teams, as well as General Practitioners and LCGs. In considering areas of Urology suitable for further development they should look towards erectile dysfunction, benign prostatic disease, LUTS and continence services. The review should also take into account developments elsewhere within the UK and in particular developments within PCTs in relation to shifting care closer to home.

Section 4 – Capacity, Demand and Activity

11. Trusts (Urology departments) will be required to evidence (in their implementation plans) delivery of the key elements of the Elective Reform Programme.

Section 5 – Performance Measures

12. Trust Urology Teams must as a matter of urgency redesign and enhance capacity to provide single visit outpatient and assessment (diagnostic) services for suspected urological cancer patients.

13. Trusts should implement the key elements of the elective reform programme with regard to admission on the day of surgery, pre-operative assessment and increasing day surgery rates.

14. Trusts should participate in a benchmarking exercise of a set number of elective (procedure codes) and non-elective (diagnostic codes) patients by Consultant and by hospital with a view to agreeing a target length of stay for these groups of patients.

15. Trusts will be required to include in their implementation plans, an action plan for increasing the percentage of elective operations undertaken as day surgery, redesigning their day surgery theatre facilities and should work with Urology Team in other Trusts to agree procedures for which day care will be the norm for elective surgery.

16. Trusts should review their outpatient review practice, redesign other methods/staff (telephone follow-up/nurse) where appropriate and subject to casemix/complexity issues reduce new:review ratios to the level of peer colleagues.

17. Trusts must modernise and redesign outpatient clinic templates and admin/booking processes to ensure they maximise their capacity for new and review patients and to prevent backlogs occurring in the future.

Section 7 – Urological Cancers

18. The NICaN Group in conjunction with each Trust and Commissioners should develop and implement a clear action plan with timelines for the implementation of the new arrangements/enhanced services in working towards compliance with IOG.

19. By March 2010, at the latest, all radical pelvic surgery should be undertaken on a single site, in BCH, by a specialist team of surgeons. The transfer of this work should be phased to enable BCH to appoint appropriate staff and ensure infrastructure and systems are in place. A phased implementation plan should be agreed with all parties.

20. Trusts should ensure that surgeons carrying out small numbers (<5 per annum) of either radical pelvic operation, make arrangements to pass this work on to more specialised colleagues, as soon as is practicably possible, (whilst a single site service is being established).

Section 8 – Clinical Workforce Requirements

21. To deliver the level of activity from 2008/09 and address the issues around casemix and complexity it is recommended that the number of Consultant Urologists is increased to 23 wte.

22. Urology Teams must ensure that current capacity is optimised to deliver the number FCEs by Consultant as per BAUS guidelines (subject to casemix and complexity). This may require access to additional operating sessions up to at least 4 per week (42 weeks per year) and an amendment to job plans.

23. At least 5 Clinical Nurse Specialists (cancer) should be appointed (and trained). The deployment of these staff within particular teams will need to be decided and Trusts will be required to develop detailed job plans with caseload, activity and measurable outcomes agreed prior to implementation. A further review and benchmarking of cancer CNS's should be undertaken in mid 2010.

Section 9 – Service Configuration Model

24. Urology services in Northern Ireland should be reconfigured into a 3 team model, to achieve long term stability and viability.

25. Teams North and East (Northern, Western, Belfast and South Eastern Trusts) should ensure that prior to the creation of the new Teams, there are clear, unambiguous and agreed arrangements in place with regard to Consultant on-call and out of hours arrangements.

26. Each Trust must work in partnership with the other Trust/s within the new team structure to determine and agree the new arrangements for service delivery, including inter alia, governance, employment and contractual arrangements for clinical staff, locations, frequency and prioritisation of outreach services, areas of Consultant specialist interest based on capacity and expertise required and catchment populations to be served.

Appendix 2

Estimated Team Costs for the Implementation of Adult Urology Review Recommendations.

	Team South	Team North	Team East	Total	No	Unit Cost	Total
Staffing Costs							
Consultant Urologist – additional wte team allocation	2 wte	1 wte	3 wte	6	6		
Consultant Urologists wte	[redacted]						
Consultant Anaesthetist @ 0.6 wte per Con. Urologist							
Consultant Radiologist @ 0.3 wte per Con. Urologist							
Band 5 Radiographer @ 6 per wte Con Radiologist							
Band 5 Theatre Nursing @ 1.8 wte per Con. Urologist							
Band 3 Nursing @ 0.46 wte per Con. Urologist							
Band 7 Specialist Nursing *1							
Band 5 Nursing @ 0.64 wte (day surgery)							
Band 4 Personal Secretary @ 0.5 wte per consultant urologists							

Personal Information redacted by the USI

Received from Martina Corrigan on 23/06/2023. Annotated by the Urology Services Inquiry.

Band 3 Admin support to radiologists at 0.5 wte per Radiologist	Personal Information redacted by the USI
Band 3 Admin Support to Specialist Nurses @ 0.5 wte per Nurse *2	
Band 4 Medical Records support 0.5 per unit *3	
Band 7 MLSO – Bio-medical Science *4	
Staffing Costs Sub Total	
Support Costs	
Surgical G&S @ £94,500 per Con. Urologist	Personal Information redacted by the USI
Theatre Goods/Disposables @ £50,000 per Con.Urologist	
Radiology G&S per Con. Urologist	
CSSD @ £32,000 per Con. Urologist	
Outpatients Clinics @ 2 per Con. Urologist	
Support Costs Sub Total	
Sub Total	
Less funding in 2008/09	
FINAL TOTAL	

Please note this analysis is based on the team figures included in the Review shown in Appendix 7 page 60.

*1 – this is based on the existing CNS nurse establishment and the sub specialty consultants within each of the teams. The remaining 1 CNS has been allocated to Team East for the Radical Pelvic Surgery undertaken at the Cancer Centre.

	Existing Establishment	Number of consultants with a sub-specialty interest	Additional CNS
Team South	0	2	2
Team North	2	2	0.5
Team East	2	4	2.5

*2 – 0.5 allocated to each Team as per the Specialist Nurse

*3 – 0.5 allocated to each Trust Unit within each Team

*4 – 1 wte allocated to Belfast – for increased demand for pathology

Please note this is the notional funding for each team and is subject to the agreed Commissioning arrangements of the Board

Appendix 3

The exact details of the additional activity associate with the additional Consultant appointments will require agreement with the Board Commissioning teams. As outlined in the Review, it is assumed that the additional activity will be as follows:

Ref: Review Page 40-41
Outpatients: 1176 – 1680 per Consultant
Inpatient and Daycase FCE: 1000 - 1250 per Consultant

Existing 17 Consultants in post
Outpatients 19,992 to 28,560
IP/DC FCEs – 17,000 to 21,250

New 6 Consultant Appointments
Outpatients 7,056 to 10,080
IP/DC FCEs – 6,000 to 7,500

Regional Total
Outpatients 27,048 to 38,640
IP/DC FCEs – 23,000 to 28,750

Please note:
This analysis does not take into account the improvements expected from the introduction and full implementation of the ICATS for urology, as outlined on page 19 of the Review. The additional activity from the CNS has still to be quantified. In addition, the quantification of the service improvements, to be gained from the implementation of the Review recommendations, still to be agreed with the each Trust (for each of the team) and the Board are not included.

Clinicians Name - Clinical Nurse Specialists Jenny McMahon & Kate O'Neill –
As these services have evolved it has proved most effective to have flexibility across the timetable, therefore sessions can be covered by either nurse, example of this below. (Kate O'Neill works a 5 day week – (K), Jenny McMahon works a 4 day week (J)).
All services below are provided on an out-patient basis within the Thorndale Unit at Craigavon Hospital.
Thorndale Staff (in addition to nurse specialists): The staff nurses provide support to all clinics within the Thorndale unit, for example prostate biopsy & decontamination, haematuria assessment & venepuncture for all GPwSI clinics.

S/N Kate McCreesh 23 hrs
S/N Mairead Leonard 34 hrs)
(8.5 hrs urodynamics studies)

S/N Dolores Campbell 23hrs
N/A Marie Biggs 30hrs assist with all clinics

	AM – 4 Hour Session	**PM – 4 Hour Session**	**Other**
Monday Where is the location? What service is provided? Theatre – IP or DC or LA Diagnostic Session What equipment is used? Outpatient – Number/grade of clinicians at clinic Number of slots per clinic?	(J) Lower urinary tract symptom (LUTS) review clinic 8 patients (K) Prostate assessment clinic 4 patients Equipment: ultrasound / Flow meter & bladder scanner	(J) LUTS new clinic 4 patients (K) Prostate histology 4 – 6 patients (S/N)Ward histology 8 patients Equipment: ultrasound / Flow meter	(J/K) Mon pm – Ad hoc Consultant clinic for e.g. staging results, urgent referrals.
Tuesday Where is the location? What service is provided? Theatre – IP or DC or LA Diagnostic Session What equipment is used? Outpatient – Number/grade of clinicians at clinic Number of slots per clinic?	(J&K) Prostate biopsy 5 patients – L/A and decontamination required Andrology service – (J/K) support from nurse specialist in absence of Lecturer practitioner Equipment: Ultrasound	Andrology service:– (K) support GPwSI	Tues pm – Admin (J) *All admin sessions include for eg. virtual histology clinic for negative biopsy, preparation for diagnostic services & cancer support for patients & ward management duties for Thorndale unit*

Wednesday Where is the location? What service is provided? Theatre – IP or DC or LA Diagnostic Session What equipment is used? Outpatient – Number/grade of clinicians at clinic Number of slots per clinic?	(K) Prostate biopsy 4 patients, alternate weeks, L/A and decontamination required (S/N) Haematuria clinic 4 patients (K) Ad hoc Consultant clinic for e.g. staging results, urgent referrals. (S/N) Ward histology 6 patients 1-2 clinics per month Equipment: Ultrasound	Urology clinic – (K) support GPwSI	Jenny off Wednesday.
Thursday Where is the location? What service is provided? Theatre – IP or DC or LA Diagnostic Session What equipment is used? Outpatient – Number/grade of clinicians at clinic Number of slots per clinic?	(J) Prostate assessment clinic 4 patients (red flag) alternate weeks / Andrology service- 4 patients alternate weeks Urology review clinic 4 patients support GPwSI Equipment: Ultrasound	MDM Both nurse specialists attend	(K) Admin Thursday am
Friday Where is the location? What service is provided? Theatre – IP or DC or LA Diagnostic Session What equipment is used? Outpatient – Number/grade of clinicians at clinic Number of slots per clinic?	(J) LUTS new clinic 4 patients (K) Cancer review clinic 4 patients Equipment: Ultrasound	(S/N) Flexible Cystoscopy list (as part of the Haematuria Service)	Admin session for both nurse specialists / cover for flexible cystoscopy if staff nurse unavailable

Corrigan, Martina

From: Corrigan, Martina <[redacted]>
Sent: 02 October 2014 08:41
To: Burns, Deborah
Cc: Stinson, Emma M
Subject: Urology Vision
Attachments: paper for Board re justification for 6th and 7th consultant and nursing and admin support.docx

Debbie

As discussed summary attached

Happy to discuss

Martina

Martina Corrigan
Head of ENT, Urology and Outpatients
Southern Health and Social Care Trust
Craigavon Area Hospital

Telephone: [redacted]
Mobile: [redacted]
Email: [redacted]

Anticipated position for 31 March 2015

	Status Quo	6th consultant and nursing	7th consultant and nursing **
Outpatients without ER	42weeks	26 weeks	15 weeks
Outpatients with ER	34 weeks	15 weeks	9 weeks
Inpatients	85 weeks	70 weeks	52 weeks
Day Cases GA	85 weeks	52 weeks	36 weeks
Day Cases ESWL	40 weeks	13 weeks	13 weeks
Day Cases Flexis	66 weeks	21 weeks	9 weeks

** will depend on consultant recruitment (? Locum) and will also depend on the availability of getting the additional theatre sessions

Support Staffing (Nursing and Admin) required plus costs

Band	In Post (WTE)	Proposed (WTE)	Gap (WTE)	Approx Cost
7	1.86	3.4	1.54	Personal information redacted by the USI
5/6	2.72	4.4	1.68	
2/3	0.8	3.4	2.6	
5 Admin Support	0	1	1	
			TOTAL	

There are currently a number of vacancies in Support Medical Staff

GP with Specialist Interest (Full year) - Personal Information redacted by the USI
1 Specialty Doctor (Full year) -
1 Specialty Doctor (7 months) -
Total available -

Spend from these vacant posts

Internal Budget Variation for Waiting Lists = £20,568 (end of September) – none planned for this quarter
Locum Registrars for night-time/weekend rota = £29,007 (end of August) Anticipated spend on locums until end of March = £40,610

So total until 31 March 2015 = £110,753
Still in Budget = £42,639

Required spend to implement support part of the Vision (Nursing/Admin) from December – March 2015 = £68,584

So shortfall of £25,945

Corrigan, Martina

From: Burns, Deborah <[redacted]>
Sent: 03 October 2014 10:34
To: Corrigan, Martina
Cc: Stinson, Emma M
Subject: RE: Urology Vision

Thanks I have some questions on this and we need to discuss -emma please slot in Martina Monday or Tuesday next week for 30 mins

Debbie Burns
Acting Director of Acute Services
SHSCT
[redacted]
Tel: [redacted]

From: Corrigan, Martina
Sent: 02 October 2014 08:41
To: Burns, Deborah
Cc: Stinson, Emma M
Subject: Urology Vision

Debbie

As discussed summary attached

Happy to discuss

Martina

Martina Corrigan
Head of ENT, Urology and Outpatients
Southern Health and Social Care Trust
Craigavon Area Hospital

Telephone: [redacted]
Mobile: [redacted]
Email: [redacted]

SOUTHERN HEALTH AND SOCIAL CARE TRUST

JOB DESCRIPTION

JOB TITLE: Acting Sister/Charge Nurse Band 6

LOCATION: Thorndale Unit, Surgical and Elective Care Division
Craigavon Area Hospital

REPORTS TO: Specialist Nurse

RESPONSIBLE TO: Lead Nurse (SEC)

JOB SUMMARY: The postholder will:

- Support the Specialist Nurse in his/her general management function and in the co-ordination of high quality services to patients and relatives.
- Under the direction of the Specialist Nurse, lead in the development of all aspects of nursing within the Unit, through the professional development of nursing staff, the implementation of evidence based practice and clinical audit.
- Function as the principal support to the Specialist Nurse, who has continuing responsibility deputising when required.

In particular, the postholder will have delegated responsibility for –

- the development and supervision of clinical practice;
- the assessment, development, implementation and evaluation of programmes and standards of care;
- teaching and supervision of nursing staff and health care support workers;
- the co-ordination of high quality patient focused care;
- ensuring that staff comply with professional and clinical policies, guidelines and protocols.

1.0 Professional Role

1.1 Promote a patient centred approach to care within the Unit.

1.2 Ensure practice reflects the standards set in the NMC Code of Professional Conduct.

1.3 Lead and enable nursing staff to implement proven research/evidence-based practice for the enhancement of patient care.

1.4 Prepare reports for and receive reports from the nursing team, ensuring effective nurse to nurse communication.

1.5 Ensure effective communication with patients/relatives to enable them to understand the nature of the care, treatment and progress.

1.6 Participate in the development of clinical pathways.

1.7 Act as an effective role model and mentor for all Registered Nurses and Nursing Auxiliaries and provide advice and support as required.

1.8 Assist the Specialist Nurse in the identification of areas of professional development within the Scope of Professional Practice and in the development of competency based practice.

1.9 Assist the Specialist Nurse in the co-ordination of the multidisciplinary team to achieve the highest possible standard of patient care.

1.10 Ensure health promotion and rehabilitation are an integral part of patient care.

1.11 Ensure adherence to Professional and Clinical Policies, Guidelines and Protocols within the Trust.

1.12 Assist the Specialist Nurse with formal appraisals and development of junior staff and nursing auxiliaries.

1.13 Develop, in association with the Specialist Nurse, the implementation and auditing of quality assurance programmes to optimise patient care within the Unit.

1.14 Participate in the implementation of the Trust's Strategy for Nursing and Midwifery within the Unit.

2.0 Managerial Role

2.1 Deputise for the Specialist Nurse as required and work shifts of duty in accordance with the Specialist Nurse arrangements.

2.2 Assist in the duty rotas/annual leave arrangements to ensure that the Unit’s appropriate skill mix is maintained in the absence of the Specialist Nurse.

2.3 Ensure a safe environment for patient care, identify clinical risk and in the presence of risk, inform the appropriate department to take corrective action.

2.4 Assist the Specialist Nurse with Risk Assessments.

2.5 Manage accidents/incidents or hazards according to the Trust's Policies and Procedures.

2.6 Prepare and implement orientation and induction programmes for new members of staff in association with the Specialist Nurse.

2.7 Assist the Specialist Nurse to maintain systems and processes to ensure a co-ordinated service is delivered to patients and relatives.

2.8 Participate in the assessment of staff performance and progress.

2.9 Observe for any signs of ill health or stress factors in staff and report same to the Specialist Nurse.

2.10 Assist the Specialist Nurse to collate information in response to complaints.

2.11 With the Specialist Nurse, ensure that there is an effective communication structure between all members of the multidisciplinary team.

2.12 Participate in Research and Audit as required.

2.13 Participate in Recruitment and Selection for the appropriate grade of staff.

2.14 Ensure that all staff are familiar with and adhere to all Policies and Procedures within the Trust.

2.15 Assist the Specialist Nurse in the monitoring of ward expenditure.

3.0 Educational Role

3.1 Identify own educational needs through performance appraisal with the Specialist Nurse.

3.2 Assist the Specialist Nurse in actively encouraging professional development of staff, and facilitate staff to meet PREP requirements.

3.3 Assist the Specialist Nurse in identifying staff training needs to meet existing and developing services.

GENERAL REQUIREMENTS

The post holder must:

- Carry out his/her duties with full regard to the Trust's Equal Opportunities Policy.
- Co-operate fully with the implementation of the Trust's Health and Safety arrangements and take appropriate remedial action on reports of any accidents/incidents, defects with work equipment or inadequate safety arrangements to his/her manager.
- Accept individual responsibility for ensuring a suitable, clean, uncluttered and safe environment for members of the public, staff, patients/clients and their relatives.
- Accept legal responsibility for all records held, created or used as part of his/her duties (including manual or electronic records).
- Comply with the Trust's Smoke Free Policy.
- Treat those whom he/she comes into contact with in the course of work, in a courteous manner.
- Accept that this job description will be subject to review in the light of changing circumstances and should be regarded as providing guidance within which the individual works rather than something which is rigid and inflexible.

November 2014

Personnel Specification

JOB TITLE **Acting Sister/Charge Nurse Band 6**

DIRECTORATE **Surgical and Elective Care**

Ref No: **November 2014**

Notes to applicants:

1. You must clearly demonstrate on your application form how you meet the required criteria – failure to do so may result in you not being shortlisted.

2. Proof of qualifications and/or professional registration will be required if an offer of employment is made – if you are unable to provide this, the offer may be withdrawn.

3. This criterion will be waived in the case of a suitable applicant whose disability prohibits driving but who is able to organise suitable alternative arrangements in order to meet the full requirements of the post.

Knowledge, skills and experience required:

Applicants must provide evidence by the closing date for application that they are a permanent employee of the Southern Health and Social Care Trust and have:

ESSENTIAL CRITERIA

1. Registered nurse Part 1 of the NMC register

2. Hold a Diploma or relevant Professional qualification or agree to do same

AND

- Experience of taking charge of a ward or unit within the Acute setting.
- Demonstrate expertise in the management of patients with urological conditions
- Evidence of how patient care has been enhanced through continuing professional development or practice development
- a full current driving licence with access to a car or access to a form of transport to meet the mobility needs of the post.

SHORTLISTING

A shortlist of candidates for interview will be prepared on the basis of the information contained in the application form. It is therefore essential that all applicants demonstrate through their application how and to what extent their experience and qualities are relevant to this post and the extent to which they satisfy each criterion specified

SUPPLEMENTARY INFORMATION

Name: _____

Post: Acting Sister/Charge Nurse Band 6 – Thorndale Unit, Surgical and Elective Care Division, Craigavon Area Hospital

When completing the following supplementary information, please refer to the definitions of the criteria overleaf. As this information will be used during the shortlisting stage, it is essential that you provide sufficiently detailed evidence.

Please detail any recognised post-registration education relevant to the post, including any education you are currently undertaking (if any).			
Details of education completed / currently being undertaken.	Name of Educational Establishment.	Dates	Qualifications/ CAT points obtained or expected.
Please provide details of other continuing professional development / practice development undertaken (other than what you have described above).			
With reference to the education and continuing professional development / practice development you have outlined above, please describe, using examples, how you have been able to enhance the quality of patient care delivered to patients.			

Please continue on a separate sheet, if necessary

Band 6

The applicant should be able to demonstrate an ongoing commitment / enthusiasm for professional development evidenced through post-registration education and other continuing professional development / practice development:

What is classed as 'continuing professional development'?

- Development activities, such as study days, conferences, research/audit activities, acting/secondment opportunities, recognised post-registration education *** etc

*** *recognised post-registration education is defined as study which:*

- *is health related;*
- *is obtained in or accredited by a recognised educational establishment eg University, BMC;*
- *is formally assessed/examined;*
- *results in a recognised qualification or can be accredited towards completion of a recognised qualification eg stand alone modules.*

What is classed as 'practice development'?

- An activity or process in which you were directly involved, in order to critically evaluate and improve service provision to patients / clients.

What is 'enhanced patient care'?

- An actual improvement in patient experiences / outcomes brought about by the practical application of any professional development / practice development undertaken.

Southern Health
and Social Care Trust

EXPRESSION OF INTEREST FORM
Band 6 in Thorndale Unit - Outpatients
Craigavon Area Hospital
Surgical and Elective Care
ACUTE SERVICES
SECONDMENT OPPORTUNITY FOR 4 MONTHS IN THE FIRST INSTANCE

PERSONAL DETAILS					
TITLE		FORENAME(S)		SURNAME	
CONTACT TELEPHONE NO			MOBILE NUMBER		
E-MAIL ADDRESS:					

CURRENT EMPLOYMENT DETAILS			
JOB TITLE			
Employment Status			
START DATE			
BAND		Job department	
		Job location	

Essential Shortlisting Criteria Requirements
Please state below how you meet the essential shortlisting requirements as detailed in the personnel specification

1. **An employee of the Southern Health & Social Care Trust and currently a Registered Nurse (Adult) on the Live NMC Register**

Southern Health and Social Care Trust

2. **Have 3 years' experience of working in an acute setting at Band 5 in the last 5 years which includes a broad range of clinical experience within a surgical setting.**

3. **Have minimum of 6 months experience of working in an acute Urology ward/department at Band 5 or above in the last 5 years which includes a broad range of clinical urology experience**

Driving Requirements

Do you hold a current driving licence valid in the UK?

Yes ☐ No ☐

If required, do you have access to a car, or form of transport which will enable you to undertake the duties of the post?

Yes ☐ No ☐

Southern Health and Social Care Trust

Declarations

The **Disability Discrimination Act 1995** provides that employers must make reasonable adjustment for staff who have a disability where this impacts on their ability to carry out day to day activities related to the post.

Do you consider yourself to have a disability relevant to this post?

Yes ☐ No ☐

If yes would you require any reasonable adjustments to be considered?

Yes ☐ No ☐

If you have answered yes, please give brief details

I hereby confirm the information provided above is accurate

Signed	
Date	

If this is submitted by email your covering email will be taken as your 'signature'. Please print your name and date.

Please return this form no later than Monday 24 November 2014 at 5pm

Interviews are planned for Wednesday 26 November 2014.

Completed forms should be returned to Martina Corrigan, Head of ENT, Urology and Outpatients, Admin Floor, Craigavon Area Hospital or to email address:

[redacted]
Personal Information redacted by the USI

Applicants will be contacted by telephone so it is important that you leave a contact number that you will be available on after the closing date.

Corrigan, Martina

From: Corrigan, Martina < Personal Information redacted by the USI >
Sent: 14 November 2014 17:57
To: Chambers, Pamela; Farley, Maureen; Hunter, Rhonda; Kennedy, Sharon; McClenaghan, Nichola; McGuigan, Tracey; Mulligan, Sheila; Donnelly, MargaretA; Fee, Helen; Cochrane, Joanne; McMahon, Jenny; ONeill, Kate; Conway, Brona; Sheridan, Patrick; McAlinden, Jacinta; Moorcroft, Caroline; Mulligan, Marilyn
Cc: Nelson, Amie; Reid, Trudy; Sharpe, Dorothy
Subject: EOI application form band 6 Thorndale Unit
Attachments: EOI application form band 6 Thorndale Unit.doc

Importance: High

Dear all

Please see attached expression of interest for a Band 6 temporary for 4 months in the first instance in Thorndale Unit, Outpatients, CAH .

Closing date is Monday 24 November and interviews are planned for Wednesday 26 November.

Could you please share this with all your staff and please include any staff on annual/study/sick/secondment and maternity leave.

Thanks

Martina

Martina Corrigan
Head of ENT, Urology and Outpatients
Southern Health and Social Care Trust
Craigavon Area Hospital

Telephone: Personal Information redacted by the USI
Mobile: Personal Information redacted by the USI
Email: Personal Information redacted by the USI

Corrigan, Martina

From: Sharpe, Dorothy <[redacted]>
Sent: 06 January 2017 11:14
To: Reddick, Fiona
Cc: Corrigan, Martina
Subject: Re: Interviews

Hi Martina.... please see Fiona. E mail

Sent from my BlackBerry 10 smartphone.

From: Reddick, Fiona
Sent: Friday, 6 January 2017 10:12
To: Sharpe, Dorothy
Subject: RE: Interviews

Dorothy

Are these band 6 nurse specialist posts and is cancer included?

Just want to be sure before sending sample questions – it might be helpful to forward JD if you have one.

Regards

Fiona

From: Sharpe, Dorothy
Sent: 06 January 2017 09:26
To: Reddick, Fiona
Subject: Interviews

Hi Fiona , was talking to Martina and she has advised that you could give us some sample questions for the Band 6 posts in Urology.

Brigeen had hoped to ask you for these but with her off at the moment I would like to get this sorted.

If you don't mind can you leave some of these questions with me please?

Thanks

Dorothy Sharpe
Lead Nurse SEC
Ext [redacted] *–CAH*
MOB - [redacted]

INTERVIEW ASSESSMENT SHEET

POST REF. NO: **DATE:** _____

CANDIDATE: _____

SIGNATURE OF INTERVIEWER: _____

SICK LEAVE: _____

PIN NO: _____

***1 = Very Poor**
2 = Weak
3 = Acceptable
4 = Good
5 = Very Good
6 = Excellent

REQUIREMENTS (List requirement and all questions)	EVIDENCE	RATING*	WEIGHT	SCORE (RATING X WEIGHT)
Question 1; **What skills and experience do you bring that are relevant to the post?**	**Expected response:** • Credibility. Motivated. Ambitious. Supportive. Reliable. • Personal Qualities. • Communication skills – interpersonal, listening. Breaking bad news. • Work as a member of the MDT – Team working. • Knowledge and relationships with people. • Academic experience – qualifications. • Education – professional development. • Leadership and expertise. Commitment. • Research and development- awareness of current clinical trials and ability to name them. • Chemotherapy competency. Telephone Triage skills. Helpline. • Organisational skills • Audit • Service Improvement- Quality. Safe effective care. • IT skills. • Ability to recognise limitations – seek support when required. • Mentorship. • Managing self and others.		X3	
			X3	

REQUIREMENTS (list all requirements and all questions)	EVIDENCE	RATING*	WEIGHT	SCORE (rating + weight)
Question 2; **Can you give an example of a recent service improvement you have made in your area of practice and demonstrate how you carried this out?**	**Expected response** • Demonstrates an understanding of service improvement tools and methodologies • Demonstrate understanding of basic principles e.g. Lean methodology/others Project management skills • Structured approach – action plans/clear time frames • Connected steps to achieve outcome • Aims /objectives • Baseline • Understanding of demand, activity, capacity, back log • Track progress • Measurement - PDSA, • Feed back to key staff • Evidence of application of knowledge to practice and evaluation of outcomes across more than one example		X3	

REQUIREMENTS (List requirement and all questions)	EVIDENCE	RATING*	WEIGHT	SCORE (RATING X WEIGHT)
<u>Question 3;</u> **Clinical Scenario – was thinking of patient due for review. Delayed review with cancer diagnosis**	**Expected response**			

REQUIREMENTS (List requirement and all questions)	EVIDENCE	RATING*	WEIGHT	SCORE (RATING X WEIGHT)
Question 4; **As you are aware the Urology MDT was recently Peer Reviewed. An area which they identified as a concern was the lack of presence of a keyworker for patients diagnosed with a Urological cancer.** **How would you envisage developing this service within your role?**	. **Expected response** • Cancer Peer Review findings • Patient Feedback – Regional Cancer Patient Experience Survey (CPES) 2015 and local patient feedback. • Expectation of patients – they want to know what next and who their point of contact will be for ongoing support and advice. • What to expect – what is normal/abnormal. • Expectations of the team – who is best to review – differing opinions of Clinicians • Holistic Needs Assessment – Psychological., emotional, physical, fertility, financial, late effects of treatment and appropriate signposting – Macmillan Template. Keyworker role and ongoing support • Development of End of treatment Summary record • Consideration of self- management programme supported by clear advice on concerning symptoms. • Post treatment clinics, advice and signposting to other disciplines for ongoing support. • Development of Health and Wellbeing Events partnership working with charities/organisations to support this patient group • Clear communication to GPs and colleagues in Primary/secondary care.			

REQUIREMENTS (list all requirements and all questions)	EVIDENCE	RATING*	WEIGHT	SCORE (rating + weight)
Question 5. **One of the responsibilities of this post will be to provide expert knowledge and advice to others within Southern Health and Social Care Trust.** **What people, groups, departments, organisations would impact upon your role and how would you ensure collaborative working?**	**Expected response** • Key stakeholders including Consultant Urologists , members of Urology MDT, Thorndale Unit, Ward 3 south - ward sister and staff, nursing and medical staff in other wards and departments, community nursing, palliative care team both in hospital and community, Allied health professionals, and Primary Care colleagues. Ongoing education in wards and departments.. • Senior managers • Regional Network Site Specific Groups – NICaN, HSCB. • National Groups BAUN • Voluntary Organisations – Macmillan, Myeloma UK, Cancer Focus, Charis, • Drug companies for Education, Training and Resources. • Candidates should demonstrate knowledge of the importance of the need for good relationships and networking to facilitate effective working and provision of effective high quality care. • Evidence of understanding the difficulties in collaborative working due to other individuals, personalities, role clarity, conflict, work load and high patient workload, complexities,			

REQUIREMENTS (list all requirements and all questions)	EVIDENCE	RATING*	WEIGHT	SCORE (rating + weight)

Question 6

What do you envisage may be the challenges of this post?

Corrigan, Martina

From: Kelly, Brigeen
Sent: 19 June 2023 09:52
To: Corrigan, Martina
Subject: FW: 100
Attachments: Urology Clinical Nurse Specialist Interview Jan 17.doc

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From: Reddick, Fiona <[redacted]>
Sent: 13 January 2017 12:31
To: Kelly, Brigeen <[redacted]>
Subject: RE: 100

Brigeen

Apologies that I am just getting back to you now. Thanks for sending the Job Description. I now have had time to read through this in detail and have immediate concerns re this post. As highlighted during our conversation yesterday I am concerned that this post is labelled 'Clinical Nurse Specialist' and reference has been made to cancer work yet nowhere in the criteria does it ask for cancer experience. I have not been asked to contribute to this post from the cancer perspective in any way. The stipulations from a regional nursing workforce perspective were that if a nurse were to hold a 'Specialist' title then the criteria should include Hold or be working towards completion an NMC recordable qualification.

Cancer work will obviously form a good part of this role and I think the job description and criteria do not match up. Do you know if this job was matched at all as I would be concerned that this is actually a Band 7 role rather than that of 6.

Happy to discuss further

I have attached a first draft of questions proposed as the key role will be designed key worker ad deputise as core member of Cancer MDT.

I will pull responses together if you think questions are suitable.

Regards

Fiona

From: Kelly, Brigeen
Sent: 11 January 2017 12:33
To: Reddick, Fiona
Subject: 100

Please send me some questions that would suit this JD ☺ ☺ ☺ – I know Dorothy had asked you
Brigeen

SOUTHERN HEALTH AND SOCIAL CARE TRUST

JOB DESCRIPTION

JOB TITLE: Sister/Charge Nurse Band 6

LOCATION: Thorndale Unit, Surgical and Elective Care Division
Craigavon Area Hospital

REPORTS TO: Specialist Nurse

RESPONSIBLE TO: Lead Nurse (SEC)

JOB SUMMARY: The postholder will:

- Support the Specialist Nurse in his/her general management function and in the co-ordination of high quality services to patients and relatives.
- Under the direction of the Specialist Nurse, lead in the development of all aspects of nursing within the Unit, through the professional development of nursing staff, the implementation of evidence based practice and clinical audit.
- Function as the principal support to the Specialist Nurse, who has continuing responsibility deputising when required.

In particular, the postholder will have delegated responsibility for –

- the development and supervision of clinical practice;
- the assessment, development, implementation and evaluation of programmes and standards of care;
- teaching and supervision of nursing staff and health care support workers;
- the co-ordination of high quality patient focused care;
- ensuring that staff comply with professional and clinical policies, guidelines and protocols.

1.0 Professional Role

1.1 Promote a patient centred approach to care within the Unit.

1.2 Ensure practice reflects the standards set in the NMC Code of Professional Conduct.

1.3 Lead and enable nursing staff to implement proven research/evidence-based practice for the enhancement of patient care.

1.4 Prepare reports for and receive reports from the nursing team, ensuring effective nurse to nurse communication.

1.5 Ensure effective communication with patients/relatives to enable them to understand the nature of the care, treatment and progress.

1.6 Participate in the development of clinical pathways.

1.7 Act as an effective role model and mentor for all Registered Nurses and Nursing Auxiliaries and provide advice and support as required.

1.8 Assist the Specialist Nurse in the identification of areas of professional development within the Scope of Professional Practice and in the development of competency based practice.

1.9 Assist the Specialist Nurse in the co-ordination of the multidisciplinary team to achieve the highest possible standard of patient care.

1.10 Ensure health promotion and rehabilitation are an integral part of patient care.

1.11 Ensure adherence to Professional and Clinical Policies, Guidelines and Protocols within the Trust.

1.12 Assist the Specialist Nurse with formal appraisals and development of junior staff and nursing auxiliaries.

1.13 Develop, in association with the Specialist Nurse, the implementation and auditing of quality assurance programmes to optimise patient care within the Unit.

1.14 Participate in the implementation of the Trust's Strategy for Nursing and Midwifery within the Unit.

2.0 Managerial Role

2.1 Deputise for the Specialist Nurse as required and work shifts of duty in accordance with the Specialist Nurse arrangements.

2.2 Assist in the duty rotas/annual leave arrangements to ensure that the Unit’s appropriate skill mix is maintained in the absence of the Specialist Nurse.

2.3 Ensure a safe environment for patient care, identify clinical risk and in the presence of risk, inform the appropriate department to take corrective action.

2.4 Assist the Specialist Nurse with Risk Assessments.

2.5 Manage accidents/incidents or hazards according to the Trust's Policies and Procedures.

2.6 Prepare and implement orientation and induction programmes for new members of staff in association with the Specialist Nurse.

2.7 Assist the Specialist Nurse to maintain systems and processes to ensure a co-ordinated service is delivered to patients and relatives.

2.8 Participate in the assessment of staff performance and progress.

2.9 Observe for any signs of ill health or stress factors in staff and report same to the Specialist Nurse.

2.10 Assist the Specialist Nurse to collate information in response to complaints.

2.11 With the Specialist Nurse, ensure that there is an effective communication structure between all members of the multidisciplinary team.

2.12 Participate in Research and Audit as required.

2.13 Participate in Recruitment and Selection for the appropriate grade of staff.

2.14 Ensure that all staff are familiar with and adhere to all Policies and Procedures within the Trust.

2.15 Assist the Specialist Nurse in the monitoring of ward expenditure.

3.0 Educational Role

3.1 Identify own educational needs through performance appraisal with the Specialist Nurse.

3.2 Assist the Specialist Nurse in actively encouraging professional development of staff, and facilitate staff to meet PREP requirements.

3.3 Assist the Specialist Nurse in identifying staff training needs to meet existing and developing services.

GENERAL REQUIREMENTS

The post holder must:

- Carry out his/her duties with full regard to the Trust's Equal Opportunities Policy.
- Co-operate fully with the implementation of the Trust's Health and Safety arrangements and take appropriate remedial action on reports of any accidents/incidents, defects with work equipment or inadequate safety arrangements to his/her manager.
- Accept individual responsibility for ensuring a suitable, clean, uncluttered and safe environment for members of the public, staff, patients/clients and their relatives.
- Accept legal responsibility for all records held, created or used as part of his/her duties (including manual or electronic records).
- Comply with the Trust's Smoke Free Policy.
- Treat those whom he/she comes into contact with in the course of work, in a courteous manner.
- Accept that this job description will be subject to review in the light of changing circumstances and should be regarded as providing guidance within which the individual works rather than something which is rigid and inflexible.

July 2016

Personnel Specification

JOB TITLE **Sister/Charge Nurse Band 6**

DIRECTORATE **Surgical and Elective Care**

Ref No: **July 2016**

Notes to applicants:

1. You must clearly demonstrate on your application form how you meet the required criteria – failure to do so may result in you not being shortlisted.

2. Proof of qualifications and/or professional registration will be required if an offer of employment is made – if you are unable to provide this, the offer may be withdrawn.

3. This criterion will be waived in the case of a suitable applicant whose disability prohibits driving but who is able to organise suitable alternative arrangements in order to meet the full requirements of the post.

Knowledge, skills and experience required:

Applicants must provide evidence by the closing date for application that they are a permanent employee of the Southern Health and Social Care Trust and have:

ESSENTIAL CRITERIA

1. Registered nurse Part 1 of the NMC register

2. Hold a Diploma or relevant Professional qualification or agree to do same

AND

- Experience of taking charge of a ward or unit within the Acute setting.
- Demonstrate expertise in the management of patients with urological conditions
- Evidence of how patient care has been enhanced through continuing professional development or practice development
- a full current driving licence with access to a car or access to a form of transport to meet the mobility needs of the post.

SHORTLISTING

A shortlist of candidates for interview will be prepared on the basis of the information contained in the application form. It is therefore essential that all applicants demonstrate through their application how and to what extent their experience and qualities are relevant to this post and the extent to which they satisfy each criterion specified

Southern Health and Social Care Trust

Southern Health and Social Care Trust

JOB DESCRIPTION

Title:	Specialist Nurse - Urology
Band :	Band 6
Reports to:	Clinical Nurse Specialist
Accountable to:	Assistant Director of ATICs, Surgery and Elective Care

Job summary

The post holder will be expected to deliver on the five functions listed below:

- Be a designated Key Worker
- Deputise as a core member of the Cancer Urological multidisciplinary team
- Deliver Nurse-Led activity including nurse led clinics and telephone work
- Education, training and Audit
- Identify and contribute to the service development and policy development

Key Worker Function:

The post holder will:

- Act as a point of contact for patients, ensuring that patients have access to information and support services and provides ongoing holistic assessments.
- The postholder should provide physical, emotional, psychological and spiritual support to patients and carers and coordination of care services.

Multi-disciplinary Team

The post holder will:

- Will be a deputy core member of the multi-disciplinary team, both locally and regionally.

Nurse-led activity

Nurse-led activity can be direct or indirect therefore the postholder will provide nurse-led clinics in an outpatient and inpatient setting and this will be on a face to face or via telephone consultations.

This nurse-led activity will be on the Craigavon Area Hospital Site

There are four levels that this nurse-led activity will provide:

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

Education & Development

The post holder will:

Education, training and audit are inherent aspects of the Specialist Nurse role and should permeate all aspects of this role:

- Develop and deliver specific and relevant specialist teaching programmes for all disciplines and grades of staff, client group and carers within the Trust and, in relation to the Urology specialism.

- Review and evaluate all teaching programmes and lead on the development of new programmes when a need is identified.
- Maintain the education of colleagues in clinical areas who contribute to the patient pathway.
- Identify own development needs in line with service requirements within personal development plan.
- Develop and distribute educational leaflets in relevant formats, for staff and patients relating to service and patient pathway.
- Ensure personal and peer support and clinical supervision needs are met.
- Act as mentor/preceptor and resource person for all nursing and support staff, as appropriate to the role.
- Provide clinical supervision in order to support development of individuals and practice.
- Ensure mentorship training is updated annually.
- Ensure clinical environment is conducive to supporting the education and learning of all staff and students.
- Provide educational and training opportunities to pre registration nursing students to ensure placements satisfy the relevant elements of their learning agreement.
- Provide an environment that encourages client centred involvement where clients are facilitated to ask for help, advice and education.
- Contribute to clinical governance outcomes.

Contribute to the service development and policy development

The post holder will:

- Contribute to and develop specialist policies and procedures, and to ensure the effective delivery of care.
- To implement policies, and inform members of the multidisciplinary team of any changes
- To support and work with other appropriate professionals to ensure a holistic and comprehensive approach to nursing care. To support and advise patients through the various stages of treatment.
- To use audit and research evidence to improve and develop the service.
- Be responsible for producing appropriate training programmes to develop staff.

GENERAL REQUIREMENTS

The post holder will be required to:

1. Ensure the Trust's policy on equality of opportunity is promoted through his/her own actions and those of any staff for whom he/she has responsibility.

2. Co-operate fully with the implementation of the Trust's Health and Safety arrangements, reporting any accidents/incidents/equipment defects to his/her manager, and maintaining a clean, uncluttered and safe environment for patients/clients, members of the public and staff.

3. Adhere at all times to all Trust policies/codes of conduct, including for example:
    - Smoke Free policy
    - IT Security Policy and Code of Conduct
    - standards of attendance, appearance and behaviour

4. All employees of the Trust are legally responsible for all records held, created or used as part of their business within the Trust including patients/clients, corporate and administrative records whether paper-based or electronic and also including emails. All such records are public records and are accessible to the general public, with limited exception, under the Freedom of Information Act 2000 the Environmental Information Regulations 2004 and the Data Protection Acts 1998. Employees are required to be conversant with the Trusts policy and procedures on records management and to seek advice if in doubt.

5. Take responsibility for his/her own ongoing learning and development, including full participation in KSF Development Reviews/appraisals, in order to maximise his/her potential and continue to meet the demands of the post.

6. Represent the Trust's commitment to providing the highest possible standard of service to patients/clients and members of the public, by treating all those with whom he/she comes into contact in the course of work, in a pleasant, courteous and respectful manner.

7. Understand that this post may evolve over time, and that this Job Description will therefore be subject to review in the light of changing circumstances. Other duties of a similar nature and appropriate to the grade may be assigned from time to time.

This Job Description will be subject to review in the light of changing circumstances and is not intended to be rigid and inflexible but should be regarded as providing guidelines within which the individual works. Other duties of a similar nature and appropriate to the Band may be assigned from time to time.

It is a standard condition that all Trust staff may be required to serve at any location within the Trust's area, as needs of the service demand

Southern Health and Social Care Trust

PERSONNEL SPECIFICATION

Job Title:	Specialist Nurse - Urology
Band:	Band 6
Directorate:	Acute
Salary:	£26,041 - £34,876
Hours:	Full-time

The following are essential criteria which will initially be measured at Shortlisting Stage although may also be further explored during the interview stage;

1. Currently a Registered Nurse (Adult) on the Live NMC Register

2. Have 3 years' experience of working in an acute setting at Band 5 in the last 5 years which includes a broad range of clinical experience within a surgical setting.

3. Have a minimum of 6 months experience of working in an acute urology ward/department at Band 5 or above in the last 5 years which includes a broad range of clinical urology experience.

4. Demonstrate ability to work effectively as part of a multi-disciplinary team

5. Experience in taking responsibility for the management of a clinical area

6. Hold a current driving licence valid for use in the UK and have, on appointment access to a car.

(note: this criterion will be waived in the case of applicants who are prevented from driving due to a disability, providing the applicant can organise suitable alternative arrangement in order to the requirements of the post in full.)

The following are essential criteria which will be measured during the interview stage.

1. Evidence of post registration education and willing to undergo training relevant to the post.

2. Sound knowledge and skills of the NMC code and standards

3. Ability and knowledge on how to undertake audit and feedback appropriately

4. Flexibility to work hours required to do the job

5. Ability to work as part of a team

6. Ability to work unsupervised

7. Computer skills or willingness to undergo training

8. Excellent interpersonal skills

9. Excellent communication skills to meet the needs of the post in full

WE ARE AN EQUAL OPPORTUNITIES EMPLOYER

Successful applicants may be required to attend for a Health Assessment

All staff are required to comply with the Trusts Smoke Free Policy

July 2016

WE ARE MACMILLAN. CANCER SUPPORT

Macmillan Partnership Application

Sections to be completed where applicable – If a section does not apply please clearly state N/A. Please see separate guidance notes for more details about the type of information required before completing. If the application requires a project management approach, please use project management documentation (e.g. Gant chart – please see guidance notes)

NAME OF SERVICE / PROJECT LOCATION AND CONTACT DETAILS FOR WHICH FUNDING IS REQUESTED.	
Name of service / Project: Macmillan CNS Workforce Plan – 1.0WTE Band 6 Urology Cancer Clinical Nurse Specialist and 0.25 WTE Band 3 Support Worker	**Name of Partner Organisation:** Southern Health and Social Care Trust
Name of Clinical Alliance / Strategic Clinical Network / Integrated Cancer Systems (if applicable): **NI Cancer Network**	**Geographical catchment area:** The Southern Health and Social Care Trust (SHSCT) was formed in April 2007. It is responsible for providing services across the council areas of Armagh, Banbridge, Craigavon, Dungannon and Newry and Mourne. The Southern Trust is an integrated organistion and thus provides a mix of both acute hospital and community health and social care services to a resident population of approximately 360,000 people. Cancer services at the Southern Trust is incorporated into all acute services as per specific tumour site.
Contact details of person submitting the application / leading the service development / project	Name: Martina Corrigan Title: Head of ENT, Urology, Ophthalmology & Outpatients Address: Craigavon Area hospital, 68 Lurgan Road, Portadown. Co. Armagh. BT 63 5QQ Telephone no: Personal Information redacted by the USI Email: Personal Information redacted by the USI

Contact details of the senior manager /commissioner sponsoring the service development / project	Name: Mrs Esther Gishkori Title: Director of Acute Services Address: Craigavon Area Hospital, 68 Lurgan Road, Portadown. Co Armagh. BT63 5QQ Telephone no: Personal Information redacted by the USI Email: Personal Information redacted by the USI
Name and contact details of the member of the Macmillan Service Development Team	Name: Ruth Thompson Partnership Manager Telephone no: Personal Information redacted by the USI Email: Personal Information redacted by the USI
PS@MAC number(s) [compulsory Macmillan use]:	
Is a Cancer Environment build envisaged? ***If yes, the Administrator must inform CE of the PS@MAC number.**	No*

PART ONE – SUSTAINABILITY

1.1 Please indicate whether the post or service is:

Permanent	Yes x ☐ No ☐
Project / fixed term	Yes ☐ No ☐
Pilot	Yes ☐ No ☐

- **What is the organisation's level of commitment to this post or service?**
  The five year incremental, prioritised Cancer CNS workforce plan has been approved through HSCB / PHA senior management team and has Department of Health support. The cancer CNS workforce expansion is a commissioning prioirity for 2016/17 and was outlined in the commissioning plan. A Urology CNS is included within the plan for 2016 /2017.

	Comments
Is pick up funding confirmed in writing?	Yes – the CNS expansion plan is an incremental expansion over 5 years and the HSCB will pick up funding recurrently.
Is pick up funding confirmed pending a successful evaluation – if so what will the evaluation be based on?	Yes – confirmed through the CNS expansion plan
Is the business case for sustainability to be submitted through the local funding process	No

No pick up funding anticipated		
For project / pilot posts – is there a letter of support from the employing organisation / commissioner and evidence to show how the recommendations will be taken forward?	Yes x☐ No☐ If no give reason:	
For project / pilot posts – Explain why this is a project or pilot and not a sustainable service	N/A	

PART TWO – BACKGROUND

2.1
Identify the key issues / problems that currently have an impact on people affected by cancer that you are trying to address through the proposed project / service

The role of the 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 improved patient experience and deliver services for individual patients according to need and patient choice. They play a vital role in the coordination of patient care and successful implementation of iniatives 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.

The number of people diagnosed with cancer each year is rising, with one in three of the population developing some form of cancer by the time they reach 75 years of age. In Northern Ireland, 11,000 people are diagnosed with cancer. Driven by the ageing population, this number is expected t orise by 25% for men and by 24% for women by 2020. By 2035, the number of cases per year is projected to be 7,181 male and 6,967 for female cases, a 65% rise among men and 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. In addition, cancer is responsible for approximately one quarter of all deaths occurring in Northern Ireland causing more deaths than any of ischemic heart disease, stroke or other diseases of the circulatory or respiratory systems.

In 2015, the NI Cancer Patient Experience Survey (CPES) reported 72% of patients having access to a CNS, much lower than England 89% (2014), and Wales 88% (2013). Key driver analysis demonstrates the support of a CNS is the most important contributing factor to people reporting a positive experience of care. In April 2014, the Macmillan Adult cancer CNS census of the Specialist Adult Cancer Workforce reported 57.4WTE in N.I. with the majority area of practice being Breast (33.8%), with minimal provision in Urology and Urology. This is significantly lower than other UK countries when incidence rates are compared to whole time equivalent posts.

This is further compounded by results from the 3 year NI Cancer Peer Reveiw Programme of Multi Disciplinary Teams (Local and Specialist). Lack of access and single handed CNS provision were found as immediate risks or serious concerns in 17 out of the 30 MDTs Peer reviewed to date.
Currently in the Southern Trust, there is 1.0 WTE Nurse Specialist for the Urology service. Some progress has been made to implement the key worker role for cancer patients, but this has been limited due to lack of resources. Therefore not all patients are supported at key stages of their pathway including at the time of receiving their diagnosis and not all benefit from the skills, knowledge and expertise of a CNS.

The Transforming Cancer Follow Up (TCFU) Programme Evaluation (2015) 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. Urology nurse led follow-up pathways have been agreed regionally but have not been implemented due to lack of dedicated staff. For further development to occur, additional staff are required.

There is an overwhelming deficit in the number of CNSs within SHSCT. By increasing the number of nurse specialists and through inclusion of support worker roles within the CNS workforce plan this 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.

Within SHSCT, there were 746 new patients with urological cancers diagnosed in 2016.

Investment in a 1.0 WTE Urology CNS will further enhance the Urology service and the development and co-ordination of the service. The 0.25WTE band 3 support worker will provide administrative support for the team and act as a point of contact for patients to ensure the most effective use of resources.

2.2 How will the proposed project/service/scheme address the issues /problems identified in 2.1

The proposed workforce plan would aim to recruit 1 WTE Band 6 Clinical Nurse Specialist, and 0.25 WTE Band 3 support worker.

The staff will work closely with the appropriate Multi-disciplinary teams to provide:

(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

Through expansion of the cancer Urology CNS and support worker team the care of patients could be improved as follows:

- The staff would work closely with the MDTs ensuring all patients would be supported as they progress in a timely manner along the appropriate diagnostic pathway
- The CNS will contribute to the MDT discussion by acting as the key worker for patients as recommended by the Manual of Cancer Services (2004)
- Patients would have a HNA and care plan with sign posting to appropriate services as recommended in the Living With and Beyond Cancer report (2013), Recovery Package & NI Cancer Services Framework
- Patients and their caregivers would have appropriate, timely information and support at each stage of their pathway to enable them to deal with physical, social, emotional or sexual issues that may arise (Improving Outcomes, 2004)
- The proposed post holders would work across internal interfaces between medicine, surgery and oncology to ensure effective transfer of information.
- The post holders will work across external service boundaries between primary and secondary care to aid implementation of the TYC principals, improve continuity of care and ensure patients experience a seamless transition from acute to primary care
- Patients could be managed through the new service models of risk-stratified follow-up in line with the regional move towards Transforming Cancer Follow-up and where appropriate and in conjunction with the medical team, nurse-led and self-directed aftercare could be introduced in close collaboration with the local Macmillan Service Improvement Manager
- Introduction of nurse-led and self-directed follow up could help to minimise any backlog of review appointments, allowing consultants more time to spend with new and complex cases
- The nurse-led activity may be direct or indirect; inpatient, outpatient or via telephone; and provided within an acute, community or primary care setting dependent on the requirements of the patient group involved.
- The CNS will provide a telephone advice number to patients to ensure patients can access follow-up advice thus reducing unnecessary anxiety, avoidable re-admissions and GP visits
- Patient education is a fundamental part of the post holders' roles and will be provided in a variety of ways including the provision of health and wellbeing events to support the SHSCT cancer survivorship program and the national Recovery Package, enabling patients to be empowered and better manage their lifestyles and any on-going support needs.
- The post-holders will keep abreast of the development of local services that may be utilised to support the patient groups and signpost the patients and their carers to those services relevant to their needs
- The post-holders in conjunction with core services will refer appropriate patients to local cancer rehabilitation and self-management programmes e.g. physical activity programmes delivered by qualified

staff in leisure centres or the HOPE programme

- Education, training and audit will be inherent aspects of the CNS role and they will contribute to advancing the body of knowledge in their respective areas and ensure their skills and competencies meet those outlined in appropriate frameworks (e.g. NIPEC (2006) and Macmillan (2014)
- The Urology CNS will have dedicated sessions in their workplan to support the development of policies, guidelines and protocols to ensure the services provide a patient-centred, evidence based service to all patients
- The support worker will enable more effective use of nursing time
- Close links will be established with the local Macmillan Health&Wellbeing Manager and Macmillan Benefits Adviser to ensure patients receive the most up to date support and information relevant to their needs
- The teams will work closely with the local Trust Volunteer Manager to ensure volunteers can be utilised where possible in the support and development of services for patients
- The teams will liaise with the regional Macmillan Work Support and Rehabilitation Service to incorporate appropriate service developments locally
- Post holders will liaise with local and national teams and networks to ensure the services remain abreast with current changes in practice.

When planning this application three options were considered:

Option Number/ Description	Shortlisted (S) or Rejected (R)	Reason for Rejection
1. Status Quo - Continue with existing arrangements	**R**	Without investment in cancer nurse specialists, the immediate risks and serious concerns flagged through the National Peer review process would not be addressed in regard to CNSs across the tumour MDT sites. Patient experience will continue to be impacted upon negatively without the expansion of CNSs across all Trusts, with NI having the lowest reported access to CNSs across the UK. Any further progress with nurse led follow-up and supported self-care models through the transforming cancer follow-up across tumour sites would not be realised.
2. Introduce clinical nurse specialists as per agreed workforce plan in partnership with Macmillan and Friends of the Cancer centre.	**S**	This is the preferred option and would introduce the regionally agreed risk based, prioritised, incremental workforce plan for the expansion of the clinical nurse specialists to support the patients across NI. The CNSs will work closely with their respective multi-disciplinary teams and in line with the regionally agreed commissioning specification and address National Peer Review measures. The partnership arrangement with Macmillan and Friends of the Cancer centre allows for the incremental planned and managed introduction of cancer nurse specialists within NI across all Trust thus ensuring equity for patients.
3. Introduce clinical nurse specialists as per agreed workforce plan without a partnership arrangement with Macmillan and Friends of the Cancer centre.	R	To introduce the clinical nurse specialists as per agreed workforce plan without a partnership arrangement with Macmillan and Friends of the Cancer centre would have the potential to increase the CNS provision however given the current financial constraints within HSC, the number of CNSs who could be recruited would be significantly reduced due to affordability, thus introducing risk with some services

		and specialities with a continued lack of investment in CNSs.

Option 2 allows expansion of the CNS role and ensures that all patients receive a patient-centred service that meets the information and support needs of them and their families.

2.3 How does this service / project address inequality? *(please refer to guidance notes)*

The NI Cancer Registry (2013) have identified that there were 69,377 people living with cancer in NI at the end of 2010. There were an average of 2497 cancers (including non-melanoma Urology cancer; NMSC) diagnosed each year in the Southern Health and Social Care Trust between 2010 and 2014. This represents 20.4% of all cancer diagnoses in Northern Ireland during this time period.

The lack of CNSs in the SHSCT results in patient inequality and patients being disadvantaged when compared regionally. The Northern Ireland Cancer Patient Experience Survey 2015 results show that in the SHSCT only 68% of patients were given the name of the CNS in charge of their care; this was the lowest percentage in NI.
At a national level it is acknowledged that NI has a shortage of CNS posts compared to the rest of the UK and this gap is widening.

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

**Source Macmillan census of the specialist adult cancer nursing workforce NI 2014, whereby incidence data sourced from personal correspondence with the biostatisticians/researchers at the Northern Ireland Cancer Registry in August 2014*
***2015/16 position and includes 11 WTE charitably funded posts with no exit strategy.*

Northern Ireland is now bottom of the UK for the total number of CNSs per region. This lack of CNSs equates to an unequal service for patients as research has shown that CNSs can significantly improve patient care and quality of life. A 2009 Macmillan report states that "CNSs can help improve quality of life for people with cancer through assisting with decision making, symptom management and emotional support".

This plan also includes the introduction of support workers, which has been shown in the 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.

Other areas of inequality will also be addressed through this project. Primarily the Trust catchment area includes pockets of social deprivation and the opportunity for patients to have holistic needs assessment and attend HWBCs with advice on smoking cessation, lifestyle changes will be beneficial.

Secondly as there is a significant elderly population in the Trust locality it is planned to offer services including nurse led telephone clinics. Thirdly, there will be access to materials for those who are visually or audibly impaired upon request.
Finally as the key elements of the workplan for the new staff would be in line with the TYC and TCFU programmes of change. Both programmes have undergone an Equality Impact Assessment and meet the required criteria.

Between 2010 and 2014 there were 1621 people diagnosed in Northern Ireland with urological cancer.
Within the Southern trust area, at the end of 2014, there were 2305 people living up to 22 years post al cancer diagnosis.Within the SHSCT on average there are 430 people diagnosed with a new urology cancer each year per 100,000 people, this is similar to the NI average.

The introduction of another Urology CNS will help to further develop the existing Urology cancer service in SHSCT and ensure full implementation of the recovery package including nurse-led follow-up for all patients living with urological cancers. Given the increase in patients living with urology cancers this is particularly pertinent.

2.4 How have users / people affected by cancer been involved in the proposed service development /project. Outline the plans for longer term user involvement in the service / project development (please refer to guidance notes)

Service user questionnaires for Peer Review in 2014/15 have identifed the need for improved information. In addition a postal survey of cancer patients in NI highlighted that just under 40% of patients have unmet needs (Santin, 2011).

The survey identified that patients did not recall being given written information about other sources of support i.e. financial support, local support groups or services offering psychological, social, spiritual/cultural support. Other patients stated that they were not provided with enough information at their diagnosis, forcing them to contact GPs instead.

These findings have been reiterated by the lower scoring Cancer Patient Experience Survey answers; the list below NI scores are given first and England 2014 CPES scores second denoted within { }.

- Q14 - given written information about the type of cancer they had: substantially lower score in NI 64% {72%}
- Q18 - given written information about the side effects of treatment 78% {82%}
- Q21 - given the name of a CNS in charge of their care 72% {89%}
- Q29 - taking part in cancer research discussed with the patient 18% {31%}
- Q33 - given written information about the operation they were having beforehand 66% {76%}

Northern Ireland cancer services seem to be less successful at giving written information on cancer, at various points along the pathway, than is the case elsewhere. The proportion of patients having access to a CNS is lower than elsewhere - and this is known to be a key driver of high scores given by patients about their care in both England and Wales. This insight into patients unmet needs has been taken on board and has resulted in the development of this proposal as it is believed additional CNS will help to provide patients and their family members with the information and support they require at a timely point in their pathway. The support worker will assist the clinical staff to co-ordinate the patient pathways, establish a robust data collection and collation system and support health and wellbeing events.

Once the posts are established service user feedback will be utilised to develop the posts and ensure they remain patient-focused. This feedback will be taken from a number of sources including patient surveys and future health and wellbeing events. Within Southern Trust significant improvements have been made within the Urology team in that the Clinical Nurse Specialist sees patients from the point of a cancer diagnosis and offers support and advice in conjunction with contact numbers. The regional patient experience survey has demonstrated positive feedback on the benefits of a having a clinical Nurse Specialist at the point of diagnosis for ongoing support and advice.

IF THIS IS A SERVICE - COMPLETE PART 3

2.5

There is a cancer user forum which meets quarterly, however communication is passed in the intervening months, for e.g. the Urology MDT patient information leaflet when developed was reviewed by the cancer service user forum and changes made based on their feedback.

IF THIS IS A SERVICE - COMPLETE PART 3

IF THIS IS A PROJECT – COMPLETE PARTS 3 AND 4

IF THIS IS A CANCER ENVIRONMENTS/BUILDING SCHEME COMPLETE PARTS 3 AND 4 AND ALSO COMPLETE PART 5

PART THREE - SERVICE SPECIFICATION – please refer to guidance before completion
(NOTE: Macmillan may, if the bid is developed further, ask its partner organisations to create an "Operational Policy" which expands on the information provided in the sections below – a template will be provided).

3.1 Service aim
The aims and anticipated outcomes should clearly reflect the evidence of need for this project /service as identified in Part One? Please see the guidance notes and refer to Macmillan's nine outcomes

a) *Describe the overall aim of the proposed service, outlining who the project / service is for / aimed at*

b) *Identify the anticipated outcomes of the project / service (the outcomes you would expect to see during the lifetime of the project / service). Outline the impact we expect the service/project to have – i.e. what we want to achieve through it and how we will achieve it (things that can be quantified and collected through monitoring data*

c) *Outline the anticipated numbers of clients /people affected by cancer that the service/project will allow access to.*

d) *Outline how this service /project will be integrated with the wider health and social care services that are providing a service for people affected by cancer*

e) *Outline how volunteers will be supporting the service /project, and outline ongoing plans for volunteer support and engagement including how it will achieve Macmillan's Volunteer Quality Standards*

f) *What are the Learning & Development requirements to deliver the service / project? Either for the individuals within the service, associated team members or the organisation*

(a) Service Aim: To develop, introduce and evaluate the introduction of Urology Clinical Nurse Specialist posts and support worker posts that meet the physical, psyschological, social, information and support needs of Urology cancer patients throughout their pathway in the SHSCT and maintain person centred care in line with DHSSPSNI Nursing and Midwifery Strategy (2015). This will contribute to more efficient and effective service delivery, an improved patient experience throughout the pathway and support the commissioning of future service provision. The proposed plan will also 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.

(b) Outcomes

CNS Outcomes	Measurable Targets
1. The cancer clinical nurse specialists will form part of the multi-disciplinary cancer teams and provide the key worker function	1.1 Number of patients referred to service 1.2 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
2. The CNSs will act as a core member of the tumour specific multidisciplinary team	2.1 **KPI:** % attendance at MDT meetings must meet National Peer review measures standard **Baseline: 66%**
3. To provide nurse led activity to include nurse led clinics and telephone work	3.1 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)
4. To provide education / training to staff and patients	4.1 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.
5. Identify and contribute to service improvement and policy development.	5.1 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.

Support Worker outcomes:

- To support the CNSs to provide a patient-centred service
- To assist with the co-ordination of multidisciplinary clinics
- To ensure patient phone calls are registered, managed and addressed by appropriate staff in an timely manner

- To guide patients through the use of self-assessment tools and support the administration of holistic needs assessment
- To provide sign-posting to patients and family members to appropriate services
- To assist at health and wellbeing events and any rehabiliation sessions
- To establish and maintain a robust and accurate database for the services
- To support and contribute to audit, governance, research and service development within the cancer teams.

These service outcomes are in line with six of the nine Macmillan outcomes for people living with cancer, i.e.

- I understand, so I can make good decisions.
- I get the treatment & care which is best for my cancer and my life
- Those around me are well supported.
- I am treated with dinity and respect
- I know what I can do to help myself and who else can help me
- I can enjoy life

(c) Anticipated numbers that the service will support

There were an average of 2497 cancers (including non-melanoma Urology cancer; NMSC) diagnosed each year in the Southern Health and Social Care Trust between 2010 and 2014. This represents 20.4% of all cancer diagnoses in Northern Ireland during this time period.
Between 2010-2014 in SHSCT, there were 2305 people living up to 22 years post diagnosis with either an urological cancer (ref: www.lcini.macmillan.org.uk). In 2016, there were 746 new patients diagnosed with urological cancer in 2015.
Many more people with an urology cancer are living longer, surviving initial treatment and going in and out of remission. The proposed new posts will enable a much greater proportion of these patients to receive the support of a CNS during the diagnosistic phase and the immediate pre and post-operative period. The teams will also provide a service to those already living with cancer and to those who present with a recurrent cancer.

Through supporting both new and current patients it is anticipated that a high proportion of family members will be supported by the teams. There is also the opportunity to increase volunteering opportunities through the Health and wellbeing events and potential rehabilitation programmes.

(d) Integration with the wider HSC services that are providing a service for people affected by cancer

These posts will be closely linked to the priorities outlined by the Northern Ireland Cancer Network (NICaN), The Cancer Service Framework for Northern Ireland and the Transforming Cancer Follow Up Project. The proposed staff will work collaboratively with the wider health and social care team in the Trust to ensure that service boundaries do not impact on the patient pathway. Furthermore, they will collaborate with teams across other local trusts and through out the UK to ensure an evidence based, equitable service is provided acting as a link in the seamless preparation of the patients for treatment.

The post holders will work across primary and secondary care to provide a support service for advice to primary care and links with all those along the patient's cancer journey, this ranges from the general outpatients department, consultant staff, other clinical nurse specialists as appropriate, social work information and support services and to voluntary agencies supporting integrated working with primary care as key patient groups traditionally followed up in secondary care will move via risk stratification to either self-directed follow up or coordinated care.

The Trust's developing model for Health and Well Being events (HWB) will also link closely with the new postholders and through redesign of the services patients will be referred to HWB events. These events rely strongly on partnerships with a wide number of voluntary groups and volunteers including Macmillan support services, Citizens' Advice Bureau, Cancer Focus NI.

The Trust will build effective collaborative working models with partners at both strategic and operational levels thus providing significant opportunities to enhance its ability to address the needs of those with cancer across all care settings.
The post-holders will play key roles in the MDTs and will be incorporated into the current services delivered by the trust.

The new staff will work closely with other Macmillan funded staff within the trust. Particularly they will liase with:

- Macmillan Health & Wellbeing Manager to ensure patients receive information and signposting appropriate to their needs
- Macmillan Service Improvement Manager to aid implementation of the TCFU principals in cancer services
- Macmillan Benefits Advisers to ensure patients receive the financial advice and support they require
- Trust Volunteer Manager to utilise volunteers where approriate in cancer services e.g. at Health and wellbeing events

(e) Volunteer Support and Engagement
Through working closely with the SHSCT Volunteer Manager, the postholders will identify suitable volunteers who are willing to help at events. If should also be possible for the staff to identify patients or family members who are at a suitable phase in their pathway who may wish to act as volunteers to provide the patient perspective at Health and wellbeing events.

(f) Learning and development needs
All nursing practice is underpinned by the Nursing and Midwifery Council Code of Professional Practice (2015)5 which provides clear guidance on development, responsibilities and accountability. In addition, if not already attained the nurses will be required to complete an Oncology specialist practice module and if required the Health Assessment and Independent Nurse Prescribing course at QUB to ensure they are able to undertake nurse-led clinics.
The post-holder will also be encouraged to undertake continous professional development that is appropriate to their developing roles. 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. These may include a variety of inhouse training courses, in conjunction with Macmillan specific training that will enable them to develop personally and professionally.
Learning and development needs will be identified through supervision, annual staff development and performance review in line with Trust procedure.

3.2 Service Evaluation / Demonstrating Impact

a) *What measures / methods will be used to evaluate the project / service.*
b) *Identify what the longer term impact will be resulting from the outcomes.*
c) *Is there any baseline data needed now in order to assess impact after the project? – Identify how the basic monitoring data (outputs) will be collected and who will be responsible, and how you intend to capture outcomes and who will be responsible.*
d) *Identify who the evaluation will be shared with and methods of sharing*

The assurance of safety, quality and experience through appropriate performance measures has been 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. Success will be monitored though the KPIs developed in the generic commissioning specification and any unintended consequences of the changes identified so that corrective action can be taken. This has been agreed through the regional ADs performance and service improvement monthly meetings. Specific monitoring processes will be developed and agreed at the outset of the posts.

Evaluations will endeavour to identify the successful areas of work undertaken and will also aim to highlight areas that have not been successful to ensure future service development learn from any issues identified. These evaluations will aim to collect quantitative and qualitative data from a variety of sources including those receiving the service e.g. patients and family members, those working within the multidisciplinary teams and those working outside the acute setting e.g. GPs.

On-going quantitative monitoring of the services will be achieved through data collection as per Trust audit process and requirements for service improvement, peer review standards for cancer patients, contribution to the Macmillan minimum data set. This data will be collected by the post holders on an on-going basis and will utilise data available through internal hospital systems including the Cancer Patient Pathway System (CaPPS), the local laboratory system, Theatre Management System and Patient Administration System.

The service will engage with patients, carers and others who use it. One of the most reliable standards against which to measure the quality of the service is the patient's experience. Feedback from those who use the service will provide a credible outcome measure to demonstrate the value of the service and to evaluate if the service is meeting its aims and objectives.

A range of methodologies and data systems will be employed to critically assess the impact of the service in relation to meeting the needs of those for whom it has been established. These include:

- Patient satisfaction surveys (conducted at least every 2 years)
- Evaluation of any events or programmes organised by the team
- 6-monthly follow up with a sample of individuals who have accessed the service to determine if needs have been met

The post holders will liaise with the current MDTs and formative evaluation will be used on an on-going basis to ensure that the new roles are developing appropriately and meeting the needs of the team. The post holders will be expected to update to the site specific MDM Business Meetings and Lead Cancer Team to ensure the service is evolving as per the service development plan and in accordance with local and regional strategies.

3.3 Governance

It is important that services operate within a governance framework to ensure that they are safe, efficient and effective. Good governance will also help provide evidence to support the future sustainability of the service.

Please provide information on the governance arrangements for the service. This should include information about:

- *Standards the service will be working to (e.g. locally developed, professional or national)*
- *Staff performance review process*
- *Achieving Macmillan Volunteer Quality Standards*
- *Learning and development for the individuals within the service*

- *Customer satisfaction*
- *Outline details of the project team, decision making and change management forums*
- *Project reporting mechanisms.*
- *Outlining of any risks and how to mitigate against them*

The Trust has a governance structure in place, which incorporates the key elements of clinical and social care governance (safe and effective care), risk management/organisational controls, and financial governance. This integrated governance framework ensures an integrated approach to all aspects of health and social care delivery
All staff will adhere to all aspects of governance as outlined by the Trust including policies and procedures. All Trust policies are available on the Intranet and new policies introduced are highlighted and discussed at Team Meetings. Any specific policies will be developed for the service and risks identified and added to the departments risk register.

The postholder will complete a comprehensive induction corporately, in conjunction with Macmillan and departmentally. Any initial learning needs will be identified and an action plan developed.

An outline for the Knowledge and Skills Framework will be developed for the postholder and will provide the framework for an annual appraisal. This will include development of a Personal Development Learning Plan. The Postholder will be expected to contribute to the annual Departmental and Directorate User Consultation Plan, Audit Plan and Safety Quality and Patient Experience Plan.

There is a range of professional standards that the post holders will be working to, these include:

- Nursing and Midwifery Council (NMC, 2015) The Code: Standards of conduct, performance and ethics for nurses and midwives
- NMC (2007) Standards for Medicines management
- NMC (2005) Standards of proficiency for nurses and midwife prescribers
- Royal College of Nursing (RCN, 2008) Advanced Nurse Practitioners: An RCN guide to the advanced nurse practitioner role, competencies and programme accreditation

Dietetic professional standards include

- Health Professional Council (HPC) Standards of proficiency
- HPC Standards of conduct, performance and ethics
- HPC Standards for continuing professional development

Staff performance review process
All staff will participate in the Trust standard performance review process: Knowledge and Skills Framework. The nursing post holders will be line managed and supervised by the relevant assistant service manager. The support workers will be managed by the appropriate administrative team. All post holders will be accountable to the Assistant Director for the service area within which they sit. Staff performance will be monitored through regular supervision, and good practice in project management including a project initiation document, Gantt charts in relation to key milestones and a risk register to manage the project.

Annual reports will be submitted to Macmillan Cancer Support, highlighting the progress relative to the objectives and expected outcomes of the postholders.

Learning and Development
As outlined in section 3.1 (f) Learning and development needs will be identified for the staff and supported where approriate.

Customer satisfaction
As outlined in 3.2 patient satisfaction will assessed through a variety of means.

Project team, decision making & change management forums
The proposed new post holders will work within the already established MDTs. They will work collaboratively

with the teams in planning and delivering services that is focused on the needs of patients. Any changes to the current services will be managed through the MDT and implementation will be a trust wide collaborative approach.

Reporting Mechanisms

At a working level the staff will report to their line manager at regular supervisory meetings. At a strategic level progress will be reported to the MDT Business meetings and to the monthly Lead Cancer Team meeting within the Trust.

3.4 Macmillan profile and the Macmillan experience

There is an expectation that all services/ developments/builds funded by Macmillan Cancer Support will be sustained following the initial funding period (with the exception of discrete projects) and will carry the name Macmillan and the appropriate agreed levels of branding for as long as the post / service exists. It is vital that those using the service will recognise that they have had a high quality Macmillan experience. Please explain in this section:

- *How the service will be Macmillan-branded?*
- *Will the Partner Organisation agree to the service and facilities carrying the Macmillan name e.g. 'Macmillan Information and Support Centre' and the charity's brand being displayed on and inside the Centre?*
- *How will the post holder / service help raise the profile of Macmillan Cancer Support?*
- *Any possible co-branding issues?*
- *How will patients recognise that Macmillan is a partner in this service through the experience they receive?*
- *How will volunteers receive an optimum experience in line with Macmillan standards?*
- *Please add any other information you feel is relevant*

The proposed service will promote the Macmillan profile and ensure all who avail of the service recognise that they have received a high quality Macmillan experience through the following key areas:

- The postholders' title will carry the name 'Macmillan' for the life time of the post.
- All promotional materials e.g. banners, posters etc will be co-branded bearing Macmillan logo and that of Southern Health & Social Care Trust as the partner organisation.
- The Macmilllan logo will be used on all stationary, publications relating to this service and on information resources produced by the team for use at health and wellbeing events
- The profile of Macmillan Cancer Support will be raised by presenting Macmillan as a funder of a range of services not just palliative care nursing for which they are renowned.
- The service will endorse Macmillan's strategy for support and information and their commitment to patient and public involvement.
- Macmillan's Communications Dept will be utilised to assist in generating publicity
- The team will work with the Macmillan Development Manager and the Macmillan L&D Manager to gain support in service development, review, quality and educational needs
- Collaboration with the Southern Health & Social Care Trust Communications Team will be utilised to promote the service within the Trust.

- Staff will also endeavour to identify appropriate 'Case Studies' for Macmillan to promote the work related to this service

The postholder will promote Macmillan Cancer Support as an organisation and highlight the work that the organisation does at all opportunities through:

- Joint publicity and promotion of the service by Macmillan and the Trust
- All marketing will use the agreed Macmillan /Trust format
- All users will be given details of the Macmillan Cancer Service Improvement manager
- Work closely with Macmillan Cancer Support marketing and communications departments and agree all publicity materials.

3.5 Risks

Identify any risks associated with the project/service and how these can be mitigated

Key: Red = High, Amber = Medium, Green = Low

Table 1: Risk Matrix

Likelihood	Consequence: Insignificant (1)	Minor (2)	Moderate (3)	Major (4)	Catastrophic (5)
Almost certain (5)	5 L	10 M	15 M	20 H	25 H
Likely (4)	4 L	8 L	12 M	16 H	20 H
Possible (3)	3 L	6 L	9 M	12 M	15 M
Unlikely (2)	2 L	4 L	6 L	8 L	10 M
Rare (1)	1 L	2 L	3 L	4 L	5 L

Risk Identified	Score prior to mitigation	Mitigation	Score following mitigation
Unable to appoint suitable qualified nursing staff	9M	Partnership working with Southern Trust to enable appropriate nurse training and development	6L
Not all patients will make use of the additional staff	12M	The criteria for patients which are suitable to receive this service is suitably wide to ensure adequate uptake.	6L
Support workers may not have the combination of skills required for these posts i.e. clerical and clinical knowledge and experience	12M	Staff will receive additional training in the area where deficits are identified	6L

PART FOUR - PROJECT SPECIFICATION – please refer to guidance before completion

4.1 Outline initial project plan including key milestones and timelines

Urology CNS Team Development Plan - Gantt chart 2017 – 2018

Phase 1 - Actions	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May
Clerical and Managerial Teams to meet to discuss new CNS team: a)Agree and draft job descriptions b)Agree and draft job plans												
Begin recruitment process through HR												
Appoint Urology B6 CNS and B3 Support Worker												
Correlate baseline data												
Discuss evaluation methodology												
Draft Nurse Led Protocols for Clinical Oncology/Surgery												
Training for CNS and Support Worker Posts												
Establish Nurse led Clinics												
Agree and establish rapid access patients												
Engage with unit teams												
Implement recovery package												

4.2 Sustainability

How will the project outputs / outcomes be embedded locally>
Outline what the exit strategy will be.
What is required in order for the benefits to be sustained?

Given the CNS expansion has been led by the PHA and HSCB this provides a sustainable mechanism to build and expand the cancer CNS workforce in NI. With the introduction of KPIs against the agreed generic cancer CNS commissioning specification, sustainability will be achieveable and good monitoring against the KPIs will provide evidence of this.

This plan was approved by senior management team at HSCB/PHA in December 2015, with the first cohort of staff to be recruited in 2016/17. Charitable funding is being made available to support this plan with senior management team agreement to the tapered funding model to facilitate the 5 year incremental growth in the CNS workforce totalling 2.4 million over the next 11 years. The workforce plan takes account of the role of clinical nurse specialists (CNS) in contributing to high quality cancer care at the front line and the clear analysis that when patients have access to CNSs, this significantly improves patient experience. To date cancer CNS commissioning within Northern Ireland has been ad hoc and opportunistic, with provision significantly lower than the rest of the UK.

During the lifetime of the expanision plan, the associated outputs will be effectively monitored and evaluated to provide an in-depth insight into the impact achieved. This will be achieved via the use of and application of effective monitoring and evaluation systems and processes through the introduction of KPIs against the agreed generic cancer cCNS commissioning specification. Sustainability will be achieveable by ensuring embedding of protocols and pathwats into routine service and good monitoring against the KPIs will provide evidence of this.

Macmillan Application for Funding: Cost Profile: Complete the number of columns as appropriate according to the proposed funding model. **Needs changed for Band 6 costs**

Basic salary plus on costs for each grade of staff (e.g. employers pension and NI contributions)						
	Year One (16/17)	**Year Two (17/18)**	**Year Three (18/19)**	**Year Four (19/20)**	**Year Five (20/21)**	**Year Six (21/22)**
Macmillan contributions	**90%**	**80%**	**70%**	**60%**	**50%**	**20%**
Band 7 CNS	Personal Information redacted by the USI					
Band 3 Support Worker (0.25WTE)	Personal Information redacted by the USI					

Travel costs						
	Year 1	**Year 2**	**Year 3**	**Year 4**	**Year 5**	**Year 6**
Band 7 CNS	£1000	£1000	£1000	£1000	£1000	£1000
Band 3 Support Worker (0.25WTE)	-	-	-	-	-	-

Capital Costs (please specify)

Set up costs – Year One Only (please specify)
£1000

Volunteer costs (if appropriate)						
	Year 1	**Year 2**	**Year 3**	**Year 4**	**Year 5**	**Year 6**
	NA	NA	NA	NA	NA	NA

Learning & Development (if appropriate)						
	Year 1	**Year 2**	**Year 3**	**Year 4**	**Year 5**	**Year 6**
	NA	NA	NA	NA	NA	NA

User Engagement or Other – please give breakdown

Totals						
	Year 1	**Year 2**	**Year 3**	**Year 4**	**Year 5**	**Year 6**
Totals	Personal Information redacted by the USI					

Total contribution requested from Macmillan and the specified period of funding
Salaries:
Band 7: Personal Information redacted by the USI
Band 3 (0.25 WTE): £ Personal Information redacted by the
Travel: Personal Information redacted by the
Set up costs: £1000

Macmillan Contribution over 6 years - £206,000

The Partner Organisation has seen the principles set out in Appendix A (the Grant Agreement) setting out the Conditions of Grant for Capital Projects. These (and any other project specific conditions set out in the Schedules to Appendix A) will be discussed and mutually agreed prior to the application for Outline Scheme Approval (Stage 1) from Macmillan's Board of Trustees.

Signed Date

Position in Organisation

WE ARE MACMILLAN. CANCER SUPPORT

HSC Southern Health and Social Care Trust

Quality Care - for you, with you

Macmillan Urology Clinical Nurse Specialist Post

Operational Policy

Date Written: September 2017

- **Revised:**

CONTENTS

1. INTRODUCTION

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.

- 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 in NI with the majority area of practice being breast (33.8%), with minimal provision in Urology and urology. This is significantly lower that other UK countries when incidence rates are compared to whole time equivalent posts.

- This is further compounded by results from the 3 year 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.

- The transforming cancer follow-up evaluation (2015) 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.

- There is thus an overwhelming deficit in the number of CNSs within the SHSCT and by increasing the number of nurse specialists and through inclusion of support worker roles within the CNS workforce plan this 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.

Introduction

The service to be delivered is via the appointment of a 1.0 WTE Macmillan Urology Clinical Nurse Specialist (CNS) and 0.25WTE Urology Support Worker working across the wider Urology team in SHSCT. The Clinical Nurse Specialist will provide a service for patients living with urology conditions, and for their carers, friends or relatives. The CNS will play a key role within the multi-professional team to ensure a seamless, co-ordinated approach to care and timely onward referral to other professionals / agencies. The Support Worker will work alongside the Urology CNS to assist in all aspects of service delivery.

2. DESCRIPTION OF THE SERVICE

2.1 AIMS AND OBJECTIVES

(a) Service Aim:

- Equipping the workforce is an important element of the CNS expansion plan and the inclusion. The introduction of an additional 1.0 WTE band 6 Urology cancer nurse will enable the development of knowledge and skills to support the existing Urology nursing service within SHSCT.
- To introduce and evaluate the introduction of Clinical Nurse Specialist post that meets the physical, psychological, social, information and support needs of cancer patients throughout their pathway in the SHSCT and maintain person centred care in line with DHSSPSNI Nursing and Midwifery Strategy (2015). This will contribute to more efficient and effective service delivery, an improved patient experience throughout the pathway and support the commissioning of future service provision. The proposed plan will also ensure that NI HSC services have a healthy, productive workforce who is appropriately skilled trained, and provide the highest quality healthcare services at the right time in the right place.

(b) Outcomes

CNS Outcomes	Measurable Targets
1. The cancer clinical nurse specialists will form part of the multi-disciplinary cancer teams and provide the key worker function	1.1 Number of patients referred to service 1.2 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
2. The CNSs will act as a core member of the tumour specific multidisciplinary team	2.1 **KPI:** % attendance at MDT meetings must meet National Peer review measures standard **Baseline: 66%**
3. To provide nurse led activity to include nurse led clinics and telephone work	3.1 To support the delivery of 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)
4. To provide education / training to staff and patients	4.1 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.
5. Identify and contribute to service improvement and policy development.	5.1 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.

The Support Worker objectives are:

- To support the CNSs in the Urology team to provide a patient-centred service
- To assist with the coordination of clinics
- To assist in signposting patients to relevent support services

- To help patients navigate through their cancer journey
- To ensure all patient phonecalls are registered, managed nad addressed by appropriate CNS in a timely manner
- To establish and maintain databases to monitor all relevent activity within the Urology team
- To assist in the planning and delivery of health and wellbeing events

(c) Anticipated numbers that the service will support

There were an average of 2497 cancers (including non-melanoma skin cancer; NMSC) diagnosed each year in the Southern Health and Social Care Trust between 2010 and 2014. This represents 20.4% of all cancer diagnoses in Northern Ireland during this time period.

Between 2010-2014, on average, there were 300 people diagnosed with an urology cancer each year living within SHSCT. At the end of 2014, there were 2305 people living up to 22 years post cancer diagnosis. On average, there are 204 new urological cancer diagnoses per 100,000 people each year in SHSCT, this is similar to the NI average (ref: www.lcini.macmillan.org).

Many more people with a cancer diagnosis are living longer, surviving initial treatment and going in and out of remission. The proposed new posts will enable a much greater proportion of patients with a urology cancer to receive the support of a CNS during the diagnosistic phase and the immediate pre and post-operative period. The teams will also provide a service to those already living with cancer and to those who present with a recurrent cancer.

Through supporting both new and current patients it is anticipated that a high proportion of family members will be supported by the teams. There is also the opportunity to increase volunteering opportunities through the Health and wellbeing events and potential rehabilitation programmes.

(d) Integration with the wider HSC services that are providing a service for people affected by cancer

The postholder will be closely linked to the priorities outlined by the Northern Ireland Cancer Network (NICaN), The Cancer Service Framework for Northern Ireland and the Transforming Cancer Follow Up Project. Each team within the Southern Trust will work collaboratively with other trusts if regional specialist services are required including the cancer centre in Belfast for the oncological treatment of patients. The proposed services will enhance collaborative working within the existing SHSCT teams. They will work closely with the consultants across all sites.

The postholder will work collaboratively with the wider health and social care team in the Trust to ensure that service boundaries do not impact on the patient pathway. Furthermore, they will collaborate with teams across other local trusts and throughout the UK to ensure an evidence based, equitable service is provided acting as a link in the seamless preparation of the patients for treatment.

The post holder will work across primary and secondary care to provide a support service for advice to primary care and links with all those along the patient's cancer journey, this ranges from the general outpatients department, consultant staff, other clinical nurse specialists as appropriate, social

work information and support services and to voluntary agencies supporting integrated working with primary care as key patient groups traditionally followed up in secondary care will move via risk stratification to either self-directed follow up or coordinated care.

The Trust's model for Health and Well Being events (H&WB) will also link closely with the new post holder and through redesign of the services patients will be referred to H&WB events. These events rely strongly on partnerships with a wide number of voluntary groups and volunteers including Macmillan support services, Citizens' Advice Bureau, Cancer Focus NI.

The Trust will build effective collaborative working models with partners at both strategic and operational levels thus providing significant opportunities to enhance its ability to address the needs of those with cancer across all care settings.
The post-holders will play key roles in the MDTs and will be incorporated into the current services delivered by the trust.
The new staff will work closely with other Macmillan funded staff within the trust. Particularly they will liaise with:

- Macmillan Health and Well Being Coordinator to ensure patients receive information and signposting appropriate to their needs
- Macmillan Service Improvement Manager to aid implementation of the TCFU principals in cancer services
- Macmillan Benefits Advisers to ensure patients receive the financial advice and support they require
- SHSCT Volunteer Manager to utilise volunteers where appropriate in cancer services e.g. at Health and wellbeing events

(e) Volunteer Support and Engagement
Through working closely with the SHSCT Volunteer Manager the post holders will identify suitable volunteers who are willing to help at events. It should also be possible for staff to identify patients or family members who are at a suitable phase in their pathway who may wish to act as volunteers to provide the patient perspective at Health and wellbeing events.

(f) Learning and development needs
All nursing practice is underpinned by the Nursing and Midwifery Council Code of Professional Practice (2015) which provides clear guidance on development, responsibilities and accountability. In addition, if not already attained the nurses will be required to complete an Oncology specialist practice module and the Health Assessment and Independent Nurse Prescribing course at QUB to ensure they are able to undertake nurse-led clinics.

The Post-holder will also be encouraged to undertake continuous professional development that is appropriate to their developing roles. 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. These may include a variety of in-house training courses, in conjunction with Macmillan specific training that will enable them to develop personally and professionally.
Learning and development needs will be identified through supervision, annual staff development and performance review in line with Trust procedures.

2.2 WHO THE SERVICE IS FOR (SERVICE USERS)

The service is for patients affected by Urology cancer who are treated by the Southern Trust. The introduction of an additional 0.6 WTE band 7 Urology cancer nurse will support the existing Urology cancer service within SHSCT.

Between 2010 and 2014 there were 1621 people diagnosed in Northern Ireland with urological cancer.
Within the Southern trust area, at the end of 2014, there were 2305 people living up to 22 years post cancer diagnosis.Within the SHSCT, on average, there are 430 people diagnosed with a new urology cancer each year per 100,000 people (ref: www.lcini.macmillan.org).

Although modernisation and reform principals have been put in place to reduce the number of reviews over recent years, including the introduction of nurse led cancer review for low risk cancers, the overall attendance at outpatient clinics has increased by 12%.
Nurse led reviews and self-directed follow-up pathways have not been implemented within SHSCT for Urology patients and the additional nurse will enable roll-out of this follow-up system.

2.3 ACTIVITY TARGETS

The measurable targets the individual will work to are outlined below. More detail will be added when the individual is in post.

Measurable Targets
1.2 Number of patients referred to service 1.2 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

2.1 **KPI:** % attendance at MDT meetings must meet National Peer review measures standard **Baseline: 66%**
3.1 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)
4.1 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.
5.1 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.

2.4 Equality and Diversity

The 2015 NI Cancer Patient Experience Survey (CPES) reported 72% of patients in NI having access to a CNS, much lower than England (2014) 89% and Wales (2013) 88%. National analysis demonstrated the support of a CNS is the most important contributing factor to people reporting a positive experience of care. Furthermore, results from the 3 year NI cancer peer review programme of multi-disciplinary teams identified lack of access and single handed CNS service provision as an immediate risk or serious concern in 17 out of the 30 MDTs reviewed to date. Year 3 occurred in June 2016 and has found find similar access issues.

The NI Cancer Registry (2013) have identified that there were 69,377 people are living with cancer in NI at the end of 2010. The annual percentage increase in prevalence over a 10 year period shows a steady rise in males of 4.6% and 2.6% for females.
The lack of CNSs in the SHSCT results in some patients being disadvantaged when compared nationally, regionally and locally to other patient groups. At a national level it is acknowledged that NI has a shortage of CNS posts compared to the rest of the UK and this gap is widening. There are currently 76.2 WTE cancer CNSs across Northern Ireland, of which 11 WTE are charitably funded posts with no identified exit strategy.

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
**Source Macmillan census of the specialist adult cancer nursing workforce NI 2014, whereby incidence data sourced from personal correspondence with the biostatisticians/researchers at the Northern Ireland Cancer Registry in August 2014* ***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 urology). 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 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 31.8 WTE.

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 support worker role is set at 0.25 per WTE CNS.

CNSs equates to an unequal service for patients as research has shown that CNSs can significantly improve patient care and quality of life. A 2009 Macmillan report states that "CNSs can help improve quality of life for people with cancer through assisting with decision making, symptom management and emotional support".

Other areas of inequality will also be addressed through this project. Primarily the Trust catchment area includes pockets of social deprivation and the opportunity for patients to have holistic needs assessment and attend HWB events with advice on smoking cessation, lifestyle changes which will

be beneficial.

Secondly as there is a significant elderly population in the Trust locality it is planned to offer services across SHSCT and also use telephone triage where appropriate. Thirdly, there will be access to materials for those who are visually or audibly impaired upon request.

Finally as the key elements of the work plan for the new staff would be in line with the TYC and TCFU programmes of change. Both programmes have undergone an Equality Impact Assessment and meet the required criteria.

The introduction of an additional 1.0 WTE band 6 Urology cancer nurse will support the existing Urology cancer service within SHSCT.

3. OPERATIONAL DETAILS ABOUT HOW THE SERVICE WILL BE DELIVERED

3.1 STAFFING

- 1.0 WTE Band 6 Urology Cancer CNS

The Urology CNS team will be managed by the Head of Cancer Services within the SHSCT.

- 0.25 WTE Band 3 Support Worker

The Support Worker will be managed by the Cancer Services Co-ordinator

3.2 ADMINISTRATION

Administration will be provided by existing admin and clerical staff within SHSCT.

3.3 OPERATING HOURS

The post will be based in Craigavon Area Hospital and with outreach to other clinical areas as appropriate. The service will operate within the core working hours and as the service needs demand.

3.4 REFERRAL PROCESS

Referrals to the CNS will be made via the MDT or directly to the CNS mobile from other CNS and any other teams including those in primary care. Referral can be made via letter, email or phone. Triage and prioritization of referrals to the service will be managed within the Urology Cancer Nursing Team.

3.5 SERVICE PROVISION

All patients diagnosed with Urology cancer in the SHSCT will have access to the Urology cancer nursing team. Patients will be assessed and appropriate professionals will be involved in their clinical care during treatment and in the immediate post-treatment period. On-going care will be individualised according to patient need and patients will be allocated on a risk stratified basis to appropriate pathways of follow-up care.
Patients will have access to the Urology cancer nursing team through a dedicated telephone line with answering machine.
Palliative patients will be discharged from the general service to the palliative care service available within the trust.
Patients will be discharged from the service in line with regional and national guidelines.

3.6 KEY WORKING RELATIONSHIPS

This post will be closely linked to the priorities outlined by the Northern Ireland Cancer Network (NICaN), the Cancer Service Framework for Northern Ireland and the Transforming Cancer Follow Up Project. Currently there is one Urology Cancer CNS in post providing support to patients with Urology cancer within the Southern Trust; the new CNS will work collaboratively with them.
A proportion of patients also require treatment at the regional cancer centre and the new post holder will ensure a seamless transition of care for patients moving between the trusts for treatment. They will work closely with the consultants across all sites.
The CNS will work collaboratively with the wider health and social care team in the Trust to ensure that service boundaries do not impact on the patient pathway. Furthermore, they will collaborate with teams across other local trusts and throughout the UK to ensure an evidence based, equitable service is provided acting as a link in the seamless preparation of the patients for treatment.
The post holder will work across primary and secondary care providing a support service for advice to primary care and links with all those along

the patient's cancer journey, this ranges from the general outpatients department, consultant staff, other clinical nurse specialists as appropriate, social work, information and support services and to voluntary agencies supporting integrated working with primary care as key patient groups traditionally followed up in secondary care will move via risk stratification to either self-directed follow up or coordinated care.
The Trust's developing model for Health and Well Being Clinics (HWBC) will also link closely with the overall project and through the re-design of the service patients will be referred to HWBCs. These clinics rely strongly on partnerships with a wide number of voluntary groups and volunteers including Macmillan support services, Citizens' Advice Bureau, Cancer Focus NI and Action Cancer.
The Trust will build effective collaborative working models with partners at both strategic and operational levels thus providing significant opportunities to enhance its ability to address the needs of those with Urology cancer across all care settings.
The CNS will play a key role in the Urology MDT and will be incorporated into the current services delivered by the trust.
The new staff will work closely with other Macmillan funded staff within the trust. Particularly they will liaise with:

- Macmillan Health & Wellbeing Manager to ensure patients receive information and signposting appropriate to their needs
- Macmillan Service Improvement Lead to aid implementation of the TCFU principals
- Macmillan Benefits Advisers to ensure patients receive the financial advice and support they require
- SHSCT Volunteer Manager to utilise volunteers where appropriate in the service e.g. at Health and wellbeing events

3.7 COMMUNICATION

All internal and external communication systems already available within the SHSCT will be utilised by the posts holder to ensure smooth integration of the new team into the wider Cancer Services team. The CNS will be part of the regional CNS forum. There will be weekly communication with the MDT at the regional Urology MDM. The team will also be represented at quarterly Cancer Services Strategic Board meetings.
Communication between the post holders and service users will be promoted through the telephone support line, Health and Wellbeing events and any additional events organised by the Macmillan Health & Wellbeing Manager.

3.8 USER INVOLVEMENT

Service user feedback will be utilised to develop the posts and ensure they remain patient-focused. This feedback will be taken from a number of sources including the Cancer Services User Forum Group, Trust patient satisfaction survey, regional patient survey (where SHSCT patient data can be extracted), future health and wellbeing events and other internal surveys such as those conducted for the information and support service. Service

users will be actively encouraged to contribute to steering or specific working groups.

4 GOVERNANCE *(Macmillan can provide guidance in the form of frequently asked questions in relation to governance)*

4.1 GOVERNANCE STRUCTURE

The Trust has a clear governance structure in place, which incorporates the key elements of clinical and social care governance (safe and effective care), risk management/organisational controls, and financial governance. This integrated governance framework ensures an integrated approach to all aspects of health and social care delivery.

All staff adhere to all aspects of governance as outlined by the Trust including policies and procedures. All Trust policies are available on the Intranet and new policies introduced are highlighted and discussed at Team Meetings. Any specific policies will be developed for the service and risks identified and added to the departments risk register.
Formal complaints will be forwarded from the Complaints Department to the General Manager of the service and fully investigated as per Trust Policy. Action plans will be developed following any complaint.
The post holders will be line managed by the Head of Cancer services. The post holder will complete a comprehensive induction corporately, in conjunction with Macmillan and the Trust. Any initial learning needs will be identified and an action plan developed.

There is a range of professional standards that the post holders will be working to, these include:

- Nursing and Midwifery Council (NMC, 2008) The Code: Standards of conduct, performance and ethics for nurses and midwives
- NMC (2007) Standards for Medicines management
- NMC (2005) Standards of proficiency for nurses and midwife prescribers
- Royal College of Nursing (RCN, 2008) Advanced Nurse Practitioners: An RCN guide to the advanced nurse practitioner role, competencies and programme accreditation

An annual appraisal will be undertaken with interim reviews as required.
Staff will be supported in compiling and submitting:

- Regular activity data with interpretation and analysis
- Quarterly reports of work undertaken and an annual report of the Service including progress and planned developments
- Audit and service evaluation

4.2 HEALTH AND SAFETY

The post holder will attend all mandatory training relevant to Health and safety. They will receive appropriate training in risk assessment and risk management. They will be expected to regularly assess risks within the service and deal with these appropriately.
The staff will make themselves aware of and adhere to all current health and safety policies and procedures currently available in the SHSCT that are relevant to their work e.g. lone worker policy, out of hours policy, infection control, health and safety etc.

4.3 MONITORING AND EVALUATION

Monitoring processes will be developed and agreed at the outset of the post
Evaluations will endeavour to identify the successful areas of work undertaken and will also aim to highlight areas that have not been successful to ensure future service development and learn from any issues identified. These evaluations will aim to collect quantitative and qualitative data from a variety of sources including those receiving the service e.g. patients and family members and those working within the multidisciplinary teams
On-going quantitative monitoring of the services will be achieved through data collection as per Trust audit process and requirements for service improvement, PEER review Standards for cancer patients, contribution to the Macmillan minimum data set. This data will be collected by the post holders on an on-going basis and will utilise data available through internal hospital systems including the Cancer Patient Pathway System (CaPPS), the local laboratory system, Theatre Management System and Patient Administration System.

The service will engage with patients, carers and others who use it. One of the most reliable standards against which to measure the quality of the service is the patient's experience. Feedback from those who use the service will provide a credible outcome measure to demonstrate the value of the service and to evaluate if the service is meeting its aims and objectives.

A range of methodologies and data systems will be employed to critically assess the impact of the service in relation to meeting the needs of those for whom it has been established. These include:

- Patient satisfaction surveys (conducted at least every 3 years)
- Evaluation of any events or programmes organised by the team
- 6-monthly follow up with a sample of individuals who have accessed the service to determine if needs have been met

The post holders will liaise with the current MDTs and formative evaluation will be used on an on-going basis to ensure that the new roles are developing appropriately and meeting the needs of the team. The post holders will be expected to update to the site specific MDM Business Meetings and Cancer Services Strategic Board to ensure the service is evolving as per the service development plan and in accordance with local and regional strategies.

5 MACMILLAN PROFILE

The post holders will have the Macmillan name in the title and all branding of the post will adhere to that specified in the Service Agreement.

The post holders will promote Macmillan Cancer Support as an organisation and highlight the work that the organisation does at all opportunities including:

- The postholders title will carry the name 'Macmillan' for the life time of the post.
- All promotional materials e.g. banners, posters etc will be co-branded bearing Macmillan logo and that of Northern Health & Social Care Trust as the partner organisation.
- The Macmilllan logo will be used on all stationary, publications relating to this service and on information resources produced by the team for use at health and wellbeing events
- The profile of Macmillan Cancer Support will be raised by presenting Macmillan as a founder of a range of services not just palliative care nursing for which they are renowned.
- The service will endorse Macmillan's strategy for support and information and their commitment to patient and public involvement.
- Collaboration with the Northern Health & Social Care Trust Communications Team will be utilised to promote the service within the Trust.
- Macmillan's Communications Dept will be utilised to assist in generating publicity
- The team will work with the Macmillan Development Manager and the Macmillan L&D Manager to gain support in service development, review, quality and educational needs
- Staff will also endeavour to identify appropriate 'Case Studies' for Macmillan to promote the work related to this service.

6 [ANY ADDITIONAL INFORMATION NOT INCLUDED IN THE SECTIONS ABOVE]

Corrigan, Martina

From: Reddick, Fiona <[redacted]>
Sent: 06 April 2018 14:54
To: Corrigan, Martina
Cc: Carroll, Ronan
Subject: FW: partnership form for Urology
Attachments: Macmillan Partnership Application SHSCT Urology CNS Sept17.doc; Urology CNS Mac Operational Policy SHSCT Sept17.doc

Hi Martina

As discussed earlier this week I am due to meet with Macmillan next week re funding further Cancer Nurse Specialist posts and to provide an update on recruitment to date.

We are now ready to work up and progress the recruitment of a Band 7 Urology Nurse Specialist. Macmillan are funding at Band 6 but you had previously indicated that you wanted this post at band 7 and had funding to do this. I am happy to work up draft Job description for you.

I will probably be asked for an update re appointment of Head and Neck nurse so would be grateful if you could let me know expected timeline.

Regards

Fiona

Fiona Reddick
Fiona Reddick
Head of Cancer Services
Southern Health and Social Care Trust
Macmillan Building
[redacted]
[redacted]

Corrigan, Martina

From: Corrigan, Martina <[redacted]>
Sent: 17 May 2018 17:36
To: Haughey, Mary
Subject: RE: Funding from Macmillan for Band 6 Urology Cancer Nurse Specialist

Hi Mary

Sorry I missed your call earlier as I have been in lock-down finishing some work for Ronan (lol).

Fiona had said she would share this me but never did, so I have never received a copy unfortunately. Not sure when Fiona is due back but it would have been good to get this sorted as I believe other Trusts are advertising their posts shortly and I am afraid of losing some of our nurses to these posts…..

Thanks

Martina

Martina Corrigan
Head of ENT, Urology, Ophthalmology and Outpatients
Craigavon Area Hospital

INTERNAL: EXT [redacted]
EXTERNAL : [redacted]
Mobile [redacted]

From: Haughey, Mary
Sent: 17 May 2018 13:55
To: Corrigan, Martina
Subject: RE: Funding from Macmillan for Band 6 Urology Cancer Nurse Specialist

Hi Martina
I just spoke to Ruth Thompson re. below.
Ruth has the partnership application for the post but needs the job description to go along with it – she thought that Fiona had shared this with you for final review?
If we can get this to her by Monday, she would be able to process the application and have the Macmillan letter of allocation within 7-10 days.
If you send me the JD, I can forward on to Ruth?
Best regards
Mary

From: Corrigan, Martina
Sent: 16 May 2018 13:50
To: Haughey, Mary
Subject: RE: Funding from Macmillan for Band 6 Urology Cancer Nurse Specialist

Hi Mary

Not sure if Ruth would have a copy but if she did that would be brilliant if you wouldn't mind contacting her? We are really trying to get this moved

Regards

Martina

Martina Corrigan
Head of ENT, Urology, Ophthalmology and Outpatients
Craigavon Area Hospital

INTERNAL: EXT Personal Information redacted by the USI
EXTERNAL : Personal Information redacted by the USI
Mobile: Personal Information redacted by the USI

From: Haughey, Mary
Sent: 16 May 2018 12:53
To: Corrigan, Martina
Subject: RE: Funding from Macmillan for Band 6 Urology Cancer Nurse Specialist

Hi Martina
No problem. Sorry but I haven't seen this.
If you are stuck, I could contact Ruth in Macmillan and ask if she could forward you a copy?
Regards
Mary

From: Corrigan, Martina
Sent: 16 May 2018 12:03
To: Haughey, Mary
Subject: FW: Funding from Macmillan for Band 6 Urology Cancer Nurse Specialist

Hi Mary

Sorry to be a torture these days!! But by any remote chance did Fiona share the Macmillan funding letter for the Band 6 Urology nurse with you? Even though this is a Band 6 I am upgrading this to a Band 7……..

Thanks

Martina

Martina Corrigan
Head of ENT, Urology, Ophthalmology and Outpatients
Craigavon Area Hospital

INTERNAL: EXT Personal Information redacted by the USI
EXTERNAL : Personal Information redacted by the USI
Mobile: Personal Information redacted by the USI

From: Carroll, Anna
Sent: 16 May 2018 11:22
To: Corrigan, Martina
Subject: FW: Funding from Macmillan for Band 6 Urology Cancer Nurse Specialist

Martina
Have you a copy of breakdown of the funding from Macmillan

Kind Regards
Anna

Anna Carroll
Financial Management – Acute
☎ Personal Information redacted by the USI

We're here to help you find your
best way through and live life as fully as you can.

Call us free on 0808 808 00 00 or visit macmillan.org.uk

MACMILLAN
CANCER SUPPORT

Southern Health and Social Care Trust

WE ARE MACMILLAN. CANCER SUPPORT

JOB DESCRIPTION

Title of Post: Support Worker Cancer Services

Grade/ Band: Band 3

Directorate: Acute (Clinical &Cancer Services)

Reports to: Cancer Services Co-ordinator

Accountable to: Head of Cancer Services

Initial Location: Trustwide

Hours: Part time (0.25 WTE 9.375 hours)

Job Purpose

- Work in collaboration with colleagues to ensure the delivery of high quality, safe and compassionate care and support
- Assist in the delivery and co-ordination of care, education and support under the supervision of the Clinical Nurse Specialist for people with cancer care needs.
- Promote health and wellbeing for people who use health care services and their carers
- Maintain good communication with patients/clients, relatives and carers and report issues to line manager and other members of the multidisciplinary team

Main Responsibilities

Clinical/Professional/Specific Managerial Responsibilities

- Provide general information and support about cancer and cancer services to enable people to access appropriate information and support.
- Ensure any Intervention undertaken is within the limits of competence and authority
- Signpost to a range of information and support services and take an approach which helps people to self-manage and navigate the health and social care system
- Triage incoming calls using a risk assessment framework, initiate appropriate response and relay messages and information as appropriate
- Provide basic telephone advice, identify need and refer on or signpost to other sources of support.
- Make pre planned outbound telephone calls to patients as agreed with Clinical Nurse Specialist to assess needs and take appropriate action as directed
- Co-ordinate any appointments to fast track people back into the service if required
- Report to the Clinical Nurse Specialist or appropriate professional when faced with an emergency situation.

- Coordinate the care for a defined group of patients assessed by a registered practitioner as having level one care needs for support and self-management
- Guide people through the use of self-assessment resources and contribute to the holistic needs assessment and the development of an individual care plan
- Implement, monitor and review the care plan with the patient and carer in line with protocols
- Actively engage with Macmillan Cancer Support to contribute expertise and experience and to support the Macmillan Corporate Strategy.
- Ensure service adheres to Macmillan Quality Standards Framework
- Organise and prioritise the designated workload in relation to identified needs
- Evaluate outcomes of care delivery with the registered practitioner
- Co-ordinate the handover with other teams to facilitate safe and effective transition of care between services in order to provide seamless support for people
- Act as advocate and facilitate to resolve issues that may be perceived as barriers to care
- Reinforce information given to patients on individual self-care management pathways including healthy lifestyle choices and signs and symptoms to be reported to appropriate professionals
- Support the delivery of patient and carer training and education
- Support planning, inviting and organising of Health and Well Being events
- Comment on proposed changes to policies, procedures and guidelines
- Support and contribute to audit , governance, research and service development
- Provide assistance with audit, reports and service evaluation.
- Support the Clinical Nurse Specialist in the preparation and delivery of Cancer Awareness Events
- Identify new sources of patient information from agreed Cancer websites and order relevant information as directed.
- Support the preparation of cancer information core packs and disseminate appropriately.
- Provide timely feedback on all delegated tasks and highlight any issues of concern.

Generic managerial responsibilities both within an operational and strategic context.

- Carry out administration duties appropriate to the role to include: arranging meetings and minute taking
- Ensure good communication skills are employed with both internal and external stakeholders and robust documentation
- Ensure adequate stock of information leaflets and order supplies and equipment as required
- Order supplies and equipment if required
- Act in a courteous and respectful manner
- Maintain confidentiality
- Demonstrate commitment through regular attendance, efficient completion of duties and participation in department/team activities
- Comply with nursing strategy, trust policies, procedures, guidelines and protocols and codes of conduct

- Contribute to the effective and economic use of resources and the maintenance of all equipment
- Participate in the Trust KSF Appraisal process
- Participate in staff induction, training and other learning as required
- Carry out any other duties as required
- Ensure that stakeholders and service users are aware that they are interacting with a Macmillan professional and know about the full range of resources and services available through Macmillan.

1. **Safety, Quality and Experience**

The Trust will ensure that services are safe, of a high quality and contribute towards improving the experience and outcomes for patients, clients and carers.

2. **Access**

The Trust will ensure that patients and clients receive services in a timely and accessible manner.

3. **Health and Wellbeing**

The Trust will develop partnerships with other organisations, interested groups and communities to promote and maintain health and wellbeing.

4. **Efficiency and Service Reform**

The Trust will continue to focus on the efficiency and effectiveness of services, improve organisational capability within available finances.

5. **Our Staff**

The Trust will continue to build a stable, highly motivated workforce that is committed to a culture of continuous development and ultimately service improvement.

6. **Stakeholder Engagement**

The Trust will ensure that it listens to and learns from patients, clients, carers and other interested parties in the planning and delivery of services.

GENERAL RESPONSIBILITIES

All employees are required to comply with the procedures, policies and codes of practice within the Trust.

Equality

The Trust is an Equal Opportunities employer and welcomes applications from all sectors of the community irrespective of their religious belief, political opinion, race, gender, marital status, dependants, age, sexual orientation or disability.

All staff are required to comply with our Equal Opportunities Policy and each employee must make him/herself aware of their obligations. Managers/Supervisors have a responsibility to ensure compliance with this requirement and promote equality of opportunity.

Health & Safety

All employees must fully comply with the Trust's various Health and Safety Policies and Procedures and Practices including relevant legislation and Codes of Practice.

Conduct

Staff must maintain high standards of personal accountability and abide by the Code of Business Conduct.

Members of staff are expected at all times to provide a caring service and to treat those whom they come into contact in a courteous and respectful manner.

Performance

Employees are expected to demonstrate commitment to the Trust by ensuring regular attendance at work and the efficient discharge of their duties.

Staff will participate in the Trust's Knowledge and Skills Performance Appraisal which is designed to ensure staff can contribute to organisational goals and ensure their skills are relevant to the tasks to be undertaken and that patient and client care is of a high quality.

Records Management

All employees of the Trust are legally responsible for all records held, created or used as part of their business within the Trust including patient/client, corporate and administrative records whether paper based or electronic and also including emails.
All such records are public records and are accessible to the general public, with limited exceptions, under the Freedom of Information Act 2000, the Environmental Information Regulations 2004 and the Data Protection Act 1998. Employees are required to be conversant with the Trust's policy and procedures on records management and to seek advice if in doubt.

Environmental Cleaning Strategy

The Trust's Environmental Cleaning Strategy, recognises the key principle that "Cleanliness Matters. It is everyone's responsibility, not just the cleaners". Whilst there are staff employed by the Trust who are responsible for cleaning services, all staff employed by the Trust have a responsibility to ensure a clean, comfortable and safe environment for patients, clients, residents, visitors, staff and members of the general public.

Infection Prevention & Control

All Staff should co-operate fully with regard to Trust policies and procedures relating to infection prevention and control.

All staff should be aware of the Trust's Infection Prevention & Control strategy and their local reduction of infection plan and know their role, in keeping with key principle Infection Prevention and Control is everyone's business.

Staff, in delivery of all care must:-

- Wash their hands thoroughly between each patient contact.

- Be compliant with Standard Infection Control Precautions, Hand Hygiene and decontamination and other relevant infection prevention and control measures.

- Be aware of the Infection Control guidance within the Trust's Infection Control Manual and ensure they obtain mandatory Infection prevention control training or other specific infection control related training as required.

Hygiene & Prevention of Infection

You will at all times be required to observe hygiene/infection prevention & control standards and notices in operation throughout the Trust. Hygiene and control of -infection are key elements in delivery of safe, quality services and you will, in certain jobs, be required to undertake an appropriate training course at the expense of the Trust.

Personal Public involvement

Staff members are expected to involve patients, clients and their families in developing, planning and delivering our services in a meaningful and effective way, as part of the Trust's Personal Public Involvement (PPI) Strategy.

Location

Please note that it is a standard condition that all Trust staff may be required to work at any location within the Trust's area, as needs of the service demand.

Terms and Conditions

Applicants should note that the terms and conditions attached to this post will be as set out in the Agenda for Change Terms & Conditions.

This is not intended to be a comprehensive list of all the duties involved in the post and may be amended to meet the changing needs of the South Eastern Health and Social Care Trust; consequently an employee may be required to perform other duties appropriate to the post as assigned to them.

All Job Descriptions are subject to regular review and should be formally reviewed within a two year period.

March 2017

Southern Health and Social Care Trust

PERSONNEL SPECIFICATION

JOB TITLE **Macmillan Health and Well Being Support Worker, Band 3**

DIRECTORATE **Acute Services**

SALARY **£16,434 - £19,461 pro rata**

HOURS **Part time (0.25 WTE 9.375 hours)**

Waiting List Information:

Following interviews for the above post a waiting list may be compiled for future Permanent, Temporary, Full-Time Health and Well Being Support Worker Band 3 posts that may arise within the Southern Health & Social Care trust. This waiting list may be held for a period of 9-12 months from the date of interview**.**

Notes to applicants:

1. *You must clearly demonstrate on your application form how you meet the required criteria – failure to do so may result in you not being shortlisted. You should clearly demonstrate this for both the essential and desirable criteria.*
2. *Proof of qualifications and/or professional registration will be required if an offer of employment is made – if you are unable to provide this, the offer may be withdrawn.*

ESSENTIAL CRITERIA – *these are criteria all applicants MUST be able to demonstrate either at shortlisting or at interview. Applicants should therefore make it clear on their application form whether or not they meet these criteria. Failure to do so may result in you not being shortlisted. The stage in the process when the criteria will be measured is stated below;*

The following are essential criteria which will initially be measured at Shortlisting Stage although may also be further explored during the interview stage;

QUALIFICATIONS / EXPERIENCE

You must therefore clearly demonstrate your eligibility on your application form. **Please note that failure to do this will result in you not being shortlisted.**

NVQ level 3 in administration, Health, Health & Social Care or equivalent

OR

NVQ level 2 in administration, Health, Health and Social Care or equivalent and 1 years relevant experience willing to undertake NVQ level 3 or equivalent

OR

4 GCSEs including Maths, English, Grade A-C and 1 year's relevant experience and willing to undertake an NVQ level 3 or equivalent

AND

Knowledge and experience of IT systems including email and use of spread sheets

Relevant experience:

- Experience of multi professional working
- Evidence of good communication skills
- Relevant health or social care experience at AfC Band 3 or equivalent
- Understanding of person centred care
- Understanding of the health and social care environment

Knowledge & Skills:

- Able to use own initiative
- Effective organisational skills
- Ability to communicate both verbally and non-verbally on a daily basis with people at all levels
- Hold a current full driving licence valid in UK with access to suitable transport on appointment. This criterion will be waived in the case of an applicant whose disability prohibits driving but who is able to organise suitable alternative arrangements. (the postholder may be expected to travel to locations across the Trust)

DESIRABLE CRITERIA – *these will only be used where it is necessary to introduce additional job related criteria to ensure files are manageable. Applicants should therefore make it clear on their application form whether or not they meet these criteria. Failure to do so may result in you not being shortlisted*

Qualifications/Experience

- Evidence of continuous role development

Knowledge, Training & Skills

- Knowledge of relevant cancer treatments, interventions and terminology

The remaining criteria should be based on the 6 core dimensions of KSF.

Communication
Communicate with a range of people on a range of matters

Personal and People Development
Develop own skills and knowledge and provide information to others and to help their development

Health, Safety and Security
Monitor and maintain health, safety and security of self and others

Service improvement
Contribute to the development of services

Quality
Contribute to the improvement of services

Equality and Diversity
Support equality and value diversity

Vetting

As part of the Recruitment and Selection process, it may be necessary for the Trust to carry out an Enhanced Disclosure Check through Access NI before any appointment to this post can be confirmed.

WE ARE AN EQUAL OPPORTUNITIES EMPLOYER

Successful applicants may be required to attend for a Health Assessment

All staff are required to comply with the Trusts Smoke Free Policy

March 2017

Southern Health and Social Care Trust

Quality Care - for you, with you

WE ARE MACMILLAN. CANCER SUPPORT

JOB DESCRIPTION

Title of Post: Macmillan Urology Clinical Nurse Specialist

Grade of Post: Band 7

Reports to: Head of ENT, Urology and Outpatients

Accountable to: Assistant Director for Surgery and Elective Care

Initial Location: Southern Health and Social Care Trust

Hours of Work: 37.5 hours

Job Purpose

In order to meet the overall mission of the Trust, the post holder will:

- Plan to deliver effective patient focused services which meet local, regional and national requirements
- Provide clinical expertise within the specialist area of urological cancer working closely with Consultants, Nursing and the wider multidisciplinary team.
- Lead by example in promoting and delivering high standards of evidence based clinical treatment and sharing clinical expertise.
- The post holder will work closely with the in- patient ward staff, Oncology teams and Palliative Care teams to ensure holistic assessment and management.

Main Responsibilities

The postholder will focus and lead on the following key areas within the organisation's framework

Clinical/Professional/Specific Managerial Responsibilities

1.1 ***Professional, ethical and legal***

- Adhere to DHSSPS and NMC Guidelines for practice requirements and standards for example, safe handling , administration, storage and custody of medicinal products
- Adhere to Trust guidelines, policies and procedures and comply with nursing strategy. Ensure that organisational goals are reflected in own and service objectives
- Contribute to the development of the Trusts policies and strategies where appropriate
- Maintain own professional and personal development in accordance with the NMC Codes (2008), standards and professional guidelines
- Establish and maintain relationship based on mutual respect communicating on a regular basis with the patient, relatives and carers in the provision of care and services, providing timely information at all stages of the patient pathway ensuring that individual needs are met and addressing any issues identified. Ensure appropriate systems are developed and operational to facilitate the dissemination of information within the team

  Adhere to the Data Protection Act (1998)

1.2 ***Evidence-based practice***

- To act as a role model to promote a culture of research and reflective practice within the department to enhance person-centred care.
- Ensure evidence-based care is provided to agreed standards within the ward / department for patients with head and neck cancers.
- Assist in developing, implementing and monitoring policies, procedures and protocols.
- Create an environment which supports a culture of learning and reflective practice for all staff.

- Assist the line manager to ensure that systems and processes are in place to support effective mentoring of relevant staff.

1.3 *Environment*

- To maintain a safe and clean environment for staff, patients / clients and visitors by ensuring compliance with legislation, policies and protocols including health and safety, healthcare associated infection, risk management and critical incident reporting.
- Ensure staff awareness of environmental issues and take appropriate action as per HSC Trust policy.
- Assist the line manager to with the analysis, assessment and management of actual and potential risks to health and well-being.
- Ensure safe and effective use of equipment as per HSC Trust policy.
- Ensure near misses, incidents, accidents and faulty devices are recorded, reported, investigated and learning disseminated as per HSC Trust policy.

1.4 *Multi-professional working*

- Contribute to the establishment of systems and processes to ensure effective communication and continuity of patient / client care, liaising with multi-disciplinary / multi-agency teams and community services.

2. Enhance the patient/client experience

2.1 *Person-centred care*

- Develop and maintain a culture of person-centred care within the service.
- Promote a caring environment where equality and diversity issues are respected and patients/clients and their carers are enabled to be partners in their care.
- Develop strategies for communication between staff, patients/clients, relatives and their carers, showing awareness of barriers to understanding.
- Facilitate communication between all members of the multi-disciplinary/multi-agency team, and across care settings.
- Enhance the patient experience through the provision of information and support throughout the patient journey
- Act as the patient's advocate, providing education and information, which enables the patient to make informed choices.
- Provide advice on palliative symptom control as required
- Develop and promote post treatment recovery programmes as required
- Ensure signposting and referral to health and well-being services

2.2 *Coordination of the patient/client journey*

- Ensure the safety and quality of the patient's/client's journey by effective planning and co-ordination at all stages of the pathway.
- Support development of a patient centred service, within the multidisciplinary team, that provides specialist nursing care and support to patients and their families/carers.
- Arrange and coordinate investigations in a timely manner
- Be responsible for and positively influence the assessment, planning, delivery and evaluation of nursing care, establishing mechanism by which each patient has a coherent and comprehensive management plan. These plans will be developed with the patients and carers according to their needs and included referral to other disciplines and services observing the principles of holistic care
- Co-ordinate effective and holistic nursing care in a multi professional setting
- Provide nurse led clinics as deemed appropriate to the service needs.
- Monitor and report on patient's/client's progress and maintain contemporaneous records
- Make decisions based on professional knowledge and experience
- Assess both the physical and psychological needs of the patient and act as a resource to all disciplines involved in the delivery of care to the client group.

2.3 *Patient/client involvement*

- Identify opportunities for meaningful involvement of patients and carers in relation to the development of care and services.
- Ensure effective systems are in place to gain patient and carers feedback on their experience of care.
- Ensure patient involvement in the design and redesign of services
- Ensure compliments and complaints are managed in line with HSC Trust policy including the dissemination of shared learning.

3. Provide effective leadership and management

3.1 *Role model*

- Act as a visible leader within the service.
- Provide leadership that enables professional decision making and effective team working.

- Empower and enable staff to contribute to the delivery of high quality person-centred care.
- Provide professional leadership and expert nursing advice and support to the MDT and other care professionals across the Trust and actively support their professional development.
- Attend and contribute to Departmental, Directorate and other meetings on a regular basis as required.
- Undertake delegated responsibilities from the Service Manager
- Actively engages with Macmillan Cancer Support to contribute expertise and experience and supports the Macmillan Strategy.
- Ensure that stakeholders and service users are aware that they are interacting with a Macmillan professional and know about the full range of resources and services available through Macmillan.

3.2 Develop team performance

- Promote, develop and facilitate a learning culture within the service.
- Promote equality of opportunity for all, in accordance with HSC Trust Equality Opportunity Policy.
- Lead and participate in annual staff appraisal/development review, ensuring effective implementation of the Knowledge and Skills Framework (DH, 2004).
- Lead and participate in learning needs analysis and facilitate annual personal development plans for the nursing team as required.
- Lead and participate in orientation and induction programmes for staff within the department.
- Promote a person-centred culture to facilitate good staff relationships and morale among staff.
- Contribute to the education commissioning process for nursing staff as required.
- Manage poor performance and practice of staff in line with HSC Trust policies as required.

3.3 Effective use of resources

- Deliver a safe and effective service within allocated resources, ensuring the resources are used to maximum effect.
- Adhere to financial policies and procedures, particularly Standing Financial Instructions, Authorisation Frameworks, Procurement Legislation and associated processes, and Prompt Payment Code.
- Adhere to HSC Trust financial controls and fraud awareness principles (e.g. verification of authenticity / accuracy of the Staff-in-Post records).

- Adhere to HSC Trust systems for effectively managing stock and safeguarding fixed assets.
- Promote the principles of good governance and protects the department from financial risk, particularly in respect of patient/client monies and property and charitable funds.
- Display managerial and organisational skills to ensure that products required for patient/client care/treatment are procured in timely fashion and demonstrate value for money.
- Show a commitment to effectively manage resources and achieve statutory financial targets.

4. Contribute to the delivery of the organisation's objectives

4.1 Continuous quality and improvement

- Promote a culture of continuous quality improvement through the use of audit, patient/client feedback and reflection on practice by self and other members of the team.
- Deliver and promote evidence based practice and agreed care pathways for patients with Cancer

4.2 Service improvement, development and modernisation

- Work in partnership with a range of clinicians and managers in the planning or development of own service promoting the involvement of patients and carers.
- Review processes /practices including those within the ward to support patients/clients to improve their own health and well-being.
- Review processes/practices to ascertain if there are better ways of working within the service to enhance patient/client care, service delivery and deliver required efficiencies
- Liaise with NICaN in the development of regional and local services
- Collate and analyse statistical data for the service.
- Lead on business planning for development of the service.
- Actively promote new ways of working and models of service delivery to improve services for Cancer patients

4.3 Nursing

- Liaise with nursing managers and heads of nursing on all professional nursing issues.
- Ensure staff are aware of and act in accordance with all relevant policies, procedures, guidelines, protocols, codes of conduct and nursing strategy

- Ensure processes are in place to manage sickness/absenteeism and take appropriate action in line with HSC Trust policies.
- Promote the health and well-being of staff and observe for any signs of ill health or stress factors in staff assigned to the area and take appropriate action in line with HSC Trust policies and NMC guidelines.

5.00 General Responsibilities

Equality

The Trust is an Equal Opportunities employer and welcomes applications from all sectors of the community irrespective of their religion, politics, race, gender, sexual orientation or disability.

However, due to under-representation, the Trust particularly welcomes applications from Catholics for vacancies in the North Down and Ards geographical area and Protestants for vacancies in the Downpatrick area.

All staff are required to comply with our Equal Opportunities Policy and each employee must make him/herself aware of their obligations. Managers/Supervisors have a responsibility to ensure compliance with this requirement.

Smoking and Health

The Trust is a Smoke Free Organisation.

Health & Safety

All employees must comply with the Trust's various Health and Safety Policies and Procedures including relevant legislation and Codes of Practice.

Conduct

Staff must maintain high standards of personal accountability and abide by the Code of Business Conduct.

Performance

Employees are expected to demonstrate commitment to the Trust by ensuring regular attendance at work and the efficient discharge of their duties.

Staff will participate in the Trust's Personal Development and Contribution review process which is designed to ensure staff can contribute to organisational goals and ensure their skills are relevant to the tasks to be undertaken and that patient and client care is of a high quality.

Service Quality

The Southern Health and Social Care Trust is committed to providing the highest possible quality of service to all patients, clients and community. Members of

staff are expected at all times to provide a caring service and to treat those with whom they come into contact in a courteous and respectful manner.

Records Management

All employees of the Trust are legally responsible for all records held, created or used as part of their business within the Trust including patient/client, corporate and administrative records whether paper based or electronic and also including emails. All such records are public records and are accessible to the general public, with limited exceptions, under the Freedom of Information Act 2000, the Environmental Information Regulations 2004 and the Data Protection Act 1998. Employees are required to be conversant with the Trust's policy and procedures on records management and to seek advice if in doubt.

Environmental Cleaning Strategy

The Trust's Environmental Cleaning Strategy, recognises the key principle that "Cleanliness Matters. It is everyone's responsibility, not just the cleaners". Whilst there are staff employed by the Trust who are responsible for cleaning services, all staff employed by the Trust have a responsibility to ensure a clean, comfortable and safe environment for patients, clients, residents, visitors, staff and members of the general public.

Infection Prevention & Control

All staff should be aware of the Trust's Infection Prevention & Control strategy and their local reduction of infection plan and know their role, in keeping with key principle Infection Prevention and Control is everyone's business.

Staff, in delivery of all care must:-

-Wash their hands thoroughly between each patient contact.

- Be compliant with Standard Infection Control Precautions, Hand Hygiene and decontamination and other relevant infection prevention and control measures.

- Be aware of the Infection Control guidance within the Trust's Infection Control

Manual and ensure they obtain mandatory Infection prevention control training or other specific infection control related training as required.

Terms and Conditions

Applicants should note that the terms and conditions attached to this post may change as a result of National negotiations and the NHS pay system called Agenda for Change.

This job description is not definitive and may be amended to meet the changing needs of the Trust.

All Job Descriptions are subject to regular review and should be formally reviewed within a two year period. This is not intended to be a comprehensive list of all the duties involved in the post, consequently an employee may be required to perform other duties appropriate to the post as assigned to them.

All staff are required to observe the Trust's No Smoking Policy

April 2017

Southern Health and Social Care Trust

WE ARE MACMILLAN. CANCER SUPPORT

PERSONNEL SPECIFICATION

Applicants, please note the Trust reserves the right to use the desirable criteria (if stated), at shortlisting. Applicants should therefore make it clear on their application form whether or not they meet the desirable criteria. Failure to do so may result in you not being shortlisted.

Title of Post:	Macmillan Urology Clinical Nurse Specialist
Grade of Post:	Band 7
SALARY	£30,764 – £40,558 per annum
HOURS	37.5 per week

Notes to applicants:

1. *You must clearly demonstrate on your application form how you meet the required criteria – failure to do so may result in you not being shortlisted. You should clearly demonstrate this for both the essential and desirable criteria.*
2. *Proof of qualifications and/or professional registration will be required if an offer of employment is made – if you are unable to provide this, the offer may be withdrawn.*

***ESSENTIAL CRITERIA** – these are criteria all applicants MUST be able to demonstrate either at shortlisting or at interview. Applicants should therefore make it clear on their application form whether or not they meet these criteria. Failure to do so may result in you not being shortlisted. The stage in the process when the criteria will be measured is stated below;*

The following are essential criteria which will initially be measured at Shortlisting Stage although may also be further explored during the interview stage;

QUALIFICATIONS / EXPERIENCE

You must therefore clearly demonstrate your eligibility on your application form. **Please note that failure to do this will result in you not being shortlisted.**

1. Currently a Registered Nurse (Adult) on the live NMC Register

2. Hold a Degree in Nursing/Health Studies qualification allowing registration with NMC

3. Hold an NMC Specialist recordable qualification or be willing to undertake and complete within a timeframe as agreed with line manager.

3. Five Years Post Registration nursing experience, two of which must be at Band 6 level or equivalent.

4. Have a proven track record of making significant improvements to service delivery

5 Demonstrate experience of leadership and independent decision making

6 Hold a full current driving license valid for use in the UK and have, on appointment, access to a car

Knowledge

7 Demonstrate expertise and experience in the total management of patients with Urological Cancers

8 Demonstrate an up to date knowledge of current therapies in the treatment of patients with urological cancers, management of side effects/complications and advancing disease.

9 Knowledge of current research in relation to urological cancers.

10 Provide evidence of continuous personal and professional development

Training & Skills

11 Ability to influence and manage change, including the promotion of evidence based practice.

12 Have effective communication skills to meet the needs of the post in full.

13 Advanced Communication Skills to meet the needs of the post in full or willingness to undertake.

14 Demonstrate ability to work effectively as part of a multi-disciplinary team and to work autonomously.

15 Highly computer literate including ability to effectively use MS Office or equivalent

16 Teaching and assessment skills

17 Organisation and negotiation skills

18 Ability to deal with complex and difficult emotional situations

19 Hold a current full driving licence valid in UK with access to suitable transport on appointment. This criterion will be waived in the case of an applicant whose disability prohibits driving but who is able to organise suitable alternative arrangements.

Vetting

As part of the Recruitment and Selection process, it may be necessary for the Trust to carry out an Enhanced Disclosure Check through Access NI before any appointment to this post can be confirmed.

Canvassing either directly or indirectly will be an absolute disqualification for appointment.

The Trust is an Equal Opportunities Employer.

Additional Information:

Candidates shortlisted for interview will be required to produce original certificates and photocopies of the same.

If successful staff will be required to produce documentary evidence that they are legally entitled to live and work in the UK eg P45, payslip, National Insurance Card, Birth Certificate. Failure to do so will result in a non appointment.

WE ARE MACMILLAN. CANCER SUPPORT

Macmillan Partnership Application

Sections to be completed where applicable – If a section does not apply please clearly state N/A. Please see separate guidance notes for more details about the type of information required before completing. If the application requires a project management approach, please use project management documentation (e.g. Gant chart – please see guidance notes)

NAME OF SERVICE / PROJECT LOCATION AND CONTACT DETAILS FOR WHICH FUNDING IS REQUESTED.	
Name of service / Project: Macmillan CNS Workforce Plan – 1.0WTE Band 7 Macmillan Urology Cancer Clinical Nurse Specialist and 0.25 WTE Band 3 Macmillan Support Worker	**Name of Partner Organisation:** Southern Health and Social Care Trust
Name of Clinical Alliance / Strategic Clinical Network / Integrated Cancer Systems (if applicable): **NI Cancer Network**	**Geographical catchment area:** The Southern Health and Social Care Trust (SHSCT) was formed in April 2007. It is responsible for providing services across the council areas of Armagh, Banbridge, Craigavon, Dungannon and Newry and Mourne. The Southern Trust is an integrated organistion and thus provides a mix of both acute hospital and community health and social care services to a resident population of approximately 360,000 people. Cancer services at the Southern Trust is incorporated into all acute services as per specific tumour site.
Contact details of person submitting the application / leading the service development / project	Name: Martina Corrigan Title: Head of ENT, Urology, Ophthalmology & Outpatients Address: Craigavon Area hospital, 68 Lurgan Road, Portadown. Co. Armagh. BT 63 5QQ Telephone no: Personal Information redacted by the USI Email: Personal Information redacted by the USI

Contact details of the senior manager /commissioner sponsoring the service development / project	Name: Mrs Esther Gishkori Title: Director of Acute Services Address: Craigavon Area Hospital, 68 Lurgan Road, Portadown. Co Armagh. BT63 5QQ Telephone no: Personal Information redacted by the USI Email: Personal Information redacted by the USI
Name and contact details of the member of the Macmillan Service Development Team	Name: Ruth Thompson Partnership Manager Telephone no: Personal Information redacted by the USI Email: Personal Information redacted by the USI
PS@MAC number(s) [compulsory Macmillan use]:	
Is a Cancer Environment build envisaged? ***If yes, the Administrator must inform CE of the PS@MAC number.**	No*

PART ONE – SUSTAINABILITY

1.1 Please indicate whether the post or service is:

Permanent	Yes ☒ No ☐
Project / fixed term	Yes ☐ No ☐
Pilot	Yes ☐ No ☐

- **What is the organisation's level of commitment to this post or service?**

The five year incremental, prioritised Cancer CNS workforce plan has been approved through HSCB / PHA senior management team and has Department of Health support. The cancer CNS workforce expansion is a commissioning prioirity commencing 2016/17 for 5 years and was outlined in the commissioning plan. A Urology CNS is included within the plan for 2018 /2019. This was included in the plan as a Band 6 post but the Service Manager has requested the post be appointed at Band 7. This has been discussed and agreed with the Nurse Consultant PHA / NICAN

	Comments
Is pick up funding confirmed in writing?	Yes – the CNS expansion plan is an incremental expansion over 5 years and the HSCB will pick up funding recurrently. The Trust will also provide the difference in salary from B6 to B7 to support the HSCB contribution towards the post.
Is pick up funding confirmed pending a successful evaluation – if so what will the evaluation be based on?	Yes – confirmed through the CNS expansion plan

Is the business case for sustainability to be submitted through the local funding process	No	
No pick up funding anticipated		
For project / pilot posts – is there a letter of support from the employing organisation / commissioner and evidence to show how the recommendations will be taken forward?	Yes ☐ No☐ If no give reason:	
For project / pilot posts – Explain why this is a project or pilot and not a sustainable service	N/A	

PART TWO – BACKGROUND

2.1
Identify the key issues / problems that currently have an impact on people affected by cancer that you are trying to address through the proposed project / service

The role of the 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 improved patient experience and deliver services for individual patients according to need and patient choice. They play a vital role in the coordination of patient care and successful implementation of iniatives 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.

The number of people diagnosed with cancer each year is rising, with one in three of the population developing some form of cancer by the time they reach 75 years of age. In Northern Ireland, 11,000 people are diagnosed with cancer. Driven by the ageing population, this number is expected t orise by 25% for men and by 24% for women by 2020. By 2035, the number of cases per year is projected to be 7,181 male and 6,967 for female cases, a 65% rise among men and 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. In addition, cancer is responsible for approximately one quarter of all deaths occurring in Northern Ireland causing more deaths than any of ischemic heart disease, stroke or other diseases of the circulatory or respiratory systems.

In 2015, the NI Cancer Patient Experience Survey (CPES) reported 72% of patients having access to a CNS, much lower than England 89% (2014), and Wales 88% (2013). Key driver analysis demonstrates the support of a CNS is the most important contributing factor to people reporting a positive experience of care. In April 2014, the Macmillan Adult cancer CNS census of the Specialist Adult Cancer Workforce reported 57.4WTE in N.I. with the majority area of practice being Breast (33.8%), with minimal provision in Urology. This is significantly lower than other UK countries when incidence rates are compared to whole time equivalent posts.

This is further compounded by results from the 3 year NI Cancer Peer Reveiw Programme of Multi Disciplinary Teams (Local and Specialist). Lack of access and single handed CNS provision were found as immediate risks or serious concerns in 17 out of the 30 MDTs Peer reviewed to date.
Currently in the Southern Trust, there is 1.0 WTE Nurse Specialist for the Urology service. Some progress has been made to implement the key worker role for cancer patients, but this has been limited due to lack of resources. Therefore not all patients are supported at key stages of their pathway including at the time of receiving their diagnosis and not all benefit from the skills, knowledge and expertise of a CNS.

The Transforming Cancer Follow Up (TCFU) Programme Evaluation (2015) 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. Urology nurse led follow-up pathways have been agreed regionally but have not been implemented in SHSCT due to lack of dedicated staff. For further development to occur, additional staff are required.

There is an overwhelming deficit in the number of CNSs within SHSCT. By increasing the number of nurse specialists and through inclusion of support worker roles within the CNS workforce plan this 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.

Within SHSCT, there were 746 new patients with urological cancers diagnosed in 2016.

There are currently two Urology CNSs within the Trust providing care for patients with all urological disordrers. Investment in a 1.0 WTE Urology CNS will further enhance the uro-oncology service and the development and co-ordination of the service. This CNS will work primarily with patients with prostate and renal cancer. The 0.25WTE band 3 support worker will provide administrative support for the team and act as a point of contact for patients to ensure the most effective use of resources.

2.2 How will the proposed project/service/scheme address the issues /problems identified in 2.1

The proposed workforce plan would aim to recruit 1 WTE Band 7 Clinical Nurse Specialist, and 0.25 WTE Band 3 support worker.

The staff will work closely with the appropriate Multi-disciplinary teams to provide:

(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

Through expansion of the cancer Urology CNS and support worker team the care of patients could be improved as follows:

- The staff would work closely with the MDTs ensuring all patients would be supported as they progress in a timely manner along the appropriate diagnostic pathway
- The CNS will contribute to the MDT discussion by acting as the key worker for patients as recommended by the Manual of Cancer Services (2004)
- Patients would have a HNA and care plan with sign posting to appropriate services as recommended in the Living With and Beyond Cancer report (2013), Recovery Package & NI Cancer Services Framework
- Patients and their caregivers would have appropriate, timely information and support at each stage of their pathway to enable them to deal with physical, social, emotional or sexual issues that may arise (Improving Outcomes, 2004)
- The proposed post holders would work across internal interfaces between medicine, surgery and oncology to ensure effective transfer of information. They will also liaise with staff in the Cancer Centre.
- The post holders will work across external service boundaries between primary and secondary care to aid implementation of the TYC principles, improve continuity of care and ensure patients experience a seamless transition from acute to primary care.
- Patients could be managed through the new service models of risk-stratified follow-up in line with the regional move towards Transforming Cancer Follow-up and where appropriate and in conjunction with the medical team, nurse-led and self-directed aftercare could be introduced in close collaboration with the local Macmillan Service Improvement Manager
- Introduction of nurse-led and self-directed follow up could help to minimise any backlog of review appointments, allowing consultants more time to spend with new and complex cases
- The nurse-led activity may be direct or indirect; inpatient, outpatient or via telephone; and provided within an acute, community or primary care setting dependent on the requirements of the patient group involved.
- The CNS will provide a telephone advice number to patients to ensure patients can access follow-up advice thus reducing unnecessary anxiety, avoidable re-admissions and GP visits. The Support Worker will be involved in triaging calls.
- Patient education is a fundamental part of the post holders' roles and will be provided in a variety of ways including the provision of health and wellbeing events to support the SHSCT cancer survivorship

program and the national Recovery Package, enabling patients to be empowered and better manage their lifestyles and any on-going support needs.

- The post-holders will keep abreast of the development of local services that may be utilised to support the patient groups and signpost the patients and their carers to those services relevant to their needs
- The post-holders in conjunction with core services will refer appropriate patients to local cancer rehabilitation and self-management programmes e.g. physical activity programmes delivered by qualified staff in leisure centres or the HOPE programme
- Education, training and audit will be inherent aspects of the CNS role and they will contribute to advancing the body of knowledge in their respective areas and ensure their skills and competencies meet those outlined in appropriate frameworks (e.g. NIPEC (2006) and Macmillan (2014)
- The Urology CNS will have dedicated sessions in their workplan to support the development of policies, guidelines and protocols to ensure the services provide a patient-centred, evidence based service to all patients
- The support worker will enable more effective use of nursing time
- Close links will be established with the local Macmillan Health & Wellbeing Manager and Macmillan Benefits Advisers to ensure patients receive the most up to date support and information relevant to their needs
- The teams will work closely with the local Trust Volunteer Manager to ensure volunteers can be utilised where possible in the support and development of services for patients
- The teams will liaise with the regional Macmillan Work Support and Rehabilitation Service to incorporate appropriate service developments locally
- Post holders will liaise with local and national teams and networks to ensure the services remain abreast with current changes in practice.

When planning this application three options were considered:

Option Number/ Description	Shortlisted (S) or Rejected (R)	Reason for Rejection
1. Status Quo - Continue with existing arrangements	**R**	Without investment in cancer nurse specialists, the immediate risks and serious concerns flagged through the National Peer review process would not be addressed in regard to CNSs across the tumour MDT sites. Patient experience will continue to be impacted upon negatively without the expansion of CNSs across all Trusts, with NI having the lowest reported access to CNSs across the UK. Any further progress with nurse led follow-up and supported self-care models through the transforming cancer follow-up across tumour sites would not be realised.
2. Introduce clinical nurse specialists as per agreed workforce plan in partnership with Macmillan and Friends of the Cancer centre.	**S**	This is the preferred option and would introduce the regionally agreed risk based, prioritised, incremental workforce plan for the expansion of the clinical nurse specialists to support the patients across NI. The CNSs will work closely with their respective multi-disciplinary teams and in line with the regionally agreed commissioning specification and address National Peer Review measures. The partnership arrangement with Macmillan and Friends of the Cancer centre allows for the incremental planned and managed introduction of cancer nurse specialists within NI across all Trust thus ensuring equity for patients.
3. Introduce clinical nurse	R	To introduce the clinical nurse specialists as per

specialists as per agreed workforce plan without a partnership arrangement with Macmillan and Friends of the Cancer centre.		agreed workforce plan without a partnership arrangement with Macmillan and Friends of the Cancer centre would have the potential to increase the CNS provision however given the current financial constraints within HSC, the number of CNSs who could be recruited would be significantly reduced due to affordability, thus introducing risk with some services and specialities with a continued lack of investment in CNSs.

Option 2 allows expansion of the CNS role and ensures that all patients receive a patient-centred service that meets the information and support needs of them and their families.

2.3 How does this service / project address inequality? *(please refer to guidance notes)*

The NI Cancer Registry (2013) have identified that there were 69,377 people living with cancer in NI at the end of 2010. There were an average of 2497 cancers (including non-melanoma skin cancer; NMSC) diagnosed each year in the Southern Health and Social Care Trust between 2010 and 2014. This represents 20.4% of all cancer diagnoses in Northern Ireland during this time period.

The lack of CNSs in the SHSCT results in patient inequality and patients being disadvantaged when compared regionally. The Northern Ireland Cancer Patient Experience Survey 2015 results show that in the SHSCT only 68% of patients were given the name of the CNS in charge of their care; this was the lowest percentage in NI. At a national level it is acknowledged that NI has a shortage of CNS posts compared to the rest of the UK and this gap is widening.

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

**Source Macmillan census of the specialist adult cancer nursing workforce NI 2014, whereby incidence data sourced from personal correspondence with the biostatisticians/researchers at the Northern Ireland Cancer Registry in August 2014*
***2015/16 position and includes 11 WTE charitably funded posts with no exit strategy.*

Prior to the initiation of the Regional CNS Workforce Plan, Northern Ireland was bottom of the UK for the total number of CNSs per region. This lack of CNSs equates to an unequal service for patients as research has shown that CNSs can significantly improve patient care and quality of life. A 2009 Macmillan report stated that "CNSs can help improve quality of life for people with cancer through assisting with decision making, symptom management and emotional support".

The plan also includes the introduction of support workers, which has been shown in the 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.

Other areas of inequality will also be addressed through this project. Primarily the Trust catchment area includes pockets of social deprivation and the opportunity for patients to have holistic needs assessment and attend HWBCs with advice on smoking cessation, lifestyle changes will be beneficial.

Secondly as there is a significant elderly population in the Trust locality it is planned to offer services including nurse led telephone clinics. Thirdly, there will be access to materials for those who are visually or audibly

impaired upon request.
Finally as the key elements of the workplan for the new staff would be in line with the TYC and TCFU programmes of change. Both programmes have undergone an Equality Impact Assessment and meet the required criteria.

Between 2010 and 2014 there were 1621 people diagnosed in Northern Ireland with urological cancer.
Within the Southern trust area, at the end of 2014, there were 2305 people living up to 22 years post al cancer diagnosis.Within the SHSCT on average there are 204 people diagnosed with a new urology cancer each year per 100,000 people, this is similar to the NI average. In 2016 there were 746 new diagnoses in SHSCT. The population in the Trust area is approx 369,500.
The introduction of this additional Urology CNS will help to further develop the existing Urology cancer nursing service in SHSCT and ensure full implementation of the recovery package including nurse-led follow-up for all patients living with urological cancers. Given the increase in patients living with urology cancers this is particularly pertinent.

2.4 How have users / people affected by cancer been involved in the proposed service development /project. Outline the plans for longer term user involvement in the service / project development (please refer to guidance notes)

Service user questionnaires for Peer Review in 2014/15 have identifed the need for improved information. In addition a postal survey of cancer patients in NI highlighted that just under 40% of patients have unmet needs (Santin, 2011).

The survey identified that patients did not recall being given written information about other sources of support i.e. financial support, local support groups or services offering psychological, social, spiritual/cultural support. Other patients stated that they were not provided with enough information at their diagnosis, forcing them to contact GPs instead.

These findings have been reiterated by the lower scoring Cancer Patient Experience Survey answers; the list below NI scores are given first and England 2014 CPES scores second denoted within { }.

- Q14 - given written information about the type of cancer they had: substantially lower score in NI 64% {72%}
- Q18 - given written information about the side effects of treatment 78% {82%}
- Q21 - given the name of a CNS in charge of their care 72% {89%}
- Q29 - taking part in cancer research discussed with the patient 18% {31%}
- Q33 - given written information about the operation they were having beforehand 66% {76%}

Northern Ireland cancer services seem to be less successful at giving written information on cancer, at various points along the pathway, than is the case elsewhere. The proportion of patients having access to a CNS is lower than elsewhere - and this is known to be a key driver of high scores given by patients about their care in both England and Wales. This insight into patients unmet needs has been taken on board and has resulted in the development of this proposal as it is believed additional CNS will help to provide patients and their family members with the information and support they require at a timely point in their pathway. The support worker will assist the clinical staff to co-ordinate the patient pathways, establish a robust data collection and collation system and support health and wellbeing events.

Once the posts are established service user feedback will be utilised to develop the posts and ensure they remain patient-focused. This feedback will be taken from a number of sources including patient surveys and future health and wellbeing events. Within Southern Trust significant improvements have been made within the Urology team in that the Clinical Nurse Specialist sees patients from the point of a cancer diagnosis and offers support and advice in conjunction with contact numbers. The regional patient experience survey has demonstrated positive feedback on the benefits of a having a clinical Nurse Specialist at the point of diagnosis for ongoing support and advice.

IF THIS IS A SERVICE - COMPLETE PART 3

2.5

There is a cancer user forum which meets quarterly, however communication is passed in the intervening months, for e.g. the Urology MDT patient information leaflet when developed was reviewed by the cancer service user forum and changes made based on their feedback.

IF THIS IS A SERVICE - COMPLETE PART 3

IF THIS IS A PROJECT – COMPLETE PARTS 3 AND 4

IF THIS IS A CANCER ENVIRONMENTS/BUILDING SCHEME COMPLETE PARTS 3 AND 4 AND ALSO COMPLETE PART 5

PART THREE - SERVICE SPECIFICATION – please refer to guidance before completion
(NOTE: Macmillan may, if the bid is developed further, ask its partner organisations to create an "Operational Policy" which expands on the information provided in the sections below – a template will be provided).

3.1 Service aim
The aims and anticipated outcomes should clearly reflect the evidence of need for this project /service as identified in Part One? Please see the guidance notes and refer to Macmillan's nine outcomes

a) *Describe the overall aim of the proposed service, outlining who the project / service is for / aimed at*

b) *Identify the anticipated outcomes of the project / service (the outcomes you would expect to see during the lifetime of the project / service). Outline the impact we expect the service/project to have – i.e. what we want to achieve through it and how we will achieve it (things that can be quantified and collected through monitoring data*

c) *Outline the anticipated numbers of clients /people affected by cancer that the service/project will allow access to.*

d) *Outline how this service /project will be integrated with the wider health and social care services that are providing a service for people affected by cancer*

e) *Outline how volunteers will be supporting the service /project, and outline ongoing plans for volunteer support and engagement including how it will achieve Macmillan's Volunteer Quality Standards*

f) *What are the Learning & Development requirements to deliver the service / project? Either for the individuals within the service, associated team members or the organisation*

(a) Service Aim: To develop, introduce and evaluate the introduction of an additional Urology Clinical Nurse Specialist and Support Worker to address the physical, psychological, social, information and support needs of Urology cancer patients throughout their pathway in the SHSCT and maintain person centred care in line with DHSSPSNI Nursing and Midwifery Strategy (2015). This will contribute to more efficient and effective service delivery, an improved patient experience throughout the pathway and support the commissioning of future service provision. The proposed plan will also 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.

(b) Outcomes

The Regional CNS Workforce Plan suggested KPIs by which Cancer CNSs could measure outcomes. These have now been refined and the regionally agreed CNS Outcomes and KPIs are included below. The CNS will report on these KPIs annually.

1. Service Improvement

Improved clinical practices and pathways are person centred and aligned to current strategy

- The CNS will provide evidence of how they have played a key role in ongoing service improvements e.g
    - Risk stratified pathways
    - New regional / local guidelines
    - Implementing elements of the Recovery Package
- The CNS ensures patient feedback influences ongoing service improvements

2. Service Delivery

Clinical support is well coordinated across the treatment pathway

- Number of patients referred to the MDT Meeting (new / re-referrals)
- Number of patients referred to the CNS to act as keyworker
- % of patients taking part in an experience survey who report they were given / offered contact details of key worker
- Number of nurse-led clinic appointments (face to face / telephone / HNA)
- % of MDT meetings CNS is in attendance
- Number of patients, for whom the CNS is key worker, who are contacted within 48 hrs of a working week following referral/diagnosis

3. Holistic Approach

The holistic needs of patients and carers are identified and addressed

- Number of patients known to the CNS who are offered a HNA
- % of patients completing HNA for whom a care plan is developed

4. Patient Information and Support

Patients and carers get answers when they need them and are well informed and supported

- % of patients who participate in an experience survey who report that they received the right information at the right time and at the right level from their CNS and felt supported by the CNS

5. Supporting Professional Activities

The CNS will fulfil all non-clinical aspects of their role

- Education & Training:
    - Evidence of continuing personal & professional development
    - Provision of formal / informal teaching sessions for other staff
- Research & Audit:

  - Involvement in service audits
  - Participate in / lead on research projects
- Leadership & Management:
  - Interpretation and implementation of national guidelines
  - Policy and protocol development
  - Representation at regional / national forums
  - Promotion of service

Support Worker outcomes:

- To support the CNSs to provide a patient-centred service
- To assist with the co-ordination of multidisciplinary clinics
- To ensure patient phone calls are registered, managed and addressed by appropriate staff in an timely manner
- To guide patients through the use of self-assessment tools and support the administration of holistic needs assessment
- To provide sign-posting to patients and family members to appropriate services
- To assist at health and wellbeing events and any rehabiliation sessions
- To establish and maintain a robust and accurate database for the services
- To support and contribute to audit, governance, research and service development within the cancer teams.

These service outcomes are in line with six of the nine Macmillan outcomes for people living with cancer, i.e.

- I understand, so I can make good decisions.
- I get the treatment & care which is best for my cancer and my life
- Those around me are well supported.
- I am treated with dinity and respect
- I know what I can do to help myself and who else can help me
- I can enjoy life

(c) Anticipated numbers that the service will support

There were an average of 2497 cancers (including non-melanoma Urology cancer; NMSC) diagnosed each year in the Southern Health and Social Care Trust between 2010 and 2014. This represents 20.4% of all cancer diagnoses in Northern Ireland during this time period.
Between 2010-2014 in SHSCT, there were 2305 people living up to 22 years post diagnosis with either an urological cancer (ref: www.lcini.macmillan.org.uk). In 2016, there were 746 new patients diagnosed with urological cancer.
Many more people with an urology cancer are living longer, surviving initial treatment and going in and out of remission. The proposed new posts will enable a much greater proportion of these patients to receive the support of a CNS during the diagnosistic phase and the immediate pre and post-operative period. The teams will also provide a service to those already living with cancer, to those who present with a recurrent cancer and to those who require long term monitoring of their condtion.

Through supporting both new and current patients it is anticipated that a high proportion of family members will be supported by the teams. There is also the opportunity to increase volunteering opportunities through the Health and wellbeing events and potential rehabilitation programmes.

(d) Integration with the wider HSC services that are providing a service for people affected by cancer

These posts will be closely linked to the priorities outlined by the Northern Ireland Cancer Network (NICaN), The Cancer Service Framework for Northern Ireland and the Transforming Cancer Follow Up Project. The proposed staff will work collaboratively with the wider health and social care team in the Trust to ensure that service boundaries do not impact on the patient pathway. Furthermore, they will collaborate with teams across

other local trusts and through out the UK to ensure an evidence based, equitable service is provided acting as a link in the seamless preparation of the patients for treatment.

The post holders will work across primary and secondary care to provide a support service for advice to primary care and links with all those along the patient's cancer journey, this ranges from the general outpatients department, consultant staff, other clinical nurse specialists as appropriate, social work information and support services and to voluntary agencies supporting integrated working with primary care as key patient groups traditionally followed up in secondary care will move via risk stratification to either self-directed follow up or coordinated care.

The Trust's developing model for Health and Well Being events (HWB) will also link closely with the new postholders and through redesign of the services patients will be referred to HWB events. These events rely strongly on partnerships with a wide number of voluntary groups and volunteers including Macmillan support services, Citizens' Advice Bureau, Cancer Focus NI.

The Trust will build effective collaborative working models with partners at both strategic and operational levels thus providing significant opportunities to enhance its ability to address the needs of those with cancer across all care settings.
The post-holders will play key roles in the MDTs and will be incorporated into the current services delivered by the trust.

The new staff will work closely with other Macmillan funded staff within the trust. Particularly they will liase with:

- Macmillan Health & Wellbeing Manager to ensure patients receive information and signposting appropriate to their needs
- Macmillan Service Improvement Manager to aid implementation of the TCFU principals in cancer services
- Macmillan Benefits Advisers to ensure patients receive the financial advice and support they require
- Trust Volunteer Manager to utilise volunteers where approriate in cancer services e.g. at Health and wellbeing events
- Macmillan Move More Coordinators to ensure patients are encouraged to reamin physically active during and after cancer treatment.

(e) Volunteer Support and Engagement
Through working closely with the SHSCT Volunteer Manager, the postholders will identify suitable volunteers who are willing to help at events. If should also be possible for the staff to identify patients or family members who are at a suitable phase in their pathway who may wish to act as volunteers to provide the patient perspective at Health and wellbeing events.

(f) Learning and development needs
All nursing practice is underpinned by the Nursing and Midwifery Council Code of Professional Practice (2015)5 which provides clear guidance on development, responsibilities and accountability. In addition, if not already attained the nurse will be required to complete an Oncology specialist practice module and if required the Health Assessment and Independent Nurse Prescribing course at QUB to ensure they are able to undertake nurse-led clinics.
The post-holders will also be encouraged to undertake continous professional development that is appropriate to their developing roles. 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. These may include a variety of inhouse training courses, in conjunction with Macmillan specific training that will enable them to develop personally and professionally.
Learning and development needs will be identified through supervision, annual staff development and performance review in line with Trust procedure.

3.2 Service Evaluation / Demonstrating Impact

a) *What measures / methods will be used to evaluate the project / service.*
b) *Identify what the longer term impact will be resulting from the outcomes.*
c) *Is there any baseline data needed now in order to assess impact after the project? – Identify how the basic monitoring data (outputs) will be collected and who will be responsible, and how you intend to capture outcomes and who will be responsible.*
d) *Identify who the evaluation will be shared with and methods of sharing*

The assurance of safety, quality and experience through appropriate performance measures has been 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. Success will be monitored though the KPIs and any unintended consequences of the changes identified so that corrective action can be taken. This has been agreed through the regional ADs performance and service improvement monthly meetings. Specific monitoring processes will be developed and agreed at the outset of the posts.
The CNS will be expected to report on the regiaonlly agreed Cancer CNS KPIs, outlined in the previous section, on an annual basis.
Evaluations will endeavour to identify the successful areas of work undertaken and will also aim to highlight areas that have not been successful to ensure future service development learn from any issues identified. These evaluations will aim to collect quantitative and qualitative data from a variety of sources including those receiving the service e.g. patients and family members, those working within the multidisciplinary teams and those working outside the acute setting e.g. GPs.
On-going quantitative monitoring of the services will be achieved through data collection as per Trust audit process and requirements for service improvement, peer review standards for cancer patients, contribution to the Macmillan minimum data set. This data will be collected by the post holders on an on-going basis and will utilise data available through internal hospital systems including the Cancer Patient Pathway System (CaPPS), the local laboratory system, Theatre Management System and Patient Administration System.
The service will engage with patients, carers and others who use it. One of the most reliable standards against which to measure the quality of the service is the patient's experience. Feedback from those who use the service will provide a credible outcome measure to demonstrate the value of the service and to evaluate if the service is meeting its aims and objectives.
A range of methodologies and data systems will be employed to critically assess the impact of the service in relation to meeting the needs of those for whom it has been established. These include:

- Patient experience surveys (conducted at least every 2 years)
- Evaluation of any events or programmes organised by the team
- 6-monthly follow up with a sample of individuals who have accessed the service to determine if needs have been met

The post holders will liaise with the current MDTs and formative evaluation will be used on an on-going basis to ensure that the new roles are developing appropriately and meeting the needs of the team. The post holders will be expected to update to the site specific MDM Business Meetings and Lead Cancer Team to ensure the service is evolving as per the service development plan and in accordance with local and regional strategies.

3.3 Governance
It is important that services operate within a governance framework to ensure that they are safe, efficient and effective. Good governance will also help provide evidence to support the future sustainability of the service.

Please provide information on the governance arrangements for the service. This should include information about:

- *Standards the service will be working to (e.g. locally developed, professional or national)*
- *Staff performance review process*
- *Achieving Macmillan Volunteer Quality Standards*
- *Learning and development for the individuals within the service*
- *Customer satisfaction*
- *Outline details of the project team, decision making and change management forums*
- *Project reporting mechanisms.*
- *Outlining of any risks and how to mitigate against them*

The Trust has a governance structure in place, which incorporates the key elements of clinical and social care governance (safe and effective care), risk management/organisational controls, and financial governance. This integrated governance framework ensures an integrated approach to all aspects of health and social care delivery
All staff will adhere to all aspects of governance as outlined by the Trust including policies and procedures. All Trust policies are available on the Intranet and new policies introduced are highlighted and discussed at Team Meetings. Any specific policies will be developed for the service and risks identified and added to the departments risk register.

The postholder will complete a comprehensive induction corporately, in conjunction with Macmillan and departmentally. Any initial learning needs will be identified and an action plan developed.

An outline for the Knowledge and Skills Framework will be developed for the postholder and will provide the framework for an annual appraisal. This will include development of a Personal Development Learning Plan. The Postholder will be expected to contribute to the annual Departmental and Directorate User Consultation Plan, Audit Plan and Safety Quality and Patient Experience Plan.

There is a range of professional standards that the post holders will be working to, these include:

- Nursing and Midwifery Council (NMC, 2015) The Code: Standards of conduct, performance and ethics for nurses and midwives
- NMC (2007) Standards for Medicines management
- NMC (2005) Standards of proficiency for nurses and midwife prescribers
- Royal College of Nursing (RCN, 2008) Advanced Nurse Practitioners: An RCN guide to the advanced nurse practitioner role, competencies and programme accreditation

Dietetic professional standards include

- Health Professional Council (HPC) Standards of proficiency
- HPC Standards of conduct, performance and ethics
- HPC Standards for continuing professional development

Staff performance review process
All staff will participate in the Trust standard performance review process: Knowledge and Skills Framework. The nursing post holders will be line managed and supervised by the relevant assistant service manager. The support workers will be managed by the appropriate administrative team. All post holders will be accountable to the Assistant Director for the service area within which they sit. Staff performance will be monitored through

regular supervision, and good practice in project management including a project initiation document, Gantt charts in relation to key milestones and a risk register to manage the project.

Annual reports will be submitted to Macmillan Cancer Support, highlighting the progress relative to the objectives and expected outcomes of the postholders. The postholders will particpate in regular Service Reviews with the Macmillan Partnership Quality Lead.

Learning and Development
As outlined in section 3.1 (f) Learning and development needs will be identified for the staff and supported where approriate.

Customer satisfaction
As outlined in 3.2 patient satisfaction will assessed through a variety of means.

Project team, decision making & change management forums
The proposed new post holders will work within the already established MDTs. They will work collaboratively with the teams in planning and delivering services that is focused on the needs of patients. Any changes to the current services will be managed through the MDT and implementation will be a trust wide collaborative approach.

Reporting Mechanisms
At a working level the staff will report to their line manager at regular supervisory meetings. At a strategic level progress will be reported to the MDT Business meetings and to the monthly Lead Cancer Team meeting within the Trust.

3.4 Macmillan profile and the Macmillan experience
There is an expectation that all services/ developments/builds funded by Macmillan Cancer Support will be sustained following the initial funding period (with the exception of discrete projects) and will carry the name Macmillan and the appropriate agreed levels of branding for as long as the post / service exists. It is vital that those using the service will recognise that they have had a high quality Macmillan experience. Please explain in this section:

- *How the service will be Macmillan-branded?*
- *Will the Partner Organisation agree to the service and facilities carrying the Macmillan name e.g. 'Macmillan Information and Support Centre' and the charity's brand being displayed on and inside the Centre?*
- *How will the post holder / service help raise the profile of Macmillan Cancer Support?*
- *Any possible co-branding issues?*
- *How will patients recognise that Macmillan is a partner in this service through the experience they receive?*
- *How will volunteers receive an optimum experience in line with Macmillan standards?*
- *Please add any other information you feel is relevant*

The proposed service will promote the Macmillan profile and ensure all who avail of the service recognise that they have received a high quality Macmillan experience through the following key areas:

- The postholders' title will carry the name 'Macmillan' for the life time of the post.
- All promotional materials e.g. banners, posters etc will be co-branded bearing Macmillan logo and that of Southern Health & Social Care Trust as the partner organisation.
- The Macmilllan logo will be used on all stationary, publications relating to this service and on information resources produced by the team for use at health and wellbeing events
- The profile of Macmillan Cancer Support will be raised by presenting Macmillan as a funder of a range of services not just palliative care nursing for which they are renowned.
- The service will endorse Macmillan's strategy for support and information and their commitment to

patient and public involvement.

- Macmillan's Communications Dept will be utilised to assist in generating publicity
- The team will work with the Macmillan Partnership Manager, Macmillan Partnership Quality Lead and the Macmillan L&D Manager to gain support in service development, review, quality and educational needs
- Collaboration with the Southern Health & Social Care Trust Communications Team will be utilised to promote the service within the Trust.

- Staff will also endeavour to identify appropriate 'Case Studies' for Macmillan to promote the work related to this service

The postholder will promote Macmillan Cancer Support as an organisation and highlight the work that the organisation does at all opportunities through:

- Joint publicity and promotion of the service by Macmillan and the Trust
- All marketing will use the agreed Macmillan /Trust format
- All users will be given details of the Macmillan Cancer Service Improvement manager
- Work closely with Macmillan Cancer Support marketing and communications departments and agree all publicity materials.

3.5 Risks

Identify any risks associated with the project/service and how these can be mitigated

Key: Red = High, Amber = Medium, Green = Low

Table 1: Risk Matrix

Likelihood	Consequence: Insignificant (1)	Minor (2)	Moderate (3)	Major (4)	Catastrophic (5)
Almost certain (5)	5 L	10 M	15 M	20 H	25 H
Likely (4)	4 L	8 L	12 M	16 H	20 H
Possible (3)	3 L	6 L	9 M	12 M	15 M
Unlikely (2)	2 L	4 L	6 L	8 L	10 M
Rare (1)	1 L	2 L	3 L	4 L	5 L

Risk Identified	Score prior to mitigation	Mitigation	Score following mitigation
Unable to appoint suitable qualified nursing staff	9M	Partnership working with Southern Trust to enable appropriate nurse training and development	6L
Not all patients will make use of the additional staff	12M	The criteria for patients which are suitable to receive this service is suitably wide to ensure adequate uptake.	6L
Support workers may not have the combination of skills required for these posts i.e. clerical and clinical knowledge and experience	12M	Staff will receive additional training in the area where deficits are identified	6L

PART FOUR - PROJECT SPECIFICATION – please refer to guidance before completion

4.1 Outline initial project plan including key milestones and timelines

Urology CNS Team Development Plan - Gantt chart 2018 – 2019

Phase 1 - Actions	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May
Clerical and Managerial Teams to meet to discuss new CNS team: a)Agree and draft job descriptions b)Agree and draft job plans Submit MPA to Macmillan												
Begin recruitment process through HR												
Appoint Urology B6 CNS and B3 Support Worker												
Correlate baseline data												
Discuss evaluation methodology												
Draft Nurse Led Protocols for Clinical Oncology/Surgery												
Training for CNS and Support Worker Posts												
Establish Nurse led Clinics												
Agree and establish rapid access patients												
Engage with unit teams												
Implement recovery package												

4.2 Sustainability

How will the project outputs / outcomes be embedded locally>
Outline what the exit strategy will be.
What is required in order for the benefits to be sustained?

Given the CNS expansion has been led by the PHA and HSCB this provides a sustainable mechanism to build and expand the cancer CNS workforce in NI. With the introduction of KPIs against the agreed generic cancer CNS commissioning specification, sustainability will be achieveable and good monitoring against the KPIs will provide evidence of this.

This plan was approved by senior management team at HSCB/PHA in December 2015, with the first cohort of staff to be recruited in 2016/17. Charitable funding is being made available to support this plan with senior management team agreement to the tapered funding model to facilitate the 5 year incremental growth in the CNS workforce totalling 7 million over the next 11 years. The workforce plan takes account of the role of clinical nurse specialists (CNS) in contributing to high quality cancer care at the front line and the clear analysis that when patients have access to CNSs, this significantly improves patient experience. To date cancer CNS commissioning within Northern Ireland has been ad hoc and opportunistic, with provision significantly lower than the rest of the UK.

During the lifetime of the expansion plan, the associated outputs will be effectively monitored and evaluated to provide an in-depth insight into the impact achieved. This will be achieved via the use of and application of effective monitoring and evaluation systems and processes through the introduction of KPIs against the agreed generic cancer cCNS commissioning specification. Sustainability will be achieveable by ensuring embedding of protocols and pathwats into routine service and good monitoring against the KPIs will provide evidence of this.

Macmillan Application for Funding: Cost Profile: Complete the number of columns as appropriate according to the proposed funding model.

Basic salary plus on costs for each grade of staff (e.g. employers pension and NI contributions)						
	Year One (16/17)	**Year Two (17/18)**	**Year Three (18/19)**	**Year Four (19/20)**	**Year Five (20/21)**	**Year Six (21/22)**
Macmillan contributions	**90%**	**80%**	**70%**	**60%**	**50%**	**20%**
Band 7 CNS	[redacted]					
Band 3 Support Worker (0.25WTE)						

Travel costs						
	Year 1	**Year 2**	**Year 3**	**Year 4**	**Year 5**	**Year 6**
Band 7 CNS	£1000	£1000	£1000	£1000	£1000	£1000
Band 3 Support Worker (0.25WTE)	-	-	-	-	-	-

Capital Costs (please specify)

Set up costs – Year One Only (please specify)
£1000

Volunteer costs (if appropriate)						
	Year 1	**Year 2**	**Year 3**	**Year 4**	**Year 5**	**Year 6**
	NA	NA	NA	NA	NA	NA

Learning & Development (if appropriate)						
	Year 1	**Year 2**	**Year 3**	**Year 4**	**Year 5**	**Year 6**
	NA	NA	NA	NA	NA	NA

User Engagement or Other – please give breakdown

Totals						
	Year 1	**Year 2**	**Year 3**	**Year 4**	**Year 5**	**Year 6**
Totals	[redacted]					

Total contribution requested from Macmillan and the specified period of funding
Salaries:
Band 7: £ [redacted]
Band 3 (0.25 WTE): [redacted]
Travel: £ [redacted]
Set up costs: £1000

Macmillan Contribution over 6 years - £230,793

The Partner Organisation has seen the principles set out in Appendix A (the Grant Agreement) setting out the Conditions of Grant for Capital Projects. These (and any other project specific conditions set out in the Schedules to Appendix A) will be discussed and mutually agreed prior to the application for Outline Scheme Approval (Stage 1) from Macmillan's Board of Trustees.

Signed Date

Position in Organisation

Corrigan, Martina

From: Haughey, Mary <[redacted]>
Sent: 24 September 2018 15:03
To: Clayton, Wendy; Kelly, Brigeen
Cc: Carroll, Ronan; Corrigan, Martina; Conway, Barry
Subject: FW: Final paperwork - SHSCT Urology CNS and Support Worker
Attachments: SHSCT Generic Cancer Support Worker JD Mar17 (003).doc; SHSCT Urology CNS JD FINAL.docx; SHSCT Urology CNS MPA FINAL.doc

Hi Wendy
Please find attached the JDs for the Urology CNS and Support Worker and a copy of the Macmillan Partnership Agreement.
Kind regards
Mary

From: Ruth Thompson [mailto:[redacted]]
Sent: 24 September 2018 14:53
To: Haughey, Mary
Subject: Fwd: Final paperwork - SHSCT Urology CNS and Support Worker

Hi Mary
Please find attached the JD (and JD for Support Worker and final MPA for Info).
Ruth

Ruth Thompson
Partnership Manager - N Ireland
Macmillan Cancer Support
[redacted]
[redacted]

Health and Social Care Board

Directorate of Performance Management and Service Improvement

HSC Board Headquarters
12-22 Linenhall Street
Belfast
BT2 8BS

Tel : 0300 555 0115
Web Site : www.hscboard.hscni.net

Our Ref: LMcW044

Date: 18 September 2019

Aldrina Magwood
Director of Performance and Reform
Southern HSC Trust
Trust Headquarters
Craigavon Area Hospital
68 Lurgan Road
Portadown
BT63 5QQ

Dear Aldrina

Urology Expansion

I can confirm that the HSCB will provide £122,382 recurrently from 1 April 2020 and £61,191 CYE to support the expansion of urology capacity in the Southern Trust.

This investment will be used to make the urology service more sustainable by expanding the Urology Clinical Nurse Specialist Workforce.

The IPT will allow the development of 8.5 clinical sessions for urodynamics and LUTS service and a further 8.5 clinical sessions for prostate biopsies and nurse-led PSA follow-up service.

May I take this opportunity to thank Trust colleagues for your cooperation in taking forward this important initiative. Should you require further advice, please contact David McCormick ([redacted]) in the first instance or telephone ([redacted]).

Yours Sincerely

[redacted]

Lisa McWilliams
Acting Director of Performance Management and Service Improvement

Southern Health and Social Care Trust

Quality Care - for you, with you

JOB DESCRIPTION

Title of Post: Urology Clinical Nurse Specialist x 2 posts

Grade of Post: Band 7

Reports to: Lead Nurse – Surgery and Elective Care

Accountable to: Head of ENT, Urology, Ophthalmology and Outpatients

Initial Location: Southern Health and Social Care Trust

Hours of Work: 37.5 hours

Job Purpose

In order to meet the overall mission of the Trust, the post holder will:

- Plan to deliver effective patient focused services which meet local, regional and national requirements
- Provide clinical expertise within the specialist area of urological benign and cancer conditions by working closely with Consultants, Nursing and the wider multidisciplinary team.
- Lead by example in promoting and delivering high standards of evidence based clinical treatment and sharing clinical expertise.
- The post holder will work closely with the in-patient ward staff, Oncology teams and Palliative Care teams to ensure holistic assessment and management.

Main Responsibilities

The postholder will focus and lead on the following key areas within the organisation's framework

1. Clinical/Professional/Specific Managerial Responsibilities

1.1 ***Professional, ethical and legal***

- Adhere to DHSSPS and NMC Guidelines for practice requirements and standards for example, safe handling , administration, storage and custody of medicinal products
- Adhere to Trust guidelines, policies and procedures and comply with nursing strategy. Ensure that organisational goals are reflected in own and service objectives
- Contribute to the development of the Trusts policies and strategies where appropriate
- Maintain own professional and personal development in accordance with the NMC Codes (2008), standards and professional guidelines
- Establish and maintain relationship based on mutual respect communicating on a regular basis with the patient, relatives and carers in the provision of care and services, providing timely information at all stages of the patient pathway ensuring that individual needs are met and addressing any issues identified. Ensure appropriate systems are developed and operational to facilitate the dissemination of information within the team
- Adhere to the Data Protection Act (1998)

1.2 ***Evidence-based practice***

- To act as a role model to promote a culture of research and reflective practice within the department to enhance person-centred care.
- Ensure evidence-based care is provided to agreed standards within the ward / department for patients with urological conditions.
- Assist in developing, implementing and monitoring policies, procedures and protocols.
- Create an environment which supports a culture of learning and reflective practice for all staff.
- Assist the line manager to ensure that systems and processes are in place to support effective mentoring of relevant staff.

1.3 *Environment*

- To maintain a safe and clean environment for staff, patients / clients and visitors by ensuring compliance with legislation, policies and protocols including health and safety, healthcare associated infection, risk management and critical incident reporting.
- Ensure staff awareness of environmental issues and take appropriate action as per HSC Trust policy.
- Assist the line manager with the analysis, assessment and management of actual and potential risks to health and well-being.
- Ensure safe and effective use of equipment as per HSC Trust policy.
- Ensure near misses, incidents, accidents and faulty devices are recorded, reported, investigated and learning disseminated as per HSC Trust policy.

1.4 *Multi-professional working*

- Contribute to the establishment of systems and processes to ensure effective communication and continuity of patient / client care, liaising with multi-disciplinary / multi-agency teams and community services.

2. Enhance the patient/client experience

2.1 *Person-centred care*

- Develop and maintain a culture of person-centred care within the service.
- Promote a caring environment where equality and diversity issues are respected and patients/clients and their carers are enabled to be partners in their care.
- Develop strategies for communication between staff, patients/clients, relatives and their carers, showing awareness of barriers to understanding.
- Facilitate communication between all members of the multi-disciplinary/multi-agency team, and across care settings.
- Enhance the patient experience through the provision of information and support throughout the patient journey.
- Act as the patient's advocate, providing education and information, which enables the patient to make informed choices.
- Provide advice on palliative symptom control as required.
- Develop and promote post treatment recovery programmes as required.
- Ensure signposting and referral to health and well-being services.

2.2 *Coordination of the patient/client journey*

- Ensure the safety and quality of the patient's/client's journey by effective planning and co-ordination at all stages of the pathway.
- Support development of a patient centred service, within the multidisciplinary team, that provides specialist nursing care and support to patients and their families/carers.
- Arrange and coordinate investigations in a timely manner
- Be responsible for and positively influence the assessment, planning, delivery and evaluation of nursing care, establishing mechanism by which each patient has a coherent and comprehensive management plan. These plans will be developed with the patients and carers according to their needs and included referral to other disciplines and services observing the principles of holistic care
- Co-ordinate effective and holistic nursing care in a multi professional setting
- Provide nurse led clinics as deemed appropriate to the service needs.
- Monitor and report on patient's/client's progress and maintain contemporaneous records
- Make decisions based on professional knowledge and experience
- Assess both the physical and psychological needs of the patient and act as a resource to all disciplines involved in the delivery of care to the client group.

2.3 *Patient/client involvement*

- Identify opportunities for meaningful involvement of patients and carers in relation to the development of care and services.
- Ensure effective systems are in place to gain patient and carers feedback on their experience of care.
- Ensure patient involvement in the design and redesign of services
- Ensure compliments and complaints are managed in line with HSC Trust policy including the dissemination of shared learning.

3. Provide effective leadership and management

3.1 *Role model*

- Act as a visible leader within the service.
- Provide leadership that enables professional decision making and effective team working.
- Empower and enable staff to contribute to the delivery of high quality person-centred care.

- Provide professional leadership and expert nursing advice and support to the MDT and other care professionals across the Trust and actively support their professional development.
- Attend and contribute to Departmental, Directorate and other meetings on a regular basis as required.
- Undertake delegated responsibilities from the Service Manager.

3.2 Develop team performance

- Promote, develop and facilitate a learning culture within the service.
- Promote equality of opportunity for all, in accordance with HSC Trust Equality Opportunity Policy.
- Lead and participate in annual staff appraisal/development review, ensuring effective implementation of the Knowledge and Skills Framework (DH, 2004).
- Lead and participate in learning needs analysis and facilitate annual personal development plans for the nursing team as required.
- Lead and participate in orientation and induction programmes for staff within the department.
- Promote a person-centred culture to facilitate good staff relationships and morale among staff.
- Contribute to the education commissioning process for nursing staff as required.
- Manage poor performance and practice of staff in line with HSC Trust policies as required.

3.3 Effective use of resources

- Deliver a safe and effective service within allocated resources, ensuring the resources are used to maximum effect.
- Adhere to financial policies and procedures, particularly Standing Financial Instructions, Authorisation Frameworks, Procurement Legislation and associated processes, and Prompt Payment Code.
- Adhere to HSC Trust financial controls and fraud awareness principles (e.g. verification of authenticity / accuracy of the Staff-in-Post records).
- Adhere to HSC Trust systems for effectively managing stock and safeguarding fixed assets.
- Promote the principles of good governance and protect the department from financial risk, particularly in respect of patient/client monies and property and charitable funds.
- Display managerial and organisational skills to ensure that products required for patient/client care/treatment are procured in timely fashion and demonstrate value for money.

- Show a commitment to effectively manage resources and achieve statutory financial targets.

4. Contribute to the delivery of the organisation's objectives

4.1 Continuous quality and improvement

- Promote a culture of continuous quality improvement through the use of audit, patient/client feedback and reflection on practice by self and other members of the team.
- Deliver and promote evidence based practice and agreed care pathways for patients with Cancer

4.2 *Service improvement, development and modernisation*

- Work in partnership with a range of clinicians and managers in the planning or development of own service promoting the involvement of patients and carers.
- Review processes /practices including those within the department to support patients/clients to improve their own health and well-being.
- Review processes/practices to ascertain if there are better ways of working within the service to enhance patient/client care, service delivery and deliver required efficiencies
- Liaise with NICaN in the development of regional and local services
- Collate and analyse statistical data for the service.
- Lead on business planning for development of the service.
- Actively promote new ways of working and models of service delivery to improve services for Cancer patients

4.3 Nursing

- Liaise with nursing managers and heads of nursing on all professional nursing issues.
- Ensure staff are aware of and act in accordance with all relevant policies, procedures, guidelines, protocols, codes of conduct and nursing strategy.
- Ensure processes are in place to manage sickness/absenteeism and take appropriate action in line with HSC Trust policies.
- Promote the health and well-being of staff and observe for any signs of ill health or stress factors in staff assigned to the area and take appropriate action in line with HSC Trust policies and NMC guidelines.

5. General Responsibilities

The post holder will be required to:

i. Ensure the Trust's policy on equality of opportunity is promoted through his/her own actions and those of any staff for whom he/she has responsibility.

ii. Co-operate fully with the implementation of the Trust's Health and Safety arrangements, reporting any accidents/incidents/equipment defects to his/her manager, and maintaining a clean, uncluttered and safe environment for patients/clients, members of the public and staff.

iii. The HSC Code of Conduct for Employees sets out the standards of conduct expected of all staff in the Southern Health & Social Care Trust and outlines the standards of conduct and behaviours required during and after employment with the Trust. Professional staff are expected to also follow the code of conduct for their own professions.

iv. Adhere at all times to all Trust policies/codes of conduct, including for example:

   a. Smoke Free policy
   b. IT Security Policy and Code of Conduct
   c. Standards of attendance, appearance and behaviour

v. Contribute to ensuring the highest standards of environmental cleanliness within your designated area of work.

vi. Co-operate fully with regard to Trust policies and procedures relating to infection prevention and control.

vii. All employees of the Trust are legally responsible for all records held, created or used as part of their business within the Trust including patients/clients, corporate and administrative records whether paper-based or electronic and also including emails. All such records are public records and are accessible to the general public, with limited exception, under the Freedom of Information act 2000 the Environmental Information Regulations 2004, the Data Protection Act 2018 and General Data Protection Regulations. Employees are required to be conversant with the Trusts policy and procedures on records management and to seek advice if in doubt.

viii. Take responsibility for his/her own ongoing learning and development, including full participation in KSF Development Reviews/appraisals, in

order to maximise his/her potential and continue to meet the demands of the post.

ix. Represent the Trust's commitment to providing the highest possible standard of service to patients/clients and members of the public, by treating all those with whom he/she comes into contact in the course of work, in a pleasant, courteous and respectful manner. Seek to engage and involve service users and members of the public in keeping with the Trust's Personal and Public Involvement Strategy and as appropriate to the job role.

This post may evolve over time and this Job Description will therefore be subject to review in the light of changing circumstances and is not intended to be rigid and inflexible but should be regarded as providing guidelines within which the individual works. Other duties of a similar nature and appropriate to the grade may be assigned from time to time.

It is a standard condition that all Trust staff may be required to serve at any location within the Trust's area, as needs of the service demand.

November 2019

SOUTHERN HEALTH & SOCIAL CARE TRUST

PERSONNEL SPECIFICATION

Title of Post: Urology Clinical Nurse Specialist

Grade of Post: Band 7

SALARY £30,764 – £40,558 per annum

HOURS 37.5 per week

Notes to applicants:

1. *You must clearly demonstrate on your application form under each question, how you meet the required criteria as failure to do so may result in you not being shortlisted. You should clearly demonstrate this for both the essential and desirable criteria.*
2. *Shortlisting will be carried out on the basis of the essential criteria set out in Section 1 below, using the information provided by you on your application form. Please note the Trust reserves the right to use any desirable criteria outlined in Section 3 at shortlisting. You must clearly demonstrate on your application form how you meet the desirable criteria.*
3. *Proof of qualifications and/or professional registration will be required if an offer of employment is made – if you are unable to provide this, the offer may be withdrawn.*
4.

ESSENTIAL CRITERIA		
SECTION 1: The following are **ESSENTIAL** criteria which will initially be measured at shortlisting stage although may also be further explored during the interview/selection stage. You should therefore make it clear on your application form whether or not you meet these criteria. Failure to do so may result in you not being shortlisted. The stage in the process when the criteria will be measured is stated below.		
Factor	**Criteria**	**Method of Assessment**
Experience / Qualifications/ Registration	Currently a Registered Nurse Level 1, (Adult) on the Live NMC Register. **AND** University degree or relevant health/social care qualification plus at least 2 years' experience within the last 6 years at Band 6 in a hospital or community environment delivering health or social care service and people with urological conditions **AND** Have completed or be willing to undertake specialist nursing practice in Urology **OR** Have worked for at least 5 years in a senior role[1]	Shortlisting by Application Form

Other	Hold a current full driving licence which is valid for use in the UK and have access to a car on appointment. This criteria will be waived in the case of applicants whose disability prohibits driving but who have access to a form of transport approved by the Trust which will permit them to carry out the duties of the post Flexible with regards to working arrangements to meet the needs of the service	Shortlisting by Application Form
Factor	**Criteria** *Ideally no more than 6-8 criteria in this section*	**Method of Assessment**
Skills / Abilities	1. Ability to influence and manage change, including the promotion of evidence based practice. 2. Have effective communication skills to meet the needs of the post in full. 3. Ability to work independently within protocols and, where appropriate, Patient Care Directives, providing agreed standards of patient care 4. Demonstrate ability to work effectively as part of a multi-disciplinary team while managing a busy caseload 5. Ability to actively engage in research and audit processes 6. Ability to teach colleagues and patients using a range of media 7. Competent IT skills	Interview
Knowledge	8. Current evidence of informed nursing practices and treatment modalities in both oncological and general aspects of urology care. 9. Awareness of the national urological nursing agenda	Interview

[1] *"senior role" is defined as experience gained at Band 6 or above*

Vetting

As part of the Recruitment and Selection process, it may be necessary for the Trust to carry out an Enhanced Disclosure Check through Access NI before any appointment to this post can be confirmed.

Canvassing either directly or indirectly will be an absolute disqualification for appointment.

Additional Information:

Candidates shortlisted for interview will be required to produce original certificates and photocopies of the same.

If successful staff will be required to produce documentary evidence that they are legally entitled to live and work in the UK eg P45, payslip, National Insurance Card, Birth Certificate. Failure to do so will result in a non appointment.

The Trust is an Equal Opportunities Employer.

REVENUE BUSINESS CASE PROFORMA COVER

Name of organisation	Southern Health and Social Care Trust
Project Title	Expansion of Urology Clinical Nurse Specialists
Total Cost	FYE £122,382, CYE £61,191 (2019-20)
Start date	01 October 2019
Completion date	Recurrent

Complete this section if bid is for new funding

BID FOR NEW FUNDING	
Is this bid for new funding (Y/N)	Y
How much total funding required?	FYE £122,382
How much funding required per year?	FYE £122,382, CYE £61,191 (2019-20)
Is this funding to be made recurrent?	Y

Complete this section if funding available within existing allocation

Funding available within existing allocation (Y/N)	N
Total cost of proposal	
Cost of proposal per year	
Is this cost within recurrent allocation?	

Is this business case	*Y/N*
(a) Standard	Y
(b) Novel	N
© Contentious	N
(d) Setting a precedent	N
If yes to (b) or (c) or (d) , requires Departmental & DoF approval. Is Departmental / DOF approval required	

Approval & submission by Trust

This section to be completed by Trusts for all submissions

Responsible Director Signature (required for all submissions)

Name Printed Melanie McClements (signed) [redacted]

Grade/ Title Interim Director of Acute Services

Date 14/8/19

Trust Director of Finance Signature (required if bid is over £100k)

Name printed Helen O'Neill (signed) [redacted]

Date 20/8/19

Trust Chief Executive Signature (required if bid is ove[redacted])

Name printed Shane Devlin (signed) [redacted]

Date 21/8/19

Complete this section if Department / DOF approval required

Date submitted to Department
Department/ DOF approval (y/n)
Date approved

BUSINESS CASE TEMPLATE REVENUE FUNDING £50k - £250k

SECTION 1: PROJECT BACKGROUND, STRATEGIC CONTEXT & NEED

In 2008/09 A Regional Review of (Adult) Urology Services was undertaken by a multi-disciplinary and multi-organisational Steering Group in response to service concerns regarding the ability to manage growing demand and maintain quality standards. The regional review was followed in 2013/14 by a stock-take to assess progress to date. Since the completion of the stocktake, the HSCB has met with Trusts to explore how service redesign could help address the key challenges facing the service. These challenges include:

- There are regional variations in pathways for both new outpatient assessments and treatments, including cancer;
- There are regional variations in waiting times for outpatients and surgical procedures, with significant numbers of patients waiting for core urology procedures;
- There has been a significant change in referral patterns. The total number of urology referrals have increased by 7.5% since 2015, with red flag and urgent referrals increasing by 26% and 15% respectively. This has a direct impact on the cancer waiting times and those referrals classified as routine;
- A regional capacity gap across both outpatient assessments and treatments which continues to grow as demand increases;
- Across the region there are continued challenges for the recruitment and retention of clinical staff at all levels;
- There are infrastructure constraints and in particular limited access to operating theatre sessions which has resulted in excessive waiting times for routine core urology procedures;

The following IPT aims to make the urology service more sustainable by expanding the Urology Clinical Nurse Specialist Workforce. The IPT will allow:

- the recruitment of one Non-cancer Clinical Nurse Specialist (CNS) who will provide 8.5 clinical sessions for urodynamics and a nurse-led LUTs service.
- the recruitment of one Cancer Clinical Nurse Specialist who will provide 8.5 clinical sessions for prostate biopsies and a nurse-led PSA follow-up service.
- the recruitment of 0.5 WTE admin support worker (0.25 per CNS)

SECTION 2 (a): OBJECTIVES

Project Objectives	Measurable Targets
1. To reduce routine Outpatient assessment waiting times	**Target** By March 2019, 50% of patients should wait no longer than 9 weeks for a first outpatient appointment, and no patient should wait longer than 52 weeks. **Baseline** At 31st December 2018 16.4% of those waiting for a first time consultant-led outpatient appointment were in the Southern Trust (46,150 patients). As at 31st December 2018, within the Southern Trust 75.2% of patients waited longer than 9 weeks and 25.1% (11,570) were waiting longer than 52 weeks. As at 31st December 2018, within the urology specialty in the Southern Trust there were 3,383 patients waiting for a first consultant-led outpatient appointment. Of these 709 patients were waiting less than 9 weeks (21%) and 1754 patients were waiting longer than 52 weeks (52%).
2. To improve urology cancer waiting times by 31st March 2020.	**Target** At least 95% of patients should begin their first treatment for cancer within 62 days following an urgent GP referral for suspect cancer. **Baseline** In December 2018 Urology achieved 54.85% of patients commencing their treatment within 62 days of a decision to treat.
	Target At least 99% of patients should begin their first treatment for cancer within 31 days following an urgent GP referral for suspect cancer. **Baseline** In December 2018 Urology achieved 99.37% of patients commencing their treatment within 31 days of a decision to treat.
3. Increase new and review outpatient capacity for urology.	**Baseline** July 2019 - there are currently 3,983 New outpatients and 3,271 Review outpatients awaiting appointments.

	Target • Increase the number of clinical sessions for urodynamics and nurse-led LUTs Service by 31st March 2020. • Increase the number of clinical sessions for prostate biopsies and nurse-led PSA follow up service by 31st March 2020.
4. Increase capacity for diagnostic treatments (Flexible Cystoscopies/TRUS biopsies) by 31st March 2020, which will help shorten the length of the cancer pathways	To achieve the 62 day cancer pathway patients are required to have their initial Outpatients appointment or "straight to test" within 14days of RF referral: **Baseline** Currently First Out-patient appointments are (July 2019): Prostate – 82 days Haematuria – 44 days Other – 49 days **Target** • Increase number of weekly clinics with increased capacity to undertake diagnsostics ie flexible cystoscopies • Decrease the length of time on the cancer pathways.
5. To ensure that every patient diagnosed with cancer are provided with a key worker and given a Holistic Needs Assessement by 31st March 2020.	**Target** • Develop key worker role for renal cancer patients • Ensure timely follow-up on all patients diagnosed with an urological cancer

SECTION 2 (b) : CONSTRAINTS

- **Availability of recurrent funding** – delivery of the objectives and associated benefits will be dependent on sufficient funding being available.
- **Accommodation –** clinics and theatre sessions will need to be factored into available accommodation in the Trust
- **Staffing availability** - there is a workforce deficit in nursing in Northern Ireland so recruiting to these posts will be a challenge either internally or externally

SECTION 3: IDENTIFY AND DESCRIBE OPTIONS

OPTION NO.	BRIEF DESCRIPTION OF OPTION
1	**Status Quo - continue with existing arrangements**
2	Appoint the following: • 1.00 WTE Band 7 - Non-cancer clinical nurse specialist • 1.00 WTE Band 7 Cancer clinical nurse specialist • 0.50 WTE Band 3 Admin Support - 0.25 per Clinical Nurse Specialist (CNS) See detail over
3	Appoint the following: • 0.50 WTE Band Non-cancer clinical nurse specialist • 0.50 WTE Band 7 Cancer clinical nurse specialist • 0.25 WTE Band 3 Admin Support - 0.25 per CNS See detail over

Option 2 – Appoint

- 1 WTE Band 7 Non-cancer clinical nurse specialist and
- 1 WTE Band 7 Cancer clinical nurse specialist
- 0.50 WTE Band 3 Admin Support (0.25 per CNS)

Below is Job Plan for CNS posts

	Cancer Clinical Nurse Specialist	**Non-Cancer Clinical Nurse Specialist**
Independent nurse led clinics	**Clinical Activity sessions x 3** • Prostrate Biospy x 1 • Holistic Needs Assessment x 1 • Flexible Cystoscopies x1	**Clinical Activity sessions x 5.5** • Lower Urinary Tract Review Clinic x 1 • Urodynamics x 2 • Botox injections x 1.5 • Telephone Review x 1
MDM Clinics	1.5 (Keyworker)	1 x Trial Removal of Catheter/ Complex catheter change
MDM ward rounds (Meeting)	1	0.25
MDM Case management discussions	0.5	N/A
Provision of direct care recovery/ward attenders	0.5	0.5
Telephone consultations	1 (Prostrate Biopsy preparation/ PSA Tracking)	0.25
Clinical Admin / Validation	1.0	1.0
Sub-total	**8.5**	**8.50**
Supporting Professional Activity		
Teaching	0.25	0.25
Clinical Governance including audit and research	0.25	0.25
Admin – organisational requirement	0.5	0.5
Contribution to service planning / policy development	0.25	0.25
Professional development / CPD	0.25	0.25
Sub-total	**1.5**	**1.5**
Total	**10**	**10**

Option 3 – Appoint

- 0.5 wte Band 7 Non-cancer clinical nurse specialist and
- 0.5 wte Band 7 Cancer clinical nurse specialist
- 0.25 wte Band 3 Admin Support (0.125 per CNS)

Below is Job Plan for CNS posts

	Cancer Clinical Nurse Specialist	Non-Cancer Clinical Nurse Specialist
Independent nurse led clinics	**Clinical Activity sessions x 2.5** • Prostrate Biospy x 1 • Holistic Needs Assessment x 0.5 • Flexible Cystoscopies x1	**Clinical Activity sessions x 2.5** • Lower Urinary Tract Review Clinic x 1 • Urodynamics x 0.5 • Botox injections x 0.5 • Telephone Review x 0.5
MDM Clinics	1 (Keyworker)	1 x Trial Removal of Catheter/ Complex catheter change
MDM ward rounds (Meeting)	0.5	0.25
MDM Case management discussions	0.25	N/A
Provision of direct care recovery/ward attenders	0.25	0.25
Telephone consultations	0.25 (Prostrate Biopsy preparation/PSA Tracking)	0.25
Clinical Admin / Validation	0.25	0.25
Sub-total	**5.0**	**5.0**
Supporting Professional Activity		
Teaching	0	0
Clinical Governance including audit and research	0.25	0.25
Admin – organisational requirement	0.25	0.25
Contribution to service planning / policy development	0	0
Professional development / CPD	0.25	0.25
Sub-total	**0.75**	**0.75**
Total	**5.75**	5.75

SECTION 4: MONETARY COSTS AND BENEFITS OF OPTIONS

Option 1: Status Quo – continue with existing arrangements	**Year 0 19/20 £ 000**	**Year 1 20/21 £ 000**	**Year 2 21/22 £ 000**	**Year 3 22/23 £ 000**	**Year 4 23/24 £ 000**	**Year 5 24/25 £ 000**	**Totals £ 000**
Capital Costs							
Capital Cost	0.0	0.0	0.0	0.0	0.0	0.0	0.0
(a) Total Capital Cost	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
Revenue Costs							
Baseline Costs	1,888.5	1,888.5	1,888.5	1,888.5	1,888.5	1,888.5	11,331.0
(b) Total Revenue Cost	**1,888.5**	**1,888.5**	**1,888.5**	**1,888.5**	**1,888.5**	**1,888.5**	**11,331.0**
(c) Total Cost = (a) + (b)	**1,888.5**	**1,888.5**	**1,888.5**	**1,888.5**	**1,888.5**	**1,888.5**	**11,331.0**
(d) Disc Factor @ 3.5%pa	1.0000	0.9662	0.9335	0.9019	0.8714	0.8420	
(e) NPC = (c) x (d)	**1,888.5**	**1,824.7**	**1,762.9**	**1,703.2**	**1,645.6**	**1,590.1**	**10,415.0**

COST ASSUMPTIONS:

Finance Assumptions:

1. Year 0 is 2019/20 Financial Year.
2. The baseline costs for this case is the recurrent opening 2019/20 budget for the HoS for Urology (CA7830) within the Acute directorate of the SHSCT.
3. No other revenue or capital costs are associated with this option
4. A discount factor @3.5% pa has been applied to calculate the NPC.
5. Please note all figures above have been rounded to thousands and shown to one decimal place.
6. Total Net Present Cost (NPC) equates to £10,415.0k for this option.

Option 2 – Appoint: • 1.00 WTE Band 7 Non-cancer clinical nurse specialist • 1.00 WTE Band 7 Cancer clinical nurse specialist • 0.50 WTE Band 3 Admin Support (0.25 per CNS)	Year 0 19/20 £ 000	Year 1 20/21 £ 000	Year 2 21/22 £ 000	Year 3 22/23 £ 000	Year 4 23/24 £ 000	Year 5 24/25 £ 000	Totals £ 000
Capital Costs							
(a) Total Capital Cost	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
Revenue Costs							
Recurring revenue baseline	1,888.5	1,888.5	1,888.5	1,888.5	1,888.5	1,888.5	11,331.0
Payroll Cost	56.9	113.8	113.8	113.8	113.8	113.8	625.9
Payroll Related G&S	4.3	8.5	8.5	8.5	8.5	8.5	46.8
(b) Total Revenue Cost	**1,949.7**	**2,010.8**	**2,010.8**	**2,010.8**	**2,010.8**	**2,010.8**	**12,003.7**
(c) Total Cost = (a)+(b)	**1,949.7**	**2,010.8**	**2,010.8**	**2,010.8**	**2,010.8**	**2,010.8**	**12,003.7**
(d) Disc Factor @ 3.5%pa	1.0000	0.9662	0.9335	0.9019	0.8714	0.8420	
(e) NPC = (c) x (d)	**1,949.7**	**1,942.8**	**1,877.1**	**1,813.5**	**1,752.2**	**1,693.1**	**11,028.4**

COST ASSUMPTIONS:

Finance Assumptions:

1. Year 0 is 2019/20 Financial Year.
2. The baseline costs for this case is the recurrent opening 2019/20 budget for the HoS for Urology (CA7830) within the Acute directorate .
3. The staff identified in Section 3 are costed according to the HSCB - General Costings - 2019/20, Draft 30.04.2019.
4. An allowance has been made for Employee related G&S but no allowance has been made for unsocial hours payments.
5. The expected start date is 01/10/2019 so a six month effect is assumed in 2019/20.
6. No capital costs are identified in this case.
7. A discount factor @3.5% pa has been applied to calculate the NPC.
8. Please note all figures above have been rounded to thousands and shown to one decimal place.
9. Total Net Present Cost (NPC) equates to £11,028.4k for this option.

Option 3: Appoint • 0.50 WTE Band 7 Non-cancer clinical nurse specialist • 0.50 WTE Band 7 Cancer clinical nurse specialist • 0.25 WTE Band 3 Admin Support (0.125 per CNS)	**Year 0 19/20 £ 000**	**Year 1 20/21 £ 000**	**Year 2 21/22 £ 000**	**Year 3 22/23 £ 000**	**Year 4 23/24 £ 000**	**Year 5 24/25 £ 000**	**Totals £ 000**
Capital Costs							
(a) Total Capital Cost	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
Revenue Costs							
Recurring revenue baseline	1,888.5	1,888.5	1,888.5	1,888.5	1,888.5	1,888.5	11,331.0
Payroll Cost	28.5	56.9	56.9	56.9	56.9	56.9	313.0
Payroll Related G&S	2.1	4.3	4.3	4.3	4.3	4.3	23.6
(b) Total Revenue Cost	**1,919.1**	**1,949.7**	**1,949.7**	**1,949.7**	**1,949.7**	**1,949.7**	**11,667.6**
(c) Total Cost = (a)+(b)	**1,919.1**	**1,949.7**	**1,949.7**	**1,949.7**	**1,949.7**	**1,949.7**	**11,667.6**
(d) Disc Factor @ 3.5%pa	1.0000	0.9662	0.9335	0.9019	0.8714	0.8420	
(e) NPC = (c) x (d)	**1,919.1**	**1,883.8**	**1,820.0**	**1,758.4**	**1,699.0**	**1,641.6**	**10,721.9**

COST ASSUMPTIONS:

Finance Assumptions:

1. Year 0 is 2019/20 Financial Year.
2. The baseline costs for this case is the recurrent opening 2019/20 budget for the HoS for Urology (CA7830) within the Acute directorate.
3. The staff identified in Section 3 are costed according to the HSCB - General Costings - 2019/20, Draft 30.04.2019.
4. An allowance has been made for Employee related G&S but no allowance has been made for unsocial hours payments.
5. The expected start date is 01/10/2019 so a six month effect is assumed in 2019/20.
6. No capital costs are identified in this case.
7. A discount factor @3.5% pa has been applied to calculate the NPC.
8. Please note all figures above have been rounded to thousands and shown to one decimal place.
9. Total Net Present Cost (NPC) equates to £10,721.9k for this option

SECTION 5: NON-MONETARY BENEFITS

The Urology department in the Southern Health and Social Care Trust currently have 3 Clinical Nurse Specialists (CNS) @ Band 7 (one is funded by Macmillan). Two of these nurses are aligned to Cancer Services and the third is for benign urological disease .

Cancer Clinical Nurse Specialist

The role of the CNS in contributing to high quality cancer care is now well acknowledged. The CNS is the main point of contact for patients (key worker) . The Urology Service in SHSCT received 3,409 red flag referrals (April 2018-March 2019). From this volume of referrals 720 patients were diagnosed to have cancer. With only two Cancer CNS (one only appointed in February 2019) this means that they are unable to provide their key worker role and follow-up to a large number of patients. With this additional Cancer CNS the urology service will be able to increase the number of nurse-led clinic appointments (face to face/ telephone/ Holistic Needs Assessment).The impact of which will significantly improve patient experience and deliver services for individual patients according to their needs and choice.

Benign Clinical Nurse Specialist

Currently there are a large number of patients on the New Outpatient Waiting list awaiting lower urinary tract consultations which this CNS could see, treat and follow-up. Therefore with the appointment of the second CNS this will lead to an increase in nurse led clinics, which will help reduce waiting times and will also enable consultants to deal with the more urgent/complex patients on these waiting lists for New outpatients/Review backlogs and urodynamics.

Another benefit wll be that the service will have enough staff to provide outreach services to Daisy Hill/South Tyrone and Armagh Hospitals thus meaning patients will not have to always travel for their appointments.

SECTION 6: PROJECT RISKS & UNCERTAINITIES

- Availability of nursing staff to take up post
- Insufficient funding available to implement preferred option

SECTION 7: PREFERRED OPTION AND EXPLANATION FOR SELECTION

The preferred option is Option 2: Appoint:

- 1.00 WTE Band 7 Non-cancer clinical nurse specialist
- 1.00 WTE Band 7 Cancer clinical nurse specialist
- 0.50 WTE Band 3 Admin Support (0.25 per CNS)

Although both options 2 and 3 meet all the objectives option 2 enables more clinical sessions to be carried out and more patients seen, reducing waiting times and providing an improved patient experience.

SECTION 8: AFFORDABILITY AND FUNDING REQUIREMENTS

AFFORDABILITY STATEMENT	Year 0 2019/20 £ 000	Year 1 2020/21 £ 000	Year 2 2021/22 £ 000	Year 3 2022/23 £ 000	Totals £000's
Required					
Capital required	0.0	0.0	0.0	0.0	0.0
Revenue required	1,949.7	2,144.2	2,286.4	2,438.0	8,818.3
Existing budget :					
Capital	0.0	0.0	0.0	0.0	0.0
Revenue	1,888.5	2,013.7	2,147.2	2,289.6	8,339.0
Additional Allocation Required:					
Capital	0.0	0.0	0.0	0.0	0.0
Revenue	61.2	130.5	139.2	148.4	479.3

AFFORDABILITY ASSUMPTIONS

Finance Assumptions:

1. Year 0 is 2019/20 Financial Year.
2. The baseline costs for this case is the recurrent opening 2019/20 budget for the HoS for Urology (CA7830) within the Acute directorate.
3. The staff identified in Section 3 are costed according to the HSCB - General Costings - 2019/20, Draft 30.04.2019.
4. An allowance has been made for Employee related G&S but no allowance has been made for unsocial hour's payments.
5. The expected start date is 01/10/2019 so a six month effect is assumed in 2019/20.
6. No capital costs are identified in this case.
7. Costs have been uplifted by 6.63% for inflation from 2020/21.
8. Please note all figures above have been rounded to thousands and shown to one decimal place.

SECTION 9: MANAGEMENT ARRANGEMENTS

It is proposed to implement the organisation and management of this scheme in accordance with the requirements of the Department of Finance and Personnel guidance relating to successful project management.

The following key roles have been identified:

Project Owner: Ronan Carroll, Assistant Director of Acute Services (Surgery, Elective Care Division and ATICs)

Project Manager: Martina Corrigan Head of ENT, Urology, Opthamology and Outpatients

SECTION 10: MONITORING AND EVALUATION

Who will manage the implementation? (please provide the name of the responsible individual where possible)	Martina Corrigan Head of ENT, Urology, Opthamology and Outpatients
Who will monitor and evaluate the outcomes? (please provide the name of the responsible individual where possible)	Acute Head of Service (independent to the project) will undertake post project evaluation.
What other factors will be monitored and evaluated?	Appointment and commencement of posts.
When will this take place? (preferably 4 to 12 months after project closure)	A post project evaluation will be undertaken 12 months after implementation.

SECTION 11: ACTIVITY OUTCOMES (TRUSTS ONLY)

Specifiy activity, e.g. IP, DC OPN, OPR, Contacts etc

	OP New	OP Review	OP with Procedure New *	OP with Procedure Review **	Total New	Total Review
Baseline	-	-	-	-	-	-
Additional activity	552	676	1025	81	1,577	757
New Baseline Activity	**552**	**676**	**1025**	**81**	**1,577**	**757**

* New OPP (Prostate Biopsies and Flexis)

**Review OPP (Urodynamics andTROC)

SECTION 12: BENCHMARKING EVIDENCE TO SUPPORT PREFERRED OPTION

Hospital Site or Community development	CRAIGAVON	
Scheme Title	Expansion of Urology Clinical Nurse Specialists - 2019 20	**Commissioner Use only**
Pay and Price Levels	2019 20	**Sign and Date for TRAFFACS u**

		Base Case - option 1				Option 2				Option 3			
Pay Costs	Description	months claimed	wte	fye	cye	months claimed	wte	fye	cye	months claimed	wte	fye	cye
	BASELINE -			1,888,519	1,888,519			1,888,519	1,888,519			1,888,519	1,888,519
Band 7	Non-cancer clinical nurse specialist			0	0	6.00	1.00	50,744	25,372	6.00	0.50	25,372	12,686
Band 7	Cancer clinical nurse specialist			0	0	6.00	1.00	50,744	25,372	6.00	0.50	25,372	12,686
Band 3	Admin Support					6.00	0.50	12,355	6,178	6.00	0.25	6,178	3,089
Non-AFC posts please detail below													
				0	0			0	0			0	0
Allowances for posts noted above - please detail below													
Unsocial Hours payments													
G&S Costs associated with the above posts													
Employee Related G&S													
Band 7	Non-cancer clinical nurse specialist					6.00		3,796	1,898	6.00		1,898	949
Band 7	Cancer clinical nurse specialist					6.00		3,796	1,898	6.00		1,898	949
Band 3	Admin Support					6.00		947	473	6.00		473	237
Exceptional Recruitment and Retention costs for posts above the mean plus x% (please provide detail)													
					0				0				0
					0				0				0
	TOTAL PAY COSTS		0.00	1,888,519	1,888,519		2.50	2,010,901	1,949,710		1.25	1,949,710	1,919,114
Non-Pay Costs - please detail below													
					0				0				0
OTHER GOODS & SERVICES									0				0
					0				0				0
					0				0				0
	TOTAL NON-PAY COSTS			0	0			0	0			0	0
	GRAND TOTAL			1,888,519	1,888,519			2,010,901	1,949,710			1,949,710	1,919,114
								122,882	61,191			61,191	30,595

Phasing/Timescale	*(Can development be phased, if so provide details in this box)*	*(Can development be phased, if so provide details in this box)*	*(Can development be phased, if so provide details in this box)*
PROGRAMME OF CARE	acute	acute	acute
SUB-SPECIALTY INFORMATION eg inpatients,			
LCG	Southern	Southern	Southern
If more than one LCG in option above please give details			
LGD			
If more than one LGD in option above please give details			