Section 3 A Strategy for Breaking Bad News.

The following strategy is developed from the work of SPIKES.[28]

Preparation - Setting up the Interview

Prepare yourself -

It is natural for the bearer of bad news to be anxious about the interview with the patient or carer.

- Familiarise yourself with the patient's background, medical history and test results. You will also need to have some knowledge of the choices in the future management of the patient's condition.
- It is helpful to mentally rehearse the interview, the likely questions you will be asked, the patient's emotional and potential responses.
- While it is important to remember that the bad news may be very sad for the patient, the information that you will be giving will be important in allowing him/her to plan for the future.
- It is strongly recommended that a colleague such as the patient's named nurse or specialist nurse accompanies you. This individual may remain with the patient if appropriate and help provide continuing support to the patient.
- The patient may want a member of their family with them, however this must be established prior to the interview. The clinician must be guided by the wishes of the patient. It can be helpful to suggest to the patient, when investigations are being carried out, that they may wish a family member or friend to accompany them for support, when results are discussed with them.

Prepare your setting -

- Arrange some privacy. Ideally an interview room or where a patient is confined to bed, pull the curtains around the bed. The latter is not an ideal situation, but can occasionally be difficult to avoid. (A practical hint is to have some tissues at hand in case the patient becomes upset.)

- Do not stand over the patient. Sit down, as this is less intimidating and shows that you are not going to be rushed. It is important to have no barriers between you and the patient. If you have recently examined the patient allow them to dress before the discussion.
- It is important to gain a rapport with your patient. The mechanisms by which you do this will depend very much on the patient, their condition, cultural background and age.
- It is important that you balance the time available with the needs of the patient and that you conduct the interview accordingly. You may need to switch off your pager or get a colleague to answer calls on your behalf. If the interview is rushed the doctor/other professional may be perceived as uninterested.

Prepare your Patient -

- Patient perceptions. It is important before you begin breaking bad news that you assess the patients' understanding of their condition. At this stage you can correct any misunderstandings and it will enable you to assess if the patient is engaging in either denial, wishful thinking or unrealistic expectations of treatment.[29]
- Obtaining the Patients' Permission. While many patients increasingly want to have details about their disease and diagnosis, some patients do not and this should be respected and appropriately managed. One mechanism to help you is to assess the level of information the patient wants. If this is not explicit, broach the subject when tests are being ordered, by asking questions such as, "How would you like me to give you the results of these tests?" or " Are you the type of person who likes detailed information, or would you like a general overview?" or " Have you had any thoughts as to what may be wrong".

The Interview

Providing the Information -

There is no easy way to give a patient bad news. Warning a patient that bad news is coming may help lessen the shock and may help the patient to go on to process the information they receive.[30,31] Examples include terms such as, "Unfortunately I've got some bad news to tell you" or "I am sorry to tell you".

In providing the facts to the patient it is important to remember:

a) Start at the level of comprehension and vocabulary of the patient.

b) Use non-technical words such as 'spread' instead of 'metastases'. Remember patients may not understand the words 'malignancy' or 'tumour' to mean 'cancer'.

c) Provide information simply and honestly, avoiding excessive bluntness, as it is likely to leave the patient isolated and angry, with a tendency to blame the messenger.

d) Give the information in small chunks and stop periodically to check the patients understanding. One helpful approach is to provide information in steps, introducing more specific language at each step. For example this allows the patient with cancer to introduce the word 'cancer' themselves.

e) When the prognosis is poor, avoid using terms such as "there is nothing more we can do for you", as goals in care will change to good pain control and symptom relief, all of which are possible.

f) Encourage questions and allow time.

g) Remember it is likely that the patient may not be able to recall all of the conversation you have had. You may need to return and repeat the process at a later stage.

h) Offer to speak to family members or carers should the patient wish.

Where possible and appropriate, information given verbally should be supported with written information.[32,33] It is of equal importance to share this information and the patients response with the multidisciplinary care team and the patient's General Practitioner who may feel it is necessary to repeat the information when the patient is at home. Some patients may find it helpful if you offer to tape the interview for them.

Providing Support

Providing support to the patient begins with responding to the patient's emotions, which can range from silence to disbelief, crying, denial or anger. An empathetic response consists of five steps:

a) Observe for emotions such as tearfulness, silence or shock.

b) Acknowledge and identify with the emotion experienced by the patient. When a patient is silent use open questions, asking them how they are feeling or thinking. This will help them articulate what their emotions are. Allow time for silence and tears.

c) Do not say "I know how you feel". Even if you have had personal experience of the disease or condition, you cannot know how an individual feels. Empathy can be shown by using terms such as "I think I understand how you must be feeling".

d) Check the reason for the response. This will usually be related to the news you have just given them or the impact the news will have on their family or children.

e) Encourage and allow the patient time to express their emotions and let the patient know you understand and acknowledge their emotions. This reduces the patient's isolation, expresses solidarity and validates their feelings or thoughts as normal and to be expected.[34,35]

Unless the emotions of the patient are adequately addressed it is difficult for the doctor/other professional and patient to move on to discuss other relevant issues.

Providing a Plan -

Patients who have a clear plan for the future are less likely to feel anxious and uncertain. An important part of this is providing treatment and care options to the patient. For example in chronic illnesses such as diabetes, a clear management plan or when malignant disease is confirmed, the options for treatment and if appropriate ongoing support and palliative care. It may be helpful if the patient has the option to speak to the professional delivering the bad news at a later stage.

After the Interview

Documentation -

It is important that accurate records are maintained of the conversation and the information and details exchanged. These will assist in the future care of the patient and enhance communication within the multidisciplinary team including the patient's General Practitioner.

This record should be documented in the patient's notes. The specific words used to describe the disease should be recorded, for example, tumour, growth or malignant disease.

A template to record the information given (Appendix C), is provided for local adaptation and use. It is suggested that this should be sent immediately by secure fax if available to the patients' General Practitioner.

Despite following these guidelines patients may not be able to absorb the detail of the news being delivered. A well informed multi-disciplinary team is the key if the news is to be reinforced ensuring the patient and where appropriate, the family have the fullest understanding possible.

Taking the time to prepare for an interview to break bad news to patients will help ensure the process is more effective. That said it has to be acknowledged that receiving a diagnosis of bad news may be overwhelming for the patient and their family or carers regardless of the care the doctor or professional takes in communicating it.

Appendix A

Sub Group Membership

Name	Organisation
Dr Sheila Kelly, Consultant Palliative Medicine	Marie Curie Cancer Care, Belfast.
Dr Bernie Corcoran, Consultant Palliative Medicine	Belfast City Hospital Trust
Dr Kiran Kaur, Consultant Palliative Medicine	Northern Ireland Hospice/Royal Group Hospitals Trust
Dr Yvonne Duff, Consultant Palliative Medicine	United Hospitals Trust
Pauline Douglas Allied Health Professions Representative	Belfast City Hospital Trust
Dr Jenny Jingles, Consultant Public Health Medicine	Eastern Health and Social Services Board
Heather Monteverde Service Development Manager	Macmillan Cancer Relief
Jane Graham, Chief Officer	Eastern Health and Social Services Council
Dr Brid Farrell, Consultant Public Health Medicine	Southern Health and Social Services Board
Mary Hinds, Director of Nursing & Quality	Mater Hospital Trust

Appendix B
Breaking Bad News - A Guide for Clinical Staff

Prepare Yourself	• Familiarise yourself with the patient's background, medical history, test results and future management / treatment choices. • Mentally rehearse the interview including likely questions and potential responses. • Arrange for a colleague such as the patient's named nurse or specialist nurse to accompany you. Relatives can be in attendance, however you must be guided by the wishes of the patient.
Prepare Your Setting	• Arrange some privacy. • Do not stand over the patient, sit down as this relaxes the patient and shows that you are not going to be rushed. If you have recently examined the patient allow them to dress before the interview. • Switch your pager off or get a colleague to answer calls on your behalf.
Prepare Your Patient	• Assess the patients understanding of their condition. *"Can you help me by telling me what you understand about your illness?"* • While many patients want to have details about their disease and diagnosis, some patients do not want this detail and their wishes should be respected and appropriately managed. Never impose information.
Providing Information	• Start at the level of comprehension and vocabulary of the patient. • Use non-technical words such as 'spread' instead of 'metastases'. • Avoid excessive bluntness, as it is likely to leave the patient isolated and later angry. • Set the tone. *"I am afraid I have some bad news"* • Give the information in small chunks and stop periodically to check the patients understanding. *"Is this making sense?"* or *"Would you like me to explain more?"* When the prognosis is poor, avoid using terms such as "there is nothing more we can do for you," as goals in care will change to pain control and symptom relief.
Providing Support	• Acknowledge and identify with the emotion experienced by the patient. When a patient is silent use open questions, asking them how they are feeling or thinking. This will help them articulate what their emotions are. *"How are you feeling now?"* • Do not say "I know how you feel". Even if you have had personal experience of the disease or condition, you cannot know how an individual feels. Empathy can be shown by using terms such as, *"I think I understand how you must be feeling."* • Allow the patient time to express their emotions and let the patient know you understand and acknowledge their emotions. • Unless patients' emotions are adequately addressed it is difficult for the doctor and patient to move on to discuss other important issues but remember the patient's crisis is not your crisis - Listen.
Providing a Plan	• Provide a clear plan for the future, with treatment options or management plan discussed. • Offer to meet and talk to the family if not present.
After the Interview	• Make a clear record of the interview, the terms used, the options discussed and the future plan. Ensure the detail of the interview is shared with the multi-disciplinary team, including the General Practitioner.

Appendix C

Breaking Bad News Record Template

Patients Name/Address:	**Hospital Number:**
Date and time of interview:	
Location: Ward	**Outpatients**
Names of those present:	
Name:	**Position/Relationship:**
Clinical Diagnosis:	
Clinical Options for future management and immediate plan discussed:	
Detail of the words used when breaking the bad news:	
Copy to General Practitioner:	**Referral to Palliative Care Team: Yes/No**
	Referral to District Nurse: Yes / No
Filed in Patients Notes:	**Referral to Others (Please Specify)**
Signature of the Clinician:	**Date:**

Appendix D

Key Stakeholders Involved in Consultation

- DHSS&PS Board Members
- DHSS&PS Directors
- Chief Executives/Directors of Nursing/Directors of Public Health, Health & Social Services Boards
- Chief Executives/Directors of Nursing/Medical Directors, Health & Social Services Trusts
- Nurse Leaders Network
- Chief Executives, Health & Social Services Councils
- Hospice and Palliative Care Organisations
- Regional Advisory Committee on Cancer
- Campbell Commissioning Group
- Marie Curie Cancer Care
- NI Hospice
- Foyle Hospice
- Newry Hospice
- Macmillan Cancer Relief
- Action Cancer
- Age Concern
- Help the Aged
- NI Practice and Education Council for Nursing & Midwifery
- Postgraduate Medical & Dental Education Council
- Central Services Agency
- NI Social Care Council
- Community Practitioners & Health Visitors Association
- Central Nursing Advisory Committee
- Royal College of Nursing
- Royal College of Midwifery
- GP Forum Members
- Education Providers
- Queens University of Belfast
- University of Ulster
- The Beeches Management Centre, Nursing & Midwifery Education
- North & West In-Service Education Consortium
- In-Service Education, United Hospitals Trust

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Job Planning Guidance Toolkit

for Clinical Nurse Specialist Roles

HSC Public Health Agency

NIPEC

Development of Job Planning Guidance for Clinical Nurse Specialist Roles

This job planning toolkit has been developed by the Public Health Agency (PHA) in partnership with the Northern Ireland Practice and Education Council for Nursing and Midwifery (NIPEC) The PHA and NIPEC would like to acknowledge the significant contribution from the members of the Working Group (Appendix 1) and colleagues in the Health and Social Care Trusts, without whom the development of this job planning toolkit would not have been possible.

Reviewed November 2014.

Contents

1.0 Introduction

Within Northern Ireland, the Health and Social Care (HSC) system is facing unprecedented challenges. We have changes in demography, with a 40 percent increase in the number of individuals aged over 75 years; we need to respond to new and innovative treatments, devices and technology; we know that we need to do more to progress strategies for reducing infection rates, reducing untoward incidents across all areas of practice and achieving real improvements in hygiene to improve outcomes; and we know that central to this is the need to provide a service that is person-focused, compassionate and caring.

We also know that resources in all areas of the public sector are under pressure and we must be sure that those we use deliver the best outcomes for our populations and contribute to reducing the inequalities in our system.

Nurses are central to the delivery of services and, therefore, key to achieving the change required. Those working in areas of specialist practice, in either hospital or community, are in the vanguard of that change.

This toolkit provides guidance for the development and completion of job plans for a number of Clinical Nurse Specialist roles, which exist in more than one HSC Trust :

- in a hospital setting
- across a hospital and a community setting
- in a community setting
- guidance for Clinical Nurse Specialists in mental health and learning disabilities settings.

2.0 Job Planning Toolkit

2.1 This job planning toolkit was designed for nurses in roles who have the title Clinical Nurse Specialist and carry a defined caseload of patients and/or run their own clinics.[1]

2.2 The toolkit provides information to support:

- Clinical Nurse Specialists in meeting the requirements of their job
- nurses, managers and commissioners in designing Clinical Nurse Specialist roles
- leaders and managers in health and social care system, in accounting for and valuing appropriately the significant contribution such roles make to the provision of services.

2.4 It is important to acknowledge that the high-level job plan template is not an ideal job planning tool for all Clinical Nurse Specialist roles, for example, Emergency Nurse Practitioners and those working in mental health services.

2.5 Community Mental Health Services in HSC Trusts had already introduced The Choice and Partnership Approach Framework (CAPA[2]), to assist them with the job planning process. This Framework is accepted by HSC Commissioners as the tool of choice when job planning for Clinical Nurse Specialist posts, across mental health services throughout HSC Trusts; it can be accessed at www.capa.co.uk/homes/Adult-mental-health.htm

2.5 Midwifery leaders in Northern Ireland also recognised that the high-level job plan template was not suitable for the majority of specialist practice level posts in midwifery. They agreed to work with NIPEC and PHA to develop job planning guidance for those roles which do not meet the criteria identified in para 2.1.

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[1] Characteristics of specialist nurses have been defined in the *DHSSPS (2014) Advanced Nursing Practice Framework (Pending Publication). Belfast: NIPEC.*

[2] York A. & Kingsbury S. (2009)*The Choice and Partnership Approach.* London . CAMHS Network.

3.0 What is job planning?

Job planning provides the opportunity for nurses, managers and commissioners to assess the needs of patients/clients and to design roles that best meet these needs. It allows nurses and their managers to anticipate the needs of the organisation as it delivers its objectives, and continuously seeks to develop and maintain services for patients/clients.

Job planning also affords nurses opportunities to reflect upon current practice, assess progress and consider alternative ways of working, developing services or treatment options.

3.1 What makes up a job plan?

A job plan is a description of the work of the Clinical Nurse Specialist over an average week.

A full-time specialist nurse's week is divided into **10 sessions**: five morning and five afternoon sessions, as part of a 37.5 hour week, excluding lunch breaks. The sessions that make up the Clinical Nurse Specialist's job plan are grouped under two headings: (1) Clinical Activity sessions and (2) Supporting Professional Activity sessions. See Figure 1 for examples of activities within the two categories.

Figure 1. Clinical and Supporting Professional Activity Sessions and Examples of Activities (Appendix 2).

1. ***Clinical Activity sessions*** can include activities such as: independent clinics, multi-disciplinary clinics; ward-based work, case management discussions and telephone consultations.
2. ***Supporting Professional Activity sessions*** can incorporate, for example, audit; continuing professional development (CPD); teaching; clinical governance activity; research and administration.

The activities carried out by Clinical Nurse Specialists can be complex and varied and are, at times, difficult to define and quantify. This complexity must be considered when developing the job plan, so that it accurately reflects the role of the nurse and his/her impact on patients/clients and services. Those Clinical Nurse Specialists who have a clinical lead responsibility as part of their role should also have this reflected in their individual job plans.

It is important to note that some activities may not occur every week, so it is essential that the assessment be calculated as an average of the actual activities.

In an average full time working week of 10 sessions, the split between Clinical Activities and Supporting Professional Activities will vary among clinical nurse specialists, but generally:

An average week may be divided as follows:

8.5 sessions of Clinical Activities

and

1.5 sessions (**minimum)** of Supporting Professional Activities.

Remember, a job plan should be flexible and will change to meet the needs of patients and clients.

3.2 How often should job planning happen?

Job planning should commence when managers in HSC Trusts and commissioners are discussing the development of any new Clinical Nurse Specialist post(s). In this way, there is a clear and agreed expectation and understanding of the role and the contribution of the post to the service and to patient/client care.

Job planning and the review of a job plan, are also part of the overall development of the nurse and should link to an individual's personal development plan, appraisal and the Knowledge and Skills Framework (DH

2004[3]). The job planning process should enable Clinical Nurse Specialists to articulate more clearly their contribution to the service and provide a focus for their personal career development.

It is recommended that each Clinical Nurse Specialist's job plan be reviewed annually[4]. A review should also take place if there is a significant change to the role, for example, a change in personal circumstances, a change in commissioning direction or the impact of a new treatment or service model. The commissioner should always be involved in the job plan review process, if there are resource implications related to the Clinical Nurse Specialist's ability to deliver anticipated or previously agreed outcomes.

3.3 Are job plans fixed?

Job plans should be flexible to meet the changing needs of patients and should not be viewed as restrictive. The splitting of the job plan into different activities should reflect the complexity of each role.

3.4 Who should complete a job plan?

All Clinical Nurse Specialists, including those in established and in new roles, should have a job plan. The process of completing a job plan for established and new posts is detailed below.

4.0 How to complete a job plan

4.1 Established Posts

The Clinical Nurse Specialist and his/her line manager, linking with the relevant clinical supervisor/professional lead, should complete a job plan as part of the annual review process within a HSC Trust. The role of the clinical supervisor/professional lead is to ensure appropriate professional involvement.

The best way for the Clinical Nurse Specialist in an established role to complete a job plan is to review the role and responsibilities of the post, using

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[3] Department of Health (DH) (2004) *The NHS Knowledge and Skills Framework (NHS KSF)and the Development Review Process*. London. DH.

[4] For commissioning purposes, a full-time Clinical Nurse Specialist' s job plan is calculated over a period of 42 weeks.

the relevant template in Appendix 3, 4 or 5 of this document. The information gathered from this template can then be used to facilitate a discussion between the post holder, line manager and professional lead. This is known as a Job Plan Review meeting.

A job plan review for an established post holder can be incorporated as part of the individual's annual appraisal meeting, with the proviso that there is professional involvement as stated above.

Responsibilities

To contribute to the Job Planning Review meeting, it is important that the Clinical Nurse Specialist, line manager and professional lead prepare well for the discussion. Prior to the meeting:

The Clinical Nurse Specialist should

Stage 1: Read the template and familiarise him/herself with the key areas of practice identified. Further explanation of what each area covers is detailed in Appendix 2.

Stage 2: Review his/her diary for an average calendar month and categorise the activities into the key areas of practice listed in the template.

Stage 3: Choose from one of the high-level job plans for his/her area of specialist practice in Appendix 3, 4 or 5. These high-level job plans provide a guide to indicative hours and activity levels for a particular role.

The line manager and professional lead should

Stage 1: Review the Clinical Nurse Specialist's activity and analyse information available from, for example, Patient Administration System (PAS).

Stage 2: Consider changes in complexity of caseload, clinical practice, service or treatment regimes, which may have an impact on the Clinical Nurse Specialist's practice, either now or in the next few years.

Stage 3: Provide any appropriate information on the HSC Trust corporate objectives or changes in commissioning direction.

Shared Responsibility

The Job Plan Review meeting provides the Clinical Nurse Specialist, line manager and professional lead with the opportunity to discuss the information they have gathered in the preparation phase. Using these discussions, they are responsible for reaching a consensus job plan, which reflects the needs of the patients/clients and makes best use of the skills and competency of the nurse concerned. If the activity within the job plan is below the relevant proposed norms listed in Appendix 3, 4 or 5, then, to resolve this, a consensus action plan should be agreed.

The PHA Nurse Consultant and Commissioner should

Once the Clinical Nurse Specialist, line manager and professional lead have agreed the job plan, the Trust Workforce Lead will finally approve it. Each approved job plan should be sent to the corresponding PHA Nurse Consultant, who will then share it with relevant HSC Board (HSCB) Commissioning Lead. This will allow commissioners to incorporate current activity levels for each specialist nursing post into Service Budget Agreements (SBAs), where relevant; and using any action plans, they will help predict future activity levels for each post.

4.2 New Posts

The business case for proposed new Clinical Nurse Specialist posts should include a job plan, regardless of the funding stream. This job plan should be developed in partnership with the relevant Nurse Consultant at the Public Health Agency, the manager of the service and the HSC Trust’s Nursing Workforce Lead, taking account of this guidance. The latter will liaise with the HSC Trust Executive Director of Nursing, as required. This partnership approach should ensure that there is a shared expectation of the role and its impact on service and avoid any unnecessary delays in approval processes.

If a new Clinical Nurse Specialist post is being commissioned by the HSCB/PHA, discussions about the expectations for that post will be held between the PHA Nurse Consultant and Commissioning Lead at Local Commissioning level and the HSC Trust service and professional leads.

This discussion should be informed by issues such as:

- commissioning direction provided by the Department of Health Social Services and Public Safety
- Joint Commissioning Plan and priorities within the commissioning services teams
- local health economy priorities
- current service provision.

When the job plan is agreed, including details of outpatient activity, where relevant, an implementation plan should be developed to take account of the need for any incremental development of skills, competencies or any increase in activity. The HSC Trust and Local Commissioning Group should review this after an agreed period, generally six months.

5.0 Summary

The role and contribution of Clinical Nurse Specialists are well documented and valued by patients/clients and the HSC system. The job planning process will enable a more consistent, person-centred approach to these roles, with shared expectations and a greater understanding of the unique contribution of Clinical Nurse Specialists.

Appendix 1

MEMBERSHIP OF WORKING GROUP

Organisation	Representative
PHA	Mary Hinds, Director of Nursing (Chair) (until November 2011) Paul Kavanagh, Nurse Consultant (Chair) (from December 2011)
Belfast HSC Trust	Nicki Patterson, Co-Director of Nursing (until July 2013) Moira Mannion, Co-Director of Nursing (from August 2013)
Northern HSC Trust	Allison Hume, Assistant Director of Nursing
South Eastern HSC Trust	Caroline Lee, Assistant Director of Nursing (until August 2013) Sharon McRoberts, Assistant Director of Nursing (from September 2013)
Southern HSC Trust	Glynis Henry, Assistant Director of Nursing (until end of August 2011) Lynn Fee, Assistant Director of Nursing (from January 2012)
Western HSC Trust	Brendan McGrath, Assistant Director of Nursing
Northern Ireland Cancer Network	Liz Henderson, Network Nurse Director (until August 2012)
HSCB	Paula Tweedie, Commissioning Lead Regional Services (until June 2012) Roger Kennedy, Senior Commissioning Manager (from July 2012)
Royal College of Nursing	Garrett Martin, Deputy Director of Nursing
DHSSPS	Anne Mills, Nursing Officer (until January 2013) Kathy Fodey, Nursing Officer (until February 2013) Caroline Lee, Nursing Officer (from September 2013)
NIPEC	Cathy McCusker, Senior Professional Officer

Appendix 2

DESCRIPTION OF SESSIONAL ACTIVITY **TABLE A**

A job plan comprises 10 sessions per week.

1.0	**Clinical Activity Sessions**
	Activities
1.1	**Independent Nurse-led Clinics**
	These are clinics which nurses run independently of medical staff colleagues. The nurse should have the clinical activity recorded separately on Patient Administration System (PAS)/Local Community Information Development System (LCID) or other relevant recording systems. A new attendance is a new referral to the nurse; this can come directly from GPs but, more generally, would be a patient referred by colleagues in nursing, allied health professions and medical colleagues. Some services, such as Integrated Clinical and Assessment Treatment Services (ICATS), take all of their referrals directly from GPs. In this case, it is important that this be reflected in the detail of the job plan. Review patients/clients are defined as those who are re-attending the nurse-led clinic.
1.2	**Multi-disciplinary Clinics**
	These are clinics which are organised on a multi-disciplinary basis, in hospital or in community. The activity is generally recorded on PAS/LCID, or other relevant recording systems, under the name of the medical consultant.
1.3	**Multi-disciplinary Ward Rounds**
	Many Clinical Nurse Specialists attend ward rounds led by the medical consultant, as part of the multi-disciplinary team caring for patients/clients.
1.4	**Multi-disciplinary Case Management Discussions**
	A Case management discussion is the dialogue nurses have with other members of the clinic team to plan care, or when they respond to urgent or emerging issues, or provide advice to colleagues. These discussions could form part of the 'rescue' function of Clinical Nurse Specialists, whereby the actions they take - either independently or as part of the multi-disciplinary team – could, for example, prevent an admission to hospital, or deterioration of a patient's condition.

DESCRIPTION OF SESSIONAL ACTIVITY TABLE A

1.0	**Clinical Activity Sessions continued**
	Activities
1.5	**Provision of Direct Care**
	Some Clinical Nurse Specialists spend a significant amount of time caring for patients/clients directly in hospital wards or community facilities. This can include a range of duties, such as direct clinical care or education.
1.6	**Patient Education**
	Many Clinical Nurse Specialists provide patient/client education as part of clinics or in direct care environments. This section, however, refers to specific educational sessions for patients/clients, such as rehabilitation classes.
1.7	**Home Visits**
	These are defined as essential home consultations, where patients/clients cannot travel to an independent clinic, due to their clinical condition.
1.8	**Telephone Consultations**
	These are an important aspect of a Clinical Nurse Specialist's role, as they enable the nurse to provide advice and care to patients/clients, helping discharge the 'rescue' function, prevent or manage exacerbations and ensure that secondary prevention is effective.
1.9	**Tele-health**
	This is a new and innovative way of managing and sharing clinical information through technology enabled solutions. Remote tele-monitoring is one example of tele-health, which maximises the Clinical Nurse Specialist's capacity to manage his/her patients/clients in their own home, whilst enabling them to become expert in their own condition. Remote tele-monitoring can be provided for a wide range of conditions including, for example, remote monitoring of blood pressure.
1.10	**Clinical Administration/Clinical Validation**
	This covers the wide range of administration/validation the Clinical Nurse Specialist is responsible and accountable for, such as recording clinical and care data, developing care plans, communicating with colleagues etc. This is a regulatory requirement for nursing and midwifery (NMC, 2008)[5].

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[5] Nursing and Midwifery Council (2008) *The Code:Standards of conduct, performance and ethics for nurses and midwives.* London: NMC.

DESCRIPTION OF SESSIONAL ACTIVITY TABLE B

2.0	**Supporting Professional Activity Sessions**
	Activities
2.1	**Teaching**
	Some Clinical Nurse Specialists have, appropriately, a contribution to the education and training of nurses, midwives and other members of the multi-disciplinary team. This activity should reflect that commitment and may include delivering in-house nurse and medical education programmes or teaching sessions organised for, e.g. the Clinical Education Centre or Higher Education Institutions.
2.2	**Clinical Governance Activities, including Audit and Research**
	Undertaking audit, research and governance activities can form part of the specialist nurse's evidence for *Prep*[6] and for meeting future revalidation requirements. It is important, therefore, that these activities should be reflected in the job plan. It is likely that these activities will span a number of sessions, rather than being allocated to a fixed session. The job plan should reflect the average time spent on the activity.
2.3	**Administration**
	This refers to corporate administration. If the Clinical Nurse Specialist has identified an allocation to this session, he/she must specify what this commitment is and if another staff member could carry out this role. This will help the individual, line manager and professional lead, discuss and agree the best use of the Clinical Nurse Specialist's time.
2.4	**Contribution to Service Planning and Policy Development**
	Many Clinical Nurse Specialists contribute to specific projects, local HSC Trust service planning and policy development at the DHSSPS. This section should reflect this but, as with governance activities, the plan should reflect an average figure, as this work can be sporadic in nature.
2.5	**Continuous Professional Development (CPD)**
	CPD forms part of a registrant's requirement for *Prep* and, in the future, for revalidation and **must** be reflected in the job plan. It is likely that CPD activities will span a number of sessions, rather than being allocated to a fixed session. The job plan should reflect the average time spent on the activity.

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[6] Post-registration education and practice (Prep) is a set of NMC standards and guidance, designed to help registrants provide a high standard of practice and care: NMC (2011) *The Prep handbook*. London: NMC.

Appendix 3

HIGH-LEVEL JOB PLANS FOR CLINICAL NURSE SPECIALISTS IN A HOSPITAL SETTING

1. Breast Cancer	15. Pre Assessment
2. Chest Pain	16. Respiratory
3. Colorectal Cancer	17. Skin Cancer
4. Dermatology	18. Urology
5. Diabetes	19. Urology Cancer
6. Endoscopy	20. Epilepsy
7. Genitourinary	21. Stoma/Coloproctology/Stoma Care (includes Irritable Bowel Disease)
8. Gynaecology Cancer	22. Rheumatology
9. Haematology	23. Paediatric Diabetes
10. Heart Failure	24. Head and Neck Cancer
11. Lung Cancer	25. Stroke and Neurovascular
12. Ophthalmology	26. Colposcopy
13. Pain (Acute)	27. Acute Oncology
14. Pain (Chronic)	

1. Specialist Nurse Role: Breast Cancer

		Proposed Norm
1.1	Independent Nurse led clinics	
	• Number of clinics per week	**3**
	• Average number of patients per clinic (New and Review)	*6*
	• Indicate the location (H - hospital C-community)	H
1.2	Multidisciplinary Clinics	
	• Number of clinics per week	**2**
	• Indicate the location (H- hospital C-community)	H
1.3	Multidisciplinary Ward Rounds	
	• Number per week	
1.4	Multidisciplinary Case Management discussions	
	• Number per week	**1**
1.5	Provision of Direct Care	
	• Average time spent per week in wards	
	• Average time spent per week in community	**1**
1.6	Patient Education	**As part of 1.1/1.2/1.5**
1.7	Home visits	
	• Average number per week	
	• Average time spent per week	
1.8	Telephone Consultations	
	• Average time spent per week	**1**
1.9	Tele-health	
	• Average time spent per week	
1.10	Clinical Administration/Clinical Validation	**0.5**
	Sub Total	**8.5** Sessions

		Proposed Norm
2.1	Teaching	
2.2	Clinical governance activities including audit & research	
2.3	Administration; organisational requirement	
2.4	Contribution to service planning and policy development	
2.5	Professional development / CPD	
	Sub Total	**1.5 Sessions**
	Total	**10 Sessions**

2. Specialist Nurse Role: Chest Pain

		Proposed Norm
1.1	Independent Nurse led clinics	
	• Number of clinics per week	**0***
	• Average number of patients per clinic (New and Review)	*0*
	• Indicate the location (H - hospital C-community)	
1.2	Multidisciplinary Clinics	
	• Number of clinics per week • (Patient activity counted as Consultant led on PAS)	**7/8** *5*
	• Indicate the location (H- hospital C-community)	H
1.3	Multidisciplinary Ward Rounds	
	• Number per week	
1.4	Multidisciplinary Case Management discussions	
	• Number per week	As part of 1.1
1.5	Provision of Direct Care	As part of 1.1
	• Average time spent per week in wards	
	• Average time spent per week in community	
1.6	Patient Education	**As part of 1.1**
1.7	Home visits	
	• Average number per week (3-4)	
	• Average time spent per week	
1.8	Telephone Consultations	
	• Average time spent per week	**0.5**
1.9	Tele-health	
	• Average time spent per week	
1.10	Clinical Administration/Clinical Validation	**0.5**
	Sub Total	**8.5 Sessions**

		Proposed Norm
2.1	Teaching	
2.2	Clinical governance activities including audit & research	
2.3	Administration; organisational requirement	
2.4	Contribution to service planning and policy development	
2.5	Professional development / CPD	
	Sub Total	**1.5 Sessions**
	Total	**10 Sessions**

3. Specialist Nurse Role: Colorectal Cancer

		Proposed Norm
1.1	Independent Nurse led clinics	
	• Number of clinics per week	**1-2**
	• Average number of patients per clinic (New and Review)	*6-10*
	• Indicate the location (H - hospital C-community)	H
1.2	Multidisciplinary Clinics	
	• Number of clinics per week	**1**
	• Indicate the location (H- hospital C-community)	H
1.3	Multidisciplinary Ward Rounds	
	• Number per week	
1.4	Multidisciplinary Case Management discussions	
	• Number per week	**1**
1.5	Provision of Direct Care	
	• Average time spent per week in wards	**2**
	• Average time spent per week in community	
1.6	Patient Education	**As part of 1.1/1.2/1.5**
1.7	Home visits	
	• Average number per week (3-4)	**1**
	• Average time spent per week	
1.8	Telephone Consultations	
	• Average time spent per week	**1**
1.9	Tele-health	
	• Average time spent per week	
1.10	Clinical Administration/Clinical Validation	**0.5**
	Sub Total	**8.5Sessions**

		Proposed Norm
2.1	Teaching	
2.2	Clinical governance activities including audit & research	
2.3	Administration; organisational requirement	
2.4	Contribution to service planning and policy development	
2.5	Professional development / CPD	
	Sub Total	**1.5 Sessions**
	Total	**10 Sessions**

4. Specialist Nurse Role: Dermatology

		Proposed Norm
1.1	Independent Nurse led clinics	
	• Number of clinics per week	**6/7**
	• Average number of patients per clinic (New and Review)	*8-12*
	• Indicate the location (H – hospital C-community)	H
	• ICATS Service	Yes
1.2	Multidisciplinary Clinics	
	• Number of clinics per week	
	• Indicate the location (H- hospital C-community)	
1.3	Multidisciplinary Ward Rounds	
	• Number per week	
1.4	Multidisciplinary Case Management discussions	
	• Number per week	**0.5**
1.5	Provision of Direct Care	
	• Average time spent per week in wards	
	• Average time spent per week in community	
1.6	Patient Education	**As part of 1.1**
1.7	Home visits	
	• Average number per week	
	• Average time spent per week	
1.8	Telephone Consultations	0.5
	• Average time spent per week	
1.9	Tele-health	
	• Average time spent per week	
1.10	Clinical Administration/Clinical Validation	**0.5**
	Sub Total	**8.5 Sessions**
		Proposed Norm
2.1	Teaching	
2.2	Clinical governance activities including audit & research	
2.3	Administration; organisational requirement	
2.4	Contribution to service planning and policy development	
2.5	Professional development / CPD	
	Sub Total	**1.5 Sessions**
	Total	**10 Sessions**

5. Specialist Nurse Role: Diabetes

		Proposed Norm
1.1	Independent Nurse led clinics	
	• Number of clinics per week	**2**
	• Average number of patients per clinic (New and Review)	*8*
	• Indicate the location (H – hospital C-community)	H
	• ICATS Service	
1.2	Multidisciplinary Clinics	
	• Number of clinics per week • Average number of patients per clinic	**2** *6*
	• Indicate the location (H- hospital C-community)	H
1.3	Multidisciplinary Ward Rounds	
	• Number per week	
1.4	Multidisciplinary Case Management discussions	
	• Number per week	**1**
1.5	Provision of Direct Care	
	• Average time spent per week in wards	**2**
	• Average time spent per week in community	
1.6	Patient Education	As part of 1.2/1.5
1.7	Home visits	
	• Average number per week	
	• Average time spent per week	
1.8	Telephone Consultations	
	• Average time spent per week	**1**
1.9	Tele-health	
	• Average time spent per week	
1.10	Clinical Administration/Clinical Validation	**0.5**
	Sub Total	**8.5 Sessions**
		Proposed Norm
2.1	Teaching	
2.2	Clinical governance activities including audit & research	
2.3	Administration; organisational requirement	
2.4	Contribution to service planning and policy development	
2.5	Professional development / CPD	
	Sub Total	**1.5 Sessions**
	Total	**10 Sessions**

6. Specialist Nurse Role: Endoscopy

		Proposed Norm
1.1	Independent Nurse led theatre sessions	
	• Number of sessions per week	**5**
	• Number of patients	**6.5 (average)**
1.2	Multidisciplinary Clinics	
	• Number of clinics per week	**1**
	• Indicate the location (H- hospital C-community)	H
1.3	Validation of Waiting Lists	
	• Number per sessions	**1**
1.4	Multidisciplinary Case Management discussions	
	• Number per week	**0.5**
1.5	Provision of Direct Care	
	• Average time spent per week in wards	
	• Average time spent per week in community	
1.6	Patient Education	**As part of 1.1**
1.7	Home visits	
	• Average number per week	
	• Average time spent per week	
1.8	Telephone Consultations	
	• Average time spent per week	
1.9	Tele-health	
	• Average time spent per week	
1.10	Clinical Administration/Clinical Validation	**0.5**
	Sub Total	**8 Sessions**

		Proposed Norm
2.1	Teaching	
2.2	Clinical governance activities including audit & research	
2.3	Administration; organisational requirement	
2.4	Contribution to service planning and policy development	
2.5	Professional development / CPD	
	Sub Total	**2 Sessions**
	Total	**10 Sessions**

7. Specialist Nurse Role: Genito Urinary

1.0 Clinical Activity Sessions (CAS)		
		Proposed Norm
1.1	Independent Nurse led clinics	
	• Number of clinics per week	**6**
	• Average number of patients per clinic (New and Review)	*New -6* *Review - 2*
	• Indicate the location (H - hospital C-community)	H
1.2	Multidisciplinary Clinics	
	• Number of clinics per week	
	• Indicate the location (H- hospital C-community)	
1.3	Multidisciplinary Ward Rounds	
	• Number per week	
1.4	Multidisciplinary Case Management discussions	
	• Number per week	
1.5	Provision of Direct Care	
	• Average time spent per week in wards	
	• Average time spent per week in community	
1.6	Patient Education	As part of 1.1
1.7	Home visits	
	• Average number per week	
	• Average time spent per week	
1.8	Telephone Consultations	
	• Average time spent per week	2
1.9	Tele-health	
	• Average time spent per week	
1.10	Clinical Administration/Clinical Validation	0.5
	Sub-Total	**8.5 Sessions**
2.0 Supporting Professional Activity (SPA)		
		Proposed Norm
2.1	Teaching	
2.2	Clinical governance activities including audit & research	
2.3	Administration; organisational requirement	
2.4	Contribution to service planning and policy development	
2.5	Professional development / CPD	
	Sub Total	**1.5 Sessions**
	Total	**10 Sessions**

8. Specialist Nurse Role: Gynaecology Cancer

		Proposed Norm
1.1	Independent Nurse led clinics	
	• Number of clinics per week	**1**
	• Average number of patients per clinic (New and Review)	*6*
	• Indicate the location (H - hospital C-community)	H
1.2	Multidisciplinary Clinics	
	• Number of clinics per week	**2**
	• Indicate the location (H- hospital C-community)	H
1.3	Multidisciplinary Ward Rounds	
	• Number per week	
1.4	Multidisciplinary Case Management discussions	
	• Number per week	**0.5**
1.5	Provision of Direct Care	
	• Average time spent per week in wards	**2**
	• Average time spent per week in community	
1.6	Patient Education	**1**
1.7	Home visits	
	• Average number per week	
	• Average time spent per week	
1.8	Telephone Consultations	
	• Average time spent per week	**2.5**
1.9	Tele-health	
	• Average time spent per week	
1.10	Clinical Administration//Clinical Validation	**0.5**
	Sub Total	8.5 Sessions
		Proposed Norm
2.1	Teaching	
2.2	Clinical governance activities including audit & research	
2.3	Administration; organisational requirement	
2.4	Contribution to service planning and policy development	
2.5	Professional development / CPD	
	Sub Total	**1.5**
	Total	**10 Sessions**

* The split between independent and multidisciplinary clinics may be influenced by whether the post is based in the Cancer Centre or Units.

9. Specialist Nurse Role: Haematology

		Proposed Norm
1.1	Independent Nurse led clinics	
	• Number of clinics per week	**2**
	• Average number of patients per clinic (New and Review)	*10 Review*
	• Indicate the location (H - hospital C-community)	H
	• ICATS Service	
1.2	Multidisciplinary Clinics	
	• Number of clinics per week	**1**
	• Indicate the location (H- hospital C-community)	
1.3	Multidisciplinary Ward Rounds	
	• Number per week	**1**
1.4	Multidisciplinary Case Management discussions	
	• Number per week	**0.5**
1.5	Provision of Direct Care	
	• Average time spent per week in wards	**1.5**
	• Average time spent per week in community	
1.6	Patient Education	**As part of 1.1/1.2/1.4**
1.7	Home visits	
	• Average number per week	
	• Average time spent per week	
1.8	Telephone Consultations	
	• Average time spent per week	**1**
1.9	Tele-health	
	• Average time spent per week	**1**
1.10	Clinical Administration/Clinical Validation	**0.5**
	Sub Total	**8.5 Sessions**

		Proposed Norm
2.1	Teaching	
2.2	Clinical governance activities including audit & research	
2.3	Administration; organisational requirement	
2.4	Contribution to service planning and policy development	
2.5	Professional development / CPD	
	Sub Total	**1.5 Sessions**
	Total	**10 sessions**

10. Specialist Nurse Role: Heart Failure

		Proposed Norm
1.1	Independent Nurse led clinics	
	• Number of clinics per week	**2**
	• Average number of patients per clinic (New and Review)	*6*
	• Indicate the location (H - hospital C-community)	H
	• ICATS Service	
1.2	Multidisciplinary Clinics	**2**
	• Number of clinics per week	
	• Indicate the location (H- hospital C-community)	
1.3	Multidisciplinary Ward Rounds	
	• Number per week	0.5
1.4	Multidisciplinary Case Management discussions	
	• Number per week	
1.5	Provision of Direct Care	**2**
	• Average time spent per week in wards	
	• Average time spent per week in community	
1.6	Patient Education	As part of 1.2/1.4
1.7	Home visits	
	• Average number per week	
	• Average time spent per week	
1.8	Telephone Consultations	
	• Average time spent per week	**1**
1.9	Tele-health	
	• Average time spent per week	**0.5**
1.10	Clinical Administration/Clinical Validation	**0.5**
	Sub Total	**8.5 Sessions**
		Proposed Norm
2.1	Teaching	
2.2	Clinical governance activities including audit & research	
2.3	Administration; organisational requirement	
2.4	Contribution to service planning and policy development	
2.5	Professional development / CPD	
	Sub Total	**1.5 Sessions**
	Total	**10 sessions**

11. Specialist Nurse Role: Lung Cancer

		Proposed Norm
1.1	Independent Nurse led clinics	
	• Number of clinics per week	**1**
	• Average number of patients per clinic (New and Review)	*6*
	• Indicate the location (H - hospital C-community)	H
	• ICATS Service	
1.2	Multidisciplinary Clinics	
	• Number of clinics per week	**1**
	• Indicate the location (H- hospital C-community)	H
1.3	Multidisciplinary Ward Rounds	
	• Number per week	
1.4	Multidisciplinary Case Management discussions	
	• Number per week	**1**
1.5	Provision of Direct Care	
	• Average time spent per week in wards	**3**
	• Average time spent per week in community	
1.6	Patient Education	**As part of 1.1/1.2/1.5**
1.7	Home visits	
	• Average number per week	
	• Average time spent per week	
1.8	Telephone Consultations	
	• Average time spent per week	**2**
1.9	Tele-health	
	• Average time spent per week	
1.10	Clinical Administration/Clinical Validation	**0.5**
	Sub Total	**8.5 Sessions**

		Proposed Norm
2.1	Teaching	
2.2	Clinical governance activities including audit & research	
2.3	Administration; organisational requirement	
2.4	Contribution to service planning and policy development	
2.5	Professional development / CPD	
	Sub Total	**1.5 Sessions**
	Total	**10 sessions**

12. Specialist Nurse Role: Ophthalmology

1.0 Clinical Activity Sessions (CAS)		
		Proposed Norm
1.1	Independent Nurse led clinics	
	• Number of clinics per week	**6**
	• Average number of patients per clinic (New and Review)	*New – 6* *Review – 6*
	• Indicate the location (H - hospital C-community)	H
	• ICATS Service	Yes
1.2	Multidisciplinary Clinics	
	• Number of clinics per week	**2**
	• Indicate the location (H- hospital C-community)	H
1.3	Multidisciplinary Ward Rounds	
	• Number per week	
1.4	Multidisciplinary Case Management discussions	
	• Number per week	
1.5	Provision of Direct Care	
	• Average time spent per week in wards	
	• Average time spent per week in community	
1.6	Patient Education	
	• Average time per week – ward based	As part of 1.1
1.7	Home visits	
	• Average number per week	
	• Average time spent per week	
1.8	Telephone Consultations	
	• Average time spent per week	As part of 1.1
1.9	Tele-health	
	• Average time spent per week	
1.10	Clinical Administration/Clinical Validation	0.5
	Sub Total	**8.5 Sessions**
2.0 **Supporting Professional Activity (SPA)**		
		Proposed Norm
2.1	Teaching	
2.2	Clinical governance activities including audit & research	
2.3	Administration; organisational requirement	
2.4	Contribution to service planning and policy development	
2.5	Professional development / CPD	
	Sub Total	**1.5 Sessions**
	Total	**10 Sessions**

13. Specialist Nurse Role: Pain (Acute)

1.0	**Clinical Activity Sessions (CAS)**	
		Proposed Norm
1.1	Independent Nurse led clinics	0
	• Number of clinics per week	0
	• Average number of patients per clinic (New and Review)	
	• Indicate the location (H - hospital C-community)	H
	• ICATS Service	
1.2	Multidisciplinary Clinics	
	• Number of clinics per week	1
	• Indicate the location (H- hospital C-community)	H
1.3	Multidisciplinary Ward Rounds	
	• Number per week	1
1.4	Multidisciplinary Case Management discussions	
	• Number per week	
1.5	Provision of Direct Care	
	• Average time spent per week in wards	5.5
	• Average time spent per week in community	
1.6	Patient Education	As part of 1.2/1.3/1.5
1.7	Home visits	
	• Average number per week	
	• Average time spent per week	
1.8	Telephone Consultations	
	• Average time spent per week	**0.5**
1.9	Tele-health	
	• Average time spent per week	
1.10	Clinical Administration /coordination/Clinical Validation	0.5
	Sub total	**8.5 Sessions**
2.0	**Supporting Professional Activity (SPA)**	
		Proposed Norm
2.1	Teaching	
2.2	Clinical governance activities including audit & research	
2.3	Administration; organisational requirement	
2.4	Contribution to service planning and policy development	
2.5	Professional development / CPD	
	Sub Total	**1.5 Sessions**
	Total	**10 Sessions**

14. Specialist Nurse Role: Pain (Chronic)

1.0	**Clinical Activity Sessions (CAS)**	
		Proposed Norm
1.1	Independent Nurse led clinics	
	• Number of clinics per week	**3**
	• Average number of patients per clinic (New and Review)	*5-10*
	• Indicate the location (H – hospital C-community)	C/H
1.2	Multidisciplinary Clinics	**2**
	• Number of clinics per week	
	• Indicate the location (H- hospital C-community)	
1.3	Multidisciplinary Ward Rounds	
	• Number per week	
1.4	Multidisciplinary Case Management discussions	
	• Number per week	**1**
1.5	Provision of Direct Care	As part of 1.1
	• Average time spent per week in wards	
	• Average time spent per week in community	As part of 1.1
1.6	Patient Education	As part of 1.1
1.7	Home visits	
	• Average number per week	
	• Average time spent per week	
1.8	Telephone Consultations	
	• Average time spent per week	**2**
1.9	Tele-health	
	• Average time spent per week	
1.10	• Clinical Administration/Clinical Validation	**0.5**
	Sub Total	**8.5 Sessions**
		Proposed Norm
2.1	Teaching	
2.2	Clinical governance activities including audit & research	
2.3	Administration; organisational requirement	
2.4	Contribution to service planning and policy development	
2.6	Professional development/CPD	
	Sub Total	**1.5 Sessions**
	Total	**10 Sessions**

15. Specialist Nurse Role: Pre Assessment

		Proposed Norm
1.1	Independent Nurse led clinics	
	• Number of clinics per week	**7.5**
	• Average number of patients per clinic (New and Review)	*6-8*
	• Indicate the location (H - hospital C-community)	H
	• ICATS Service	
1.2	Multidisciplinary Clinics	
	• Number of clinics per week	
	• Indicate the location (H- hospital C-community)	
1.3	Multidisciplinary Ward Rounds	
	• Number per week	
1.4	Multidisciplinary Case Management discussions	
	• Number per week	As part of 1.1
1.5	Provision of Direct Care	As part of 1.1
	• Average time spent per week in wards	
	• Average time spent per week in community	
1.6	Patient Education	As part of 1.1
1.7	Home visits	
	• Average number per week	
	• Average time spent per week	
1.8	Telephone Consultations	
	• Average time spent per week (Health screening questionnaire & follow up)	**0.5**
1.9	Tele-health	
	• Average time spent per week	
1.10	Clinical Administration (as part of 1.1)	**0.5**
	Sub Total	**8.5 Sessions**
		Proposed Norm
2.1	Teaching	
2.2	Clinical governance activities including audit & research	
2.3	Administration; organisational requirement	
2.4	Contribution to service planning and policy development	
2.5	Professional development / CPD	
	Sub Total	**1.5 Sessions**
	Total	**10 Sessions**

16. Specialist Nurse Role: Respiratory

1.0 Clinical Activity Sessions (CAS)		
		Proposed Norm
1.1	Independent Nurse led clinics	
	- Number of clinics per week	**2**
	- Average number of patients per clinic (New and Review)	*6*
	- Indicate the location (H - hospital C-community)	H
	- ICATS Service	
1.2	Multidisciplinary Clinics	
	- Number of clinics per week	**1**
	- Indicate the location (H- hospital C-community)	
1.3	Multidisciplinary Ward Rounds	
	- Number per week	**2**
1.4	Multidisciplinary Case Management discussions	
	- Number per week	
1.5	Provision of Direct Care	
	- Average time spent per week in wards	**1**
	- Average time spent per week in community	
1.6	Patient Education	**As part of 1.1/1.2/1.5/1.7**
1.7	Home visits	
	- Average number per week	
	- Average time spent per week	
1.8	Telephone Consultations	**2**
	- Average time spent per week	
1.9	Tele-health	
	- Average time spent per week	
1.10	Clinical Administration/Clinical Validation	**0.5**
	Sub Total	**8.5 Sessions**
2.0 **Supporting Professional Activity (SPA)**		
		Proposed Norm
2.1	Teaching	
2.2	Clinical governance activities including audit & research	
2.3	Administration; organisational requirement	
2.4	Contribution to service planning and policy development	
2.5	Professional development / CPD	
	Sub Total	**1.5 Sessions**
	Total	**10 Sessions**

17. Specialist Nurse Role: Skin Cancer

1.0 Clinical Activity Sessions (CAS)		
		Proposed Norm
1.1	Independent Nurse led clinics	
	• Number of clinics per week	**6.5**
	• Average number of patients per clinic (New and Review)	*12-14*
	• Indicate the location (H - hospital C-community)	H
	• ICATS Service	
1.2	Multidisciplinary Clinics	
	• Number of clinics per week	**0.5**
	• Indicate the location (H- hospital C-community)	H
1.3	Multidisciplinary Ward Rounds	
	• Number per week	
1.4	Multidisciplinary Case Management discussions	
	• Number per week	**0.5**
1.5	Provision of Direct Care	
	• Average time spent per week in wards	As part of 1.1
	• Average time spent per week in community	
1.6	Patient Education	**As part of 1.1/1.2**
1.7	Home visits	
	• Average number per week	
	• Average time spent per week	
1.8	Telephone Consultations	
	• Average time spent per week	**0.5**
1.9	Tele-health	
	• Average time spent per week	
1.10	Clinical Administration/Clinical Validation	**0.5**
	Sub Total	**8.5 Sessions**
2.0 Supporting Professional Activity (SPA)		
		Proposed Norm
2.1	Teaching	
2.2	Clinical governance activities including audit & research	
2.3	Administration; organisational requirement	
2.4	Contribution to service planning and policy development	
2.5	Professional development / CPD	
	Sub Total	**1.5 Sessions**
	Total	**10 Sessions**

18. Specialist Nurse Role: Urology

1.0 Clinical Activity Sessions (CAS)		
		Proposed Norm
1.1	Independent Nurse led clinics	
	• Number of clinics per week	**5**
	• Average number of patients per clinic (New and Review)*	*New – 2* *Review – 6*
	• Indicate the location (H - hospital C-community)	H
	• ICATS Service	Yes
1.2	Multidisciplinary Clinics	
	• Number of clinics per week	**1**
	• Indicate the location (H- hospital C-community)	H
1.3	Multidisciplinary Ward Rounds	
	• Number per week	
1.4	Multidisciplinary Case Management discussions	
	• Number per week	
1.5	Provision of Direct Care	
	• Average time spent per week in wards	
	• Average time spent per week in community	
	• Average time spent rescue/recovery/ward attenders	**1**
1.6	Patient Education	As part of 1.1
1.7	Home visits	
	• Average number per week	
	• Average time spent per week	
1.8	Telephone Consultations	
	• Average time spent per week**	**1**
1.9	Tele-health	
	• Average time spent per week	
1.10	Clinical Administration/Clinical Validation	**0.5**
	Sub Total	**8.5 Sessions**

*The numbers will vary depending on the type of clinic, prostate assessment, prostate biopsy, histo results, uro-oncology etc

**Used for benign non symptomatic patients

2.0 **Supporting Professional Activity (SPA)**		
		Proposed Norm
2.1	Teaching	
2.2	Clinical governance activities including audit & research	
2.3	Administration; organisational requirement	
2.4	Contribution to service planning and policy development	
2.5	Professional development / CPD	
	Sub Total	**1.5 Sessions**
	Total	**10 Sessions**

19. Specialist Nurse Role: Urology Cancer

		Proposed Norm
1.1	Independent Nurse led clinics	
	• Number of clinics per week	**3**
	• Average number of patients per clinic (New and Review)	*10*
	• Indicate the location (H - hospital C-community)	H
	• ICATS Service	
1.2	Multidisciplinary Clinics	
	• Number of clinics per week	**1**
	• Indicate the location (H- hospital C-community)	H
1.3	Multidisciplinary Ward Rounds	
	• Number per week	
1.4	Multidisciplinary Case Management discussions	
	• Number per week	**0.5**
1.5	Provision of Direct Care	
	• Average time spent per week in wards	
	• Average time spent per week in community	**1**
1.6	Patient Education	**As part of 1.1/1.2/1.5**
1.7	Home visits	
	• Average number per week	
	• Average time spent per week	
1.8	Telephone Consultations	
	• Average time spent per week	**2**
1.9	Tele-health	
	• Average time spent per week	
1.10	Clinical Administration/Clinical Validation	**0.5**
	Sub Total	**8.5 Sessions**
		Proposed Norm
2.1	Teaching	
2.2	Clinical governance activities including audit and research	
2.3	Administration; organisational requirement	
2.4	Contribution to service planning and policy development	
2.5	Professional development / CPD	
	Sub Total	**1.5 Sessions**
	Total	**10 Sessions**

20. Specialist Nurse Role: Epilepsy

		Proposed Norm
1.1	Independent Nurse led clinics	
	• Number of clinics per week	**1 - 2**
	• Average number of patients per clinic (New and Review)	*6*
	• Indicate the location (H – hospital C-Community)	H
	• ICATS Service	
1.2	Multidisciplinary Clinics	
	• Number of clinics per week	**1.5 - 2**
	• Indicate the location (H- hospital C-Community)	H
1.3	Multidisciplinary Ward Rounds	0
	• Number per week	
1.4	Multidisciplinary Case Management discussions	**1 - 1.75**
	• Number per week	**10- 20**
1.5	Provision of direct care	
	• Average time spent per week in wards	**0**
	• Average time spent per week in community	**0**
1.6	Patient Education	As part of 1.1
1.7	Home visits	
	• Average number per week	**0.25**
	• Average time spent per week	
1.8	Telephone Consultations	**2 - 3**
	• Average time spent per week	
1.9	Remote tele monitoring	**0**
	• Average time spent per week	
1.10	Clinical Administration/Clinical Validation	**1**
	Sub Total	**8.5 Sessions**

		Proposed Norm
2.1	Teaching	
2.2	Clinical governance activities including audit and research	
2.3	Administration; organisational requirement	
2.4	Contribution to policy and service planning	
2.5	Professional development / CPD	
	Sub Total	**1.5 Sessions**
	Total	**10 Sessions**

HIGH-LEVEL JOB PLAN

21. Specialist Nurse Role: Stoma/Coloproctology/Stoma Care (includes Irritable Bowel Disease)

		Proposed Norm
1.1	Independent Nurse led clinics	
	• Number of clinics per week	**2**
	• Average number of patients per clinic (New and Review)	*6-8*
	• Indicate the location (H – hospital C-Community)	H
	• ICATS Service	
1.2	Multidisciplinary Clinics	
	• Number of clinics per week	**0.5**
	• Indicate the location (H- hospital C-Community)	
1.3	Multidisciplinary Ward Rounds	As part of 1.5
	• Number per week	
1.4	Multidisciplinary Case Management discussions	As part of 1.5
	• Number per week	**0.25**
1.5	Provision of direct care	**3 - 5**
	• Average time spent per week in wards	
	• Average time spent per week in community	
1.6	Patient Education	As part of 1.1
1.7	Home visits	
	• Average number per week	**1 - 2**
	• Average time spent per week	
1.8	Telephone Consultations	
	• Average time spent per week	**1 - 2**
1.9	Remote tele monitoring	
	• Average time spent per week	
1.10	Clinical Administration/Clinical Validation	**0.5 – 1**
	Sub Total	**8.5 Sessions**
		Proposed Norm
2.1	Teaching	
2.2	Clinical governance activities including audit and research	
2.3	Administration; organisational requirement	
2.4	Contribution to policy and service planning	
2.5	Professional development / CPD	
	Sub Total	**1.5 Sessions**
	Total	**10 Sessions**

HIGH-LEVEL JOB PLAN

22. Specialist Nurse Role: Rheumatology

		Proposed Norm
1.1	Independent Nurse led clinics	
	• Number of clinics per week	**5**
	• Average number of patients per clinic (New and Review)	*(6 review)*
	• Indicate the location (H – hospital C-Community)	H
	• ICATS Service	
1.2	Multidisciplinary Clinics	
	• Number of clinics per week	**1**
	• Indicate the location (H- hospital C-Community)	H
1.3	Multidisciplinary Ward Rounds	
	• Number per week	
1.4	Multidisciplinary Case Management discussions	
	• Number per week	
1.5	Provision of direct care	
	• Average time spent per week in wards	
	• Average time spent per week in community	
1.6	Patient Education	As part of 1.1
1.7	Home visits	
	• Average number per week	
	• Average time spent per week	
1.8	Telephone Consultations	
	• Average time spent per week	**1**
1.9	Remote tele monitoring	
	• Average time spent per week	
1.10	Clinical Administration/Clinical Validation	**1**
	Sub Total	**8 Sessions**

		Proposed Norm
2.1	Teaching	
2.2	Clinical governance activities including audit and research	
2.3	Administration; organisational requirement	
2.4	Contribution to policy and service planning	
2.5	Professional development / CPD	
	Sub Total	**2 Sessions**
	Total	**10 Sessions**

23. Specialist Nurse Role: Paediatric Diabetes

		Proposed Norm
1.1	Independent Nurse led clinics	
	• Number of clinics per week	**1**
	• Average number of patients per clinic (New and Review)	*6*
	• Indicate the location (H – hospital C-Community)	H
	• ICATS Service	
1.2	Multidisciplinary Clinics	
	• Number of clinics per week	**1**
	• Indicate the location (H- hospital C-Community)	H
1.3	Multidisciplinary Ward Rounds	
	• Number per week	
1.4	Multidisciplinary Case Management discussions	
	• Number per week	**1**
1.5	Provision of direct care	
	• Average time spent per week in wards	**1**
	• Average time spent per week in community	**1**
1.6	Patient Education	As part of 1.1/1.2
1.7	Home visits	
	• Average number per week	
	• Average time spent per week	
1.8	Telephone Consultations	
	• Average time spent per week	**2**
1.9	Remote tele monitoring	
	• Average time spent per week	**0.25**
1.10	Clinical Administration/Clinical Validation	**1.25**
	Sub Total	**8.5 Sessions**

		Proposed Norm
2.1	Teaching	
2.2	Clinical governance activities including audit and research	
2.3	Administration; organisational requirement	
2.4	Contribution to policy and service planning	
2.5	Professional development / CPD	
	Sub Total	**1.5 Sessions**
	Total	**10 Sessions**

24. Specialist Nurse Role: Head and Neck Cancer

		Proposed Norm
1.1	Independent Nurse led clinics	
	• Number of clinics per week	**1**
	• Average number of patients per clinic (New and Review)	*4*
	• Indicate the location (H – hospital C-Community)	H
	• ICATS Service	
1.2	Multidisciplinary Clinics	
	• Number of clinics per week	**1-2**
	• Indicate the location (H- hospital C-Community)	H
1.3	Multidisciplinary Ward Rounds	
	• Number per week	**1-2**
1.4	Multidisciplinary Case Management discussions	
	• Number per week	
1.5	Provision of direct care	
	• Average time spent per week in wards	**5-10 hours**
	• Average time spent per week in community	
1.6	Patient Education	As part of 1.1/1.2/1.5
1.7	Home visits	
	• Average number per week	
	• Average time spent per week	
1.8	Telephone Consultations	**5-10 hours**
	• Average time spent per week	
1.9	Remote tele monitoring	
	• Average time spent per week	
1.10	Clinical Administration/Clinical Validation	**0.5**
	Sub Total	**8.5 Sessions**

		Proposed Norm
2.1	Teaching	
2.2	Clinical governance activities including audit and research	
2.3	Administration; organisational requirement	
2.4	Contribution to policy and service planning	
2.5	Professional development / CPD	
	Sub Total	**1.5 Sessions**
	Total	**10 Sessions**

HIGH-LEVEL JOB PLAN

25. Specialist Nurse Role: Stroke and Neurovascular

		Proposed Norm
1.1	Independent Nurse led clinics	
	• Number of clinics per week	**1**
	• Average number of patients per clinic (New and Review)	*10*
	• Indicate the location (H – hospital C-Community)	H
	• ICATS Service	
1.2	Multidisciplinary Clinics	
	• Number of clinics per week	**1.5**
	• Indicate the location (H- hospital C-Community)	H
1.3	Multidisciplinary Ward Rounds	
	• Number per week	**0.5**
1.4	Multidisciplinary Case Management discussions	
	• Number per week	**0.5**
1.5	Provision of direct care	
	• Average time spent per week in wards	**2**
	• Average time spent per week in community	
1.6	Patient Education	As part of 1.1
1.7	Home visits	
	• Average number per week	
	• Average time spent per week	
1.8	Telephone Consultations	
	• Average time spent per week	**1.5**
1.9	Remote tele monitoring	
	• Average time spent per week	**0.25**
1.10	Clinical Administration/Clinical Validation	**1**
	Sub Total	**8.25 Sessions**

		Proposed Norm
2.1	Teaching	
2.2	Clinical governance activities including audit and research	
2.3	Administration; organisational requirement	
2.4	Contribution to policy and service planning	
2.5	Professional development / CPD	
	Sub Total	**1.75 Sessions**
	Total	**10 Sessions**

HIGH-LEVEL JOB PLAN

26. Specialist Nurse Role: Colposcopy

		Proposed Norm
1.1	Independent Nurse led clinics	
	• Number of clinics per week	**4**
	• Average number of patients per clinic (New and Review)	*8-10* *(4-5 N/4-5 R)*
	• Indicate the location (H – hospital C-Community)	H or C
	• ICATS Service	N/A
1.2	Multidisciplinary Clinics	
	• Number of clinics per week	**1**
	• Indicate the location (H- hospital C-Community)	H or C
1.3	Multidisciplinary Ward Rounds	
	• Number per week	0
1.4	Multidisciplinary Case Management discussions	
	• Number per week	**1**
1.5	Provision of direct care	
	• Average time spent per week in wards	
	• Average time spent per week in community	
1.6	Patient Education	
1.7	Home visits	
	• Average number per week	
	• Average time spent per week	
1.8	Telephone Consultations	
	• Average time spent per week	**0.5**
1.9	Remote tele monitoring	
	• Average time spent per week	
1.10	Clinical Administration/Clinical Validation	**1.5**
	Sub Total	**8 Sessions**
		Proposed Norm
2.1	Teaching	
2.2	Clinical governance activities including audit and research	
2.3	Administration; organisational requirement	
2.4	Contribution to policy and service planning	
2.5	Professional development / CPD	
	Sub Total	**2 Sessions**
	Total	**10 Sessions**

HIGH-LEVEL JOB PLAN

27. Specialist Nurse Role: Acute Oncology

		Proposed Norm
1.1	Independent Nurse led clinics	0
	• Number of clinics per week	
	• Average number of patients per clinic (New and Review)	
	• Indicate the location (H - hospital C-community)	H
1.2	Multidisciplinary Clinics	
	• Number of clinics per week	**1**
	• Indicate the location (H- hospital C-community)	H
1.3	Multidisciplinary Ward Rounds	
	• Number per week	
1.4	Multidisciplinary Case Management discussions	
	• Number per week	**1**
1.5	Provision of Direct Care	
	• Average time spent per week in wards	**5**
	• Average time spent per week in community	
1.6	Patient Education	**As part of 1.2/1.5**
1.7	Home visits	
	• Average number per week	
	• Average time spent per week	
1.8	Telephone Consultations	
	• Average time spent per week	**1**
1.9	Tele-health	
	• Average time spent per week	
1.10	Clinical Administration	**0.5**
	Sub Total	**8.5** Sessions
		Proposed Norm
2.1	Teaching	
2.2	Clinical governance activities including audit & research	
2.3	Administration; organisational requirement	
2.4	Contribution to service planning and policy development	
2.5	Professional development / CPD	
	Sub Total	**1.5 Sessions**
	Total	**10 Sessions**

October 2013

Department of
Health
An Roinn Sláinte
Männystrie O Poustie
www.health-ni.gov.uk

CORE COMPETENCE ASSESSMENT TOOL FOR PALLIATIVE CARE SPECIALIST NURSING ROLES

December 2018

HSC

NIPEC

PALLIATIVE CARE SPECIALIST NURSING

Core Specific Competency Areas and Learning Outcomes

These are the core specific competency areas and learning outcomes relevant for Palliative Care Specialist Nurses across adult services in Northern Ireland. The specific core competencies build on the generic core competencies designed for all Specialist Nurses regardless of the area of practice or setting[1]. This competence assessment tool is appropriate for all Palliative Care Specialist Nurses who care for patients with specialist and complex palliative and end of life needs in any adult care setting.

The *Assessment Tool* has been devised to be used alongside a range of general competency frameworks (that focus on core skills and competencies for all qualified nurses) and palliative care and end of life specific competency frameworks relevant to specialist palliative care for adults. The competencies and learning outcomes are informed by the following documents:

- *Competencies In Nursing - A Framework for Nurses Working in Specialist Palliative Care - Competencies Project* (RCN 2002)[2]
- *A Framework for Generalist and Specialist Palliative and End of Life Care Competency* (NICaN 2008)[3]
- *Palliative and End of Life Care Competency Assessment Tool* (NICaN / NIPEC 2012)[4]
- *A Review of Palliative Care Competence Frame*works (AIIHPC 2012)[5]

Thanks to all those involved in the development of these specific competences especially those on the Writing Group (Appendix 1), in particular the Palliative Care Specialist Nurses and all those who provided feedback to ensure they are fit for purpose.

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[1] DoH (2018) *Career Framework for Specialist Practice Nursing Roles*. Belfast: NIPEC

[2] Royal College of Nursing (2002) *A framework for nurses working in specialist palliative care Competencies Project*. London: RCN

[3] Northern Ireland Cancer Network (2008) A Framework for Generalist and Specialist Palliative and End of Life Care Competency. Belfast: NICAN

[4] Northern Ireland Cancer Network and Northern Ireland Practice & Education Council (2012) *Palliative and End of Life Care Competency Assessment Tool*. Belfast: NIPEC

[5] All Ireland Institute Hospice and Palliative Care (2012) *A Review of Palliative Care Competence Frameworks.* Dublin: AIIHPC.

Palliative Care Specialist Nursing Competence Assessment Tool

Undertaking a self-assessment using this *Competence Assessment Tool* (pages 3-9) can help you identify the knowledge, skills and attitudes required for your role. You should discuss your self-assessment with your line manager, as part of your annual appraisal and/or personal development plan, in order to agree an action plan addressing your identified learning and development needs. This self-assessment and accompanying development plan may help you provide evidence for NMC revalidation.

Assessing yourself

You should use the following rating scale to assess your learning and development needs against each of the competence statements:

Rating Scale:

LD	**I need a lot of development**
SD	**I need some development**
WD	**I feel I am well developed**

It generally takes about 15 minutes to assess yourself against the competence statements. Place a ✓ to rate the statement which is applicable to your individual learning and development. When you have finished, review the number of LDs, SDs, and WDs. You can then plan, with your line manager, the learning and development activities which are relevant to your role.

Practice Tips

Before starting your assessment, you may find it helpful to discuss the statements with one of your peers. You can also test your self-assessment with your line manager. Be honest with yourself when thinking about your role and your learning and development needs and rate them realistically.

The *Palliative Care Competence Assessment Tool* can also enable you to focus on areas for career development and, where relevant, support your preparation for job interviews.

Core Specific Competency Domains and Learning Outcomes

Core Specific Competency Domain: Clinical Practice			
Core Specific Competency Domain: Clinical Practice The Palliative Care Specialist Nurse maintains, develops, and analyses knowledge of the relevant area of practice including the relevant assessment, treatments and care interventions to make professional judgements in meeting the palliative and end of life care needs of patients, their families/carers and those important to them. **NMC Code theme:** Practise Effectively, Preserve Safety, Promote Professionalism and Trust. **KSF Core Dimensions:** Communication, Personal and People Development, Health and Safety, Quality.			
Core Learning Outcomes	**LD**	**SD**	**WD**
The Palliative Care Specialist Nurse will: • Demonstrate an understanding of the principles and philosophy of specialist palliative and end of life care as applied to people with advanced, progressive disease, and, influence practice to ensure this is embedded across all aspects of service delivery. • Practise within the context of professional, ethical, regulatory and legal codes recognising and respond to moral/ethical dilemmas and issues in day to day specialist palliative and end of life care practice. • Demonstrate an understanding of the care needs of patients living with a range of advanced progressive life limiting conditions and liaise with relevant specialists to ensure the delivery of safe, effective care. • Complete a comprehensive and systematic patient-centred holistic assessment using relevant tools/frameworks, taking into account physical, psychological, social, cultural, spiritual and environmental aspects. • Utilise knowledge of holistic needs assessment to assess, plan, implement and evaluate the needs of patients with advanced, progressive diseases at all stages of their disease trajectory, in partnership with the multidisciplinary team. • Demonstrate knowledge of symptom management and palliative care emergencies and apply appropriate clinical judgement to direct pharmacological and non-pharmacological interventions.			

Core Learning Outcomes cont'd	**LD**	**SD**	**WD**
• Act as a source of specialist knowledge for other Health and Social Care Professionals (HCPs) when dealing with complex or challenging symptoms and situations relating to the assessment, planning and delivery of care for patients with advanced, progressive disease. • Use specialist knowledge and advanced communication skills to develop and enhance therapeutic relationships with the patient their families/carers and those important to them, to sensitively assess and respond appropriately to the impact of the life limiting illness. • Demonstrate an understanding of all aspects of Advance Care Planning (ACP) (and the underpinning legal framework) and utilise ACP to support patient choice and preferences in the context of specialist palliative and end of life care. • Use the theories of loss, grief and bereavement to assess and appropriately support those facing loss and grief, including complicated grief, and bereavement in specialist palliative and end of life care. • Demonstrate professional duty of care for the patient's body after death, respecting any wishes expressed by the family, taking into account any legal, cultural, religious or health and safety requirements. • Act as a source of specialist knowledge and meet the information needs of patients, their families/carers and those important to them and staff members both directly and indirectly through information provision and signposting. • Contribute as a key member of the multi-professional team through the development and implementation of collaborative and innovative practices including the use of technology. • Identify and manage risks and contribute to multi-professional and interagency discussions related to critical, serious and adverse incidents, and/or root cause analysis. • Advocate for the rights of patient their families/carers and those important to them within the care environment and recognise the influences of power, control and conflict. • Contribute to the development and review of protocols and standard operating procedures. • Monitor and evaluate all interventions and modify care in response to patient specific outcomes.			

Core Learning Outcomes cont'd	**LD**	**SD**	**WD**
• Analyse health and care technologies and provide feedback to inform selection and use in own area of practice. • Incorporate professional accountability and responsibility to enable safe and effective practice within the context of the multi-professional team to meet the needs of patient their families/carers and those important to them.			

Core Specific Competency Domain: Education and Learning The Palliative Care Specialist Nurse maintains and develops professional knowledge and practice by participating in lifelong learning, personal and professional development for self and with colleagues through supervision, appraisal and reflective practice. **NMC Code theme:** Prioritise People, Practise Effectively, Promote Professionalism and Trust. **KSF Core Dimension:** Communication, Personal and People Development.			
Core Learning Outcomes	**LD**	**SD**	**WD**
The Palliative Care Specialist Nurse will: • Accept personal responsibility for professional development and the maintenance of professional competence and credibility. • Facilitate an effective learning environment to support the professional development of staff and students. • Engage in clinical supervision, reflective practice and self-evaluation and use this to improve care and practice. • Participate in formal and informal inter-professional teaching. • Utilise appropriate learning opportunities to facilitate others to care for patients their families/carers and those important to them. • Supervise and support others within the scope of each individual's role, competence and capability. • Identify and participate in the development, delivery and evaluation of educational initiatives for health and social care providers that address the needs of patients their families/carers and those important to them. • Participate in clinical forums or professional groups and facilitate sustainable partnerships.			

Core Specific Competency Domain: Research and Evidence-based Practice The Palliative Care Specialist Nurse develops and updates knowledge of research evidence, and policy initiatives relevant to caring for patients with specialist complex palliative care needs their families/carers and those important to them, to promote and develop effective, evidence-based practice. **NMC Code theme:** Practise Effectively. **KSF Core Dimension:** Quality.			
Core Learning Outcomes:	**LD**	**SD**	**WD**
The Palliative and End of Life Care Specialist Nurse will: • Maintain and develop knowledge and understanding of relevant local, regional and national policies and guidelines and collaborate with other members of the multi-professional/multi-agency team to implement them in own area of practice. • Critically appraise research in specialist palliative and end of life care and use knowledge of relevant findings to inform clinical decision making. • Work collaboratively with others to facilitate the implementation of research, quality improvement and audit findings into practice. • Use knowledge of specialist palliative and end of life care to identify areas of potential research, quality improvement and audit. • Contribute to audit, quality improvement, research design, data collection and analysis. • Disseminate audit, quality/service improvement and research findings through presentations, locally, in collaboration with the multi-professional team.			

Core Specific Competency Domain: Leadership and Management

The Palliative Care Specialist Nurse works in partnership with other practitioners and agencies to improve health and wellbeing. The Nurse leads in the development and delivery of palliative and end of life care, manages resources and facilitates change to enhance quality, person-centred care.

NMC Code theme: Prioritise People, Preserve Safety, Promote Professionalism and Trust.

KSF Core Dimension: Communication, Service Improvement, Equality & Diversity.

Core Learning Outcomes:	**LD**	**SD**	**WD**
The Palliative and End of Life Care Specialist Nurse will: • Work collaboratively to identify gaps in service provision within own setting and across geographical and organisational boundaries. • Work collaboratively to implement initiatives to enhance or redesign patient care and specialist palliative and end of life care services, through a process of continuous improvement. • Act as a change agent and encourage staff and service users to contribute ideas and solutions for quality improvement and innovation. • Contribute to Patient and Public Involvement through co- design and co-production initiatives and activities. • Contribute to relevant professional networks. • Negotiate and influence locally in relation to professional practice. • Respond in a transparent and structured way to any complaints about care or services. • Promote teamwork with defined areas of responsibility. • Demonstrate effective management and leadership skills by sharing own knowledge and experience with other members of the team. • Influence the multi-professional team in the development and shaping of services that meet the needs of patients their families/carers and those important to them.			

Appendix 1

Membership of Writing Group

Organisation	**Representative**
Public Health Agency	Loretta Gribben (Chair of Writing Group)
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‘YOUR RIGHT TO RAISE A CONCERN’ (WHISTLEBLOWING)

HSC FRAMEWORK

CONTENTS

INTRODUCTION

1. Health and social care services exist to promote the health, wellbeing and dignity of patients and service users and the people who deliver these services want to do the best for those they serve.

2. Encouraging staff to raise concerns openly as part of normal day-to-day practice is an important part of improving the quality of services and patient safety. Many issues are raised by staff and addressed immediately by line managers – this is very much encouraged. When concerns are raised and dealt with appropriately at an early stage, corrective action can be put in place to ensure safe, high quality and compassionate care.

3. The importance of raising concerns at work in the public interest (or "whistleblowing") is recognised by employers, workers, trade unions and the general public. Working in partnership with Trade Unions, staff associations and employee representatives is an important part of ensuring fairness and promoting awareness of the policies, procedures and support mechanisms which a good employer will have in place[1].

DEFINING WHISTLEBLOWING

4. Whistleblowing is defined as "when a worker reports suspected wrongdoing at work"[2]. The wrongdoing is often related to financial mismanagement, such as misrepresenting earnings and false accounting, but can also have more immediate consequences such as those highlighted in the Mid Staffordshire Report (2013)[3].

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[1] Raising Concerns at Work: Whistleblowing Guidance for Workers and Employers in Health & Social Care (NHS, 2014)

[2] *Government Whistleblowing Policies* National Audit Office (2014)

[3] Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry (2013)

5. Staff can report things that are not right, are illegal or if anyone is neglecting their duties. This might include, for example, concerns around:
   - patient safety;
   - health and safety at work;
   - environmental damage; or
   - a criminal offence (e.g. fraud).

6. Whistleblowing can also be broadly defined as simply 'raising a concern'[5]. People outside the organisation, including stakeholders, suppliers and service users, can also raise concerns through the Policy for Management of Complaints. However, whistleblowing is different from making a complaint or raising a grievance. Whistleblowers can often act out of a feeling of fairness or ethics rather than a personal complaint. As Public Concern at Work (PcAW) states, it is important to note that:

   > "*....the person blowing the whistle is usually not directly, personally affected by the danger or illegality. Consequently, the whistleblower rarely has a personal interest in the outcome of any investigation into their concern – they are simply trying to alert others. For this reason, the whistleblower should not be expected to prove the malpractice. He or she is a messenger raising a concern so that others can address it*".[4]

WHY DOES WHISTLEBLOWING MATTER?

7. Staff who are prepared to speak up about malpractice, risk, abuse or wrongdoing should be recognised as one of the most important sources of information for any organisation seeking to enhance its reputation by identifying and addressing problems that disadvantage or endanger other people[5].

8. It is important for individuals to feel safe and listened to when raising concerns. An open approach to whistleblowing promotes the values of openness,

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[4] Where's whistleblowing now? 10 years of legal protection for whistleblowers, PCaW, March 2010

[5] Whistleblowing in the Public Sector: A good practice guide for workers and employers, published jointly in November 2014 by Audit Scotland, the National Audit Office, the Northern Ireland Audit Office and the Wales Audit Office, with the support of Public Concern at Work

transparency and candour and encourages employees to treat patients and service users with dignity, respect and compassion.

9. From the employer's point of view, there are good business reasons for listening to staff who raise concerns, as it gives an opportunity to stop poor practice at an early stage before it becomes normalised and serious incidents take place.

10. From the staff members' perspective, the freedom to raise concerns without fear means that they have the confidence to go ahead and "do the right thing". It is part of encouraging staff to reflect on practice as a way of learning[1].

SCOPE

11. This Framework and Policy have been developed in response to the recommendations arising from the Regulation and Quality Improvement Authority's (RQIA) Review of the Operation of Health and Social Care Whistleblowing Arrangements[6]. The Policy, to be adopted by all HSC organisations in Northern Ireland, accompanies this FrameworkHSC organisations may tailor the Policy to take account of their individual organisation's policies and procedures.

12. This Framework and Policy applies to **all staff** (employees, workers[7]) involved in the work of an HSC organisation. It does not apply to patients and clients or members of the public who wish to complain or raise concerns about treatment and care provided by the HSC organisation or about issues relating to the provision of health and social care. These will be dealt with under the **Trust's Complaints Procedure**.

13. This Framework and Policy is for staff to raise issues where the interests of others or the organisation are at risk. If a member of staff is aggrieved about their

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[6] Review of the Operation of Health and Social Care Whistleblowing Arrangements (RQIA, 2016)
[7] Definitions set out in Articles 3 (3) and 67K of the Employment Rights (Northern Ireland) Order 1996

personal position they must use the organisation's **HSC Grievance Procedure, Harassment at Work Procedure** and/or the **Working Well Together Policy**.

14. All cases of suspected, attempted or actual fraud raised under this policy should be handled promptly in line with the organisation's **Fraud Response Plan.**

PURPOSE AND AIMS

15. The aim of this Framework and Policy is to ensure that under the terms of the Public Interest Disclosure (Northern Ireland) Order 1998 a member of staff is able to raise legitimate concerns when they believe that a person's health may be endangered or have concerns about systematic failure, malpractice, misconduct or illegal practice without fear of retribution and/or detriment.

16. If a member of staff has honest and reasonable suspicions about issues of malpractice/wrongdoing and raises these concerns through the channels outlined in the policy, they will be protected from any disciplinary action and victimisation, (e.g. dismissal or any action short of dismissal such as being demoted or overlooked for promotion) simply because they have raised a concern under this policy.

17. This Framework and Policy aims to improve accountability and good governance within the organisation by assuring the workforce that it is safe to raise their concerns.

18. The benefits of encouraging staff to report concerns include[1]:
    - identifying wrongdoing as early as possible;
    - exposing weak or flawed processes and procedures which make the organisation vulnerable to loss, criticism or legal action;
    - ensuring critical information gets to the right people who can deal with the concerns;
    - avoiding financial loss and inefficiency;
    - maintaining a positive corporate reputation;

- reducing the risks to the environment or the health and safety of employees or the wider community;
- improving accountability; and
- deterring staff from engaging in improper conduct.

KEY PRINCIPLES AND VALUES

Distinction between grievance & whistleblowing concerns

19. Whistleblowing concerns generally relate to a risk, malpractice or wrongdoing that affects others, and may be something which adversely affects patients, the public, other staff or the organisation itself. A grievance differs from a whistleblowing concern as it is a personal complaint regarding an individual's own employment situation. A whistleblowing concern is where an individual raises information as a witness whereas a grievance is where the individual is a complainant. Grievances are addressed using the Grievance Procedure.

Raising a concern openly, confidentially, or anonymously

20. In many cases, the best way to raise a concern is to do so openly. Openness makes it easier for the organisation to assess the issue, work out how to investigate the matter, understand any motive and get more information. A worker raises a concern confidentially if they give their name on the condition that it is not revealed without their consent. If an organisation is asked not to disclose an individual’s identity, it will not do so without the individual’s consent unless required by law (for example, by the police). A worker raises a concern anonymously if they do not give their name at all. If this happens, it is best for the organisation to assess the anonymous information as best it can, to establish whether there is substance to the concern and whether it can be addressed. Clearly if no-one knows who provided the information, it is not possible to reassure or protect them.

Malicious claims & ulterior motives

21. There may be occasions when a concern is raised either with an ulterior motive or maliciously. In such a case, and as set out in the policy, the organisation cannot give the assurances and safeguards included in the policy to someone who is found to have maliciously raised a concern that they also know to be untrue. Such situations should be handled carefully. The starting point for any organisation is to look at the concern and examine whether there is any substance to it. Every concern should be treated as genuine, unless it is subsequently found not to be. However, if it is found that the individual has maliciously raised a concern that they know is untrue, disciplinary proceedings may be commenced against that individual.

LEGAL FRAMEWORK

22. The Public Interest Disclosure (Northern Ireland) Order 1998[8] (the Order), allows a worker to breach his duty as regards confidentiality towards his employer for the purpose of 'whistle-blowing'. It was introduced in the interest of the public, to protect workers from detrimental treatment or victimisation from their employer if they raise a genuine concern, whether it is a risk to patients, financial malpractice, or other wrongdoing. These are called "qualifying disclosures". A "qualifying disclosure" means any disclosure of information which, in the reasonable belief of the worker making the disclosure, tends to show one or more of the following circumstances:

    - where criminal activity or breach of civil law has occurred, is occurring, or is likely to occur;
    - where a person has failed, is failing or is likely to fail to comply with any legal obligation he is subject to;
    - where a miscarriage of justice has occurred, is occurring or is likely to occur
    - where the health and safety of any individual has been, is, or is likely to be endangered;
    - where the environment has been, is being or is likely to be damaged;

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[8] The Public Interest Disclosure (Northern Ireland) Order 1998

- where information indicating evidence of one of the above circumstances is being or is likely to be deliberately concealed.

23. A qualifying disclosure is made by the worker:

- to his employer, or where the worker reasonably believes that the relevant failure relates solely or mainly to the conduct of a person other than his employer or any other matter for which a person other than his employer has legal responsibility, to that other person;
- to a legal adviser for the purpose of obtaining legal advice;
- to the Department of Health or the Minister for Health;
- to a person prescribed by an Order[9] made by the Department for the Economy for the purposes of Article 67F of the Employment Rights (Northern Ireland) Order 1996.[10] The worker should reasonably believe that the relevant failure falls within any description of matters in respect of which that person is so prescribed and that the information disclosed, and any allegation contained in it are substantially true.

24. If the worker makes a disclosure to a person other than his employer or to a person not noted above, it will be a qualifying disclosure in accordance with the Order provided the following conditions are met:

- the worker reasonably believes the information disclosed and any allegation contained within it are substantially true;
- the disclosure is not made for personal gain;
- the worker must act reasonably, taking into account the circumstances;

In addition one, or more, of the following conditions must be met:

- the worker reasonably believes he will suffer a detriment if he makes the disclosure to his employer; or

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[9] Public Interest Disclosure (Prescribed Persons) (Amendment) Order (Northern Ireland) 2014

[10] The Employment Rights (Northern Ireland) Order 1996 as amended by the Employment Act (Northern Ireland) 2016

- in the case where there is no prescribed person as noted above, the worker reasonably believes that it is likely that evidence relating to the relevant failure will be concealed or destroyed if he makes a disclosure to his employer; or
- the worker has previously made the disclosure to his employer or a prescribed person.

25. In determining whether it is reasonable for the worker to make the disclosure, regard shall be had, in particular, to:
    - the identity of the person to whom the disclosure is made;
    - the seriousness of the relevant failure;
    - whether the conduct is continuing or likely to occur in the future;
    - whether the disclosure is made in breach of a duty of confidentiality owed by the employer to any other person;
    - whether any previously made concern was acted upon;
    - whether the worker followed any procedure laid down by the employer.

26. It should be noted that a disclosure of information is not a qualifying disclosure if the person making the disclosure commits an offence by making it.

27. The Order covers all workers including temporary agency staff, student nurses and student midwives, persons on training courses and independent contractors who are working for and supervised by the Trust. It does not cover volunteers. It also makes it clear that any clause in a contract that purports to gag an individual from raising a concern that would have been protected under the Order is void.

HANDLING CONCERNS

28. To enable a whistleblowing policy to work in practice and to avoid unnecessary damage, it is important to ensure that policies authorise all staff, not just health and medical professionals, to raise a concern, and identifies who they can contact.

29. Legal protection is very important if staff are to be encouraged to raise a concern about wrongdoing or malpractice. However, it is vital that employers develop an open culture that recognises the potential for staff to make a valuable contribution to the running of public services, and to the protection of the public interest.

30. Where an individual is subjected to a detriment by their employer for raising a concern or is dismissed in breach of the Order, they can bring a claim for compensation under the Order to an Industrial Tribunal.

31. Managers can lead by example, by being clear to staff as to what sort of behaviour is unacceptable, and by role modelling the appropriate behaviours themselves. They should encourage staff to ask them what is appropriate if they are unsure before - not after - the event. If wrongdoing or a potential risk to patient safety is found, it should be taken seriously and dealt with immediately.

IMPLEMENTING LOCAL POLICY

32. It is important that all HSC organisations are committed to the principles set out in their whistleblowing arrangements and can ensure that it is safe and acceptable for staff to speak up about wrongdoing or malpractice within their organisation. To achieve this, it is necessary to ensure buy-in and leadership from management, and Trade Union engagement.

33. Within each organisation, an appropriate senior manager should be appointed to take responsibility for ensuring implementation of the whistleblowing arrangements. This could be the clinical governance lead, the nursing or medical director, or responsible officer. The Trust should also consider appointing an appropriate number of advisors/advocates to signpost and provide support to those wishing to raise a concern. In addition, each organisation should appoint a non-executive board member to have responsibility for oversight of the culture of raising concerns within their organisation.

34. As an employer, HSC organisations must take all concerns raised seriously. However, it may not be necessary to carry out a formal investigation in each case. Employers should consider a range of possibilities depending on the nature of each case[4]:
    - explaining the context of an issue to the person raising a concern may be enough to alleviate their concerns
    - minor concerns might be dealt with straightaway by line management
    - a review by internal audit as part of planned audit work might be sufficient to address the issue e.g. through a change to the control environment
    - there may be a role for external audit in addressing the concerns raised and either providing assurance or recommending changes to working practices
    - there may be a clear need for a formal investigation.

35. Having considered the options it is important that employers clearly document the rationale for the way forward. The HSC organisation's local policy should make it clear whose responsibility it is to decide on the approach to be adopted.

36. If necessary, the HSC organisation can also seek advice and guidance from the relevant prescribed person.

37. Once local arrangements are in place, it is important to ensure all staff are aware of them, and this can be achieved in a number of ways: through hard copy correspondence with staff, communication by email and/or via organisation's intranet sites, through team briefings and inductions, or the message appearing on payslips. It is also important to ensure that the policies are accessible.

BRIEFING & TRAINING

38. Many concerns will be raised openly with line managers as part of normal day-to-day practice. Good whistleblowing arrangements should do nothing to undermine this. It is important that this is made clear to both staff and managers.

39. All managers and designated contacts should be briefed on:

- the value and importance of an open and accountable workplace;
- how to handle concerns fairly and professionally;
- how to protect staff who raise a genuine concern and where staff can get help or refer a concern;
- how to manage expectations of confidentiality;
- the importance of an alternative to line management if the usual channels of communication are unavailable; and
- how to brief their staff on arrangements.

40. Senior managers and designated contacts who are given a specific role in the whistleblowing arrangements should receive training in the operation of their policy for raising concerns.

AUDIT, REVIEW & REFRESH

41. A well run organisation will periodically review its whistleblowing arrangements to ensure they work effectively and that staff have confidence in them. The following points can sensibly be considered to assure that the arrangements meet best practice. Monitoring the arrangements in line with this checklist will also help the organisation demonstrate to regulators that their arrangements are working:

- arrange regular feedback sessions to evaluate progress and collect data on the nature and number of concerns raised;
- check the procedures used are adequate to track the actions taken in relation to concerns raised and to ensure appropriate follow-up action has been taken to investigate and, if necessary, resolve problems indicated by whistleblowing. Is there evidence of constructive and timely feedback?
- have there been any difficulties with confidentiality?
- have any events come to the organisation's attention that might indicate that a staff member has not been fairly treated as a result of raising a concern?
- look at significant adverse incidents/incident management systems or regulatory intervention - could the issues have been picked up or resolved earlier? If so, why weren't they?

- compare and correlate data with information from other risk management systems;
- find out what is happening on the ground - organisations should consider including a question about awareness and trust of arrangements in any future local staff surveys;
- organisations should seek the views of trade unions/professional organisations, as employees might have commented on the whistleblowing arrangements or sought their assistance on raising or pursuing a whistleblowing concern;
- organisations could also consider other sources of information, including information from exit interviews, the Order or other legal claims;
- key findings from a review or surveys should be communicated to staff. This will demonstrate that the organisation listens and is willing to learn and act on how its own arrangements are working in practice;
- refresh whistleblowing arrangements regularly. Regular communication to staff about revised arrangements is also recommended;
- although volunteers are not covered by the Order, the application of this Framework and Policy should be considered in the handling of their concerns; and
- think about reporting good news - success stories encourage and reassure everybody.

REPORTING AND MONITORING

42. Concerns raised by staff are an important source of information for the HSC organisations. It is important that they capture key aspects so that the value of their whistleblowing arrangements can be determined and lessons learned where appropriate.

43. In addition to individual case files HSC organisations should maintain a central register of all concerns raised, in a readily accessible format. Any system for recording concerns should be proportionate, secure and accessible by the minimum necessary number of staff.

44. An analysis of whistleblowing caseload should be reported regularly to senior management and the HSC organisation's Audit Committee. In addition, an annual return on caseload, actions and outcomes should be made available to the Department of Health. These will help inform those charged with governance that arrangements in place for staff to raise concerns are operating satisfactorily or will highlight improvements that may be required. The HSC organisations should consider reporting on the effectiveness of their whistleblowing arrangements in their annual report[4].

Southern Health
and Social Care Trust

WHISTLEBLOWING POLICY

Policy Checklist

Name of Policy:	Whistleblowing Policy and Procedure for Raising Concerns at Work
Purpose of Policy:	The Public Interest Disclosure (Northern Ireland) Order 1998 was introduced to safeguard anyone who raises concerns, and this policy encompasses the requirements of that Order. The policy provides a mechanism for staff to raise concerns about a range of matters at an early stage and in the right way thereby developing a culture of responsible openness and constructive criticism regarding all aspects of the Trust's activities including clinical care.
Directorate responsible for Policy	Directorate of Human Resources & Organisational Development
Name & Title of Author:	Vivienne Toal - Head of Employee Engagement & Relations
Does this meet criteria of a Policy?	Yes
Staff side consultation?	Yes
Equality Screened by:	Vivienne Toal – Head of Employee Engagement & Relations
Date Policy submitted to Policy Scrutiny Committee:	30th March 2015
Policy Approved/Rejected/ Amended	Approved subject to amendments
Communication / Implementation Plan required?	Yes
Any other comments:	
Date presented to SMT	April 2015
Director Responsible	Mr Kieran Donaghy
SMT / Trust Board Approved/Rejected/Amended	Approved
Date returned to Directorate Lead for implementation (DHR& OD)	30th March 2015
Date received by Employee Engagement & Relations for database/Intranet/Internet	30th March 2015
Date for further review	March 2017

POLICY DOCUMENT – VERSION CONTROL SHEET	
Title	Title: Whistleblowing Policy Version: 2_0 Reference number/document name:
Supersedes	Supersedes: Whistleblowing Policy version 1
Originator	Name of Author: Vivienne Toal Title: Head of Employee Engagement & Relations
Policy Scrutiny Committee & SMT approval	Referred for approval by: Vivienne Toal Date of Referral: Policy Scrutiny Committee Approval SMT approval: As Above
Circulation	Issue Date: September 2017 Circulated By: Vivienne Toal Issued To: Directors, Assistant Directors, Heads of Service for onward distribution to staff.
Review	Review Date: March 2017 Responsibility of (Name): Vivienne Toal Title: Head of Employee Engagement & Relations

Southern Health
and Social Care Trust

Quality Care - for you, with you

WHISTLEBLOWING POLICY

AND

PROCEDURE FOR RAISING ISSUES OF CONCERN AT WORK

Author	Vivienne Toal, Head of Employee Engagement & Relations
Directorate responsible	Human Resources & Organisational Development
Date	March 2015
Review date	March 2017

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Appendices

1.0 INTRODUCTION TO POLICY

The Southern Health & Social Care Trust is committed to promoting a culture of openness in which staff are encouraged to raise concerns without fear of reprisal and victimisation; and to ensuring that health and social care services are provided with the highest standards of integrity and honesty. The Trust expects all employees to maintain high standards in all areas of practice. All employees are therefore strongly encouraged to report any perceived wrongdoing by the organisation, its employees or workers that fall short of these principles.

Each of us at one time or another has concerns about what is happening at work. Usually these concerns are easily resolved. However, when they are about dangers to or ill treatment of service users, staff or the public, issues relating to the quality of care provided, patient safety, professional misconduct, unlawful conduct, financial malpractice, fraud, health and safety, or dangers to the environment, it can be difficult to know what to do.

You may be worried about raising such issues. You may want to keep the concerns to yourself, perhaps feeling it's none of your business or that it's only a suspicion. You may feel that raising the matter would be disloyal to colleagues, managers or the organisation. You may decide to say something but find you have spoken to the wrong person or raised the issue in the wrong way and are not sure what to do next. You may also not be clear how your own professional code of conduct relates to Trust procedures.

2.0 PUBLIC INTEREST DISCLOSURE (NORTHERN IRELAND) ORDER 1998

The Public Interest Disclosure (Northern Ireland) Order 1998 was introduced to protect anyone who raises concerns from detriment and / or dismissal, and this policy encompasses the requirements of that Order. The Order protects employees or workers who make "protected disclosures", i.e. who reports wrongdoing within the workplace. This policy provides a process to enable employees or workers to inform the organisation about any wrongdoing in the workplace which they believe has occurred, or is likely to occur. Protection is against victimisation, disciplinary action or dismissal for employees who raise genuine concerns.

The Order 1998 has a tiered approach to disclosures which most easily gives workers protection for raising a concern internally. It is intended that this policy and associated procedure provide reassurance to staff who wish to raise such matters internally. Guidance from a range of regulatory / professional bodies encourages registrants to raise their concerns internally to ensure maximum level of protection under the Public Interest Disclosure Act.

Further details of the Order can be found using the following web address: http://www.pcaw.co.uk/law/pida.htm.

3.0 PURPOSE AND AIMS

Purpose

The Senior Management Team of the Trust is committed to running the organisation in the best way possible and to do so we need the help of those who work for us. We have this policy is place to reassure those who work for us that it is safe and acceptable to speak up and to enable all workers to raise any concerns that they may have at an early stage and in the right way.

There may be times when, after staff have raised a concern under this policy, it is deemed to be more appropriate to be dealt with differently. However this should not stop staff raising concerns under this Policy.

This policy aims to:

- Provide an avenue for you to raise a concern internally as a matter of course, and receive feedback on any action taken;
- Provide for matters to be dealt with quickly and appropriately and ensure that they are taken seriously;
- Reassure you that you will be protected from reprisals or victimisation for raising the concern in good faith;
- Allow you to take the matter further if you are dissatisfied with the Trust's response.

4.0 POLICY STATEMENT

The Trust would rather that you raised the matter when it is just a concern rather than waiting for proof. It is important to raise any concerns at an early stage, on the basis of any level of concern or relevant information. Indeed, if you have serious suspicions that an offence has been committed, you have a responsibility to report them as soon as possible. We all have a responsibility to protect the Trust, its service users, staff and public. **If in doubt – raise it!**

If something is troubling you that you think the Trust should know about or look into, please use the Procedure for Raising Concerns at Work – see section 10.0. You should never accuse individuals directly, and telling the wrong persons may jeopardise an investigation.

What we do ask is that in order to qualify for protection under this policy, you must:

  - Act in good faith (effectively this means honestly) and

- Genuinely believe the information you are going to impart is accurate and
- Not act maliciously.

Our assurances to you

Your safety

The Chair, Chief Executive & Trust Board are committed to this Policy. If you raise a genuine concern under this Policy, you will not be at risk of losing your job or suffering any form of retribution as a result. Provided you are acting in good faith, it does not matter if you are mistaken. Of course, this same assurance is not extended to someone who maliciously raises a matter they know is untrue, and in such cases disciplinary action will be considered.

Your confidence

Confidentiality
The Trust will not tolerate the harassment or victimisation of anyone raising a genuine concern under this Policy. However, we recognise that you may nonetheless want to raise a concern in confidence. If you ask us to protect your identity by keeping your confidence, we will respect your request and it will not be disclosed without your consent. However a situation may arise where we are not able to resolve the concern without revealing your identity (for instance because evidence is needed in court, or the Trust has to act on the information), and this will be discussed with you in advance of any disclosure.

Anonymous allegations
Remember that if you do not tell us who you are, it will be much more difficult for us to look into the matter or to protect your position or to give you feedback. You are encouraged to put your name to any issue of concern you are raising. Allegations expressed anonymously and/or with little detail or information are much less powerful and more difficult to address but may be considered at the discretion of the Trust. Whilst we will give due consideration to anonymous reports, we cannot follow the procedure set out in Section 11.0 for any concerns raised anonymously. The Trust endeavours to promote a supportive environment in which you are able to express your concerns in confidence, thereby hopefully negating the need for raising concerns anonymously.

5.0 SCOPE OF POLICY

This Policy applies to you whether you are a permanent, temporary or bank employee. The Trust is also very dependent on a wide range of contractors, suppliers, and others not directly employed by the Trust such as agency staff, trainees, volunteers, secondees, or a student or anyone on a work experience placement – the policy applies to all individuals in these categories where there are concerns about the activities of the Trust.

6.0 HOW WE WILL HANDLE YOUR CONCERN

Members of staff, including students, can seek support and guidance from their Trade Union or professional organisation when raising a concern. Staff may be represented at any stage of the procedure by a trade union representative or colleague where appropriate.

Once you have told us of your concern, we will look into it to assess initially what action should be taken. This may involve an internal enquiry or a more formal investigation. We will tell you who is handling the matter, how you can contact him/her, the timescale for action and whether your further assistance may be needed.

All staff who raise a concern will be automatically allocated support from the Head of Employee Engagement & Relations or a nominated deputy throughout the investigation process in line with section 8.0.

When you raise the concern you may be asked how you think the matter might best be resolved. If you do have any personal interest in the matter, we do ask that you tell us at the outset. If your concern falls more properly within the Grievance Procedure we will tell you.

While the purpose of this policy is to enable us to investigate possible malpractice and take appropriate steps to deal with it, we will give you as much feedback as we properly can and confirm our response in writing. Please note that we may not be able to tell you the precise action we take where this would infringe a duty of confidence owed by us to someone else.

7.0 RESPONSIBILITIES

7.1 Your responsibilities

The Trust wishes to encourage you to highlight areas where you are aware of inadequacies in the provision of services. In doing so concerns can be addressed at the earliest opportunity thus ensuring an overall improvement in the level of services provided to service users.

In particular you have a responsibility to:

- report any genuine concern of wrongdoing or malpractice preferably to your line manager or alternatively via one of the other options set out in the procedure in section 10.0. Proof of wrongdoing is not required, merely a genuine and reasonable concern. At the same time, you have an equal responsibility not to raise issues maliciously, where no potential evidence or indication or malpractice or danger exists; and

- familiarise yourself with and to understand the procedure for raising concerns outlined in section 11.0.

- be aware that information given unjustifiably to the media may unreasonably undermine public confidence in the Trust and Health and Social Care generally.

7.2 Our Responsibilities

All **managers** contacted by a member of staff, are responsible for:

- ensuring at the earliest opportunity that the appropriate action is taken in line with section 10, considering the nature and seriousness of the concern raised, including informing others, responding to concerns quickly and in confidence, taking all concerns seriously. This action will include deciding how any person, against whom an allegation is made, is informed of the matter, ensuring that the investigation is not jeopardised by the disclosure.

- supporting and reassuring those raising concerns – it is recognised that raising concerns can be difficult and stressful

- responding to all concerns without pre-judging

- recording all concerns, including the date the concern was raised, dates of interviews with employees, who was present at each interview and the action agreed

- keeping all records safely and securely

The **Trust's Senior Management Team,** through the Director of Human Resources & Organisational Development is responsible for:

- ensuring that these procedures are explained to all new staff, as part of Trust Induction

- protecting the interests and confidentiality of staff, for treating any concerns raised seriously, and for investigating them fairly and thoroughly

- ensuring that an investigation report relating to each Whistleblowing concern raised is considered as part of the Trust's Corporate / Clincial & Social Care Governance arrangements.

8.0 SUPPORT FOR EMPLOYEES

It is recognised that raising concerns can be difficult and stressful. Advice and support is available from the Head of Employee Engagement & Relations or a nominated deputy throughout any investigation process. The Head of Employee Engagement & Relations will not undertake an investigation role in any whistleblowing case but will oversee any investigation undertaken and provide support to the individual raising the concern throughout the process, ensuring that feedback is provided at appropriate stages of the investigation.

The Trust also provides Carecall services to all employees through its Employee Assistance Programme; this service is free to all employees and is available 24/7. Contact details are: 0808 800 0002.

The Trust will take steps to minimise any difficulties which you may experience as a result of raising a concern. For example if you are required to give evidence at disciplinary proceedings, the Head of Employee Engagement & Relations will arrange for you to receive advice about the process.

If you are dissatisfied with the resolution of the concern you have raised or you consider you have suffered a detriment for having raised a concern, this should be raised initially with the Head of Employee Engagement & Relations.

9.0 EQUALITY AND HUMAN RIGHTS CONSIDERATIONS

This policy has been screened for equality implications as required by Section 75 and Schedule 9 of the Northern Ireland Act 1998. Equality Commission guidance states that the purpose of screening is to identify those policies which are likely to have a significant impact on equality of opportunity so that greatest resources can be devoted to these.

Using the Equality Commission's screening criteria, no significant equality implications have been identified. The policy will therefore not be subject to an equality impact assessment.

Similarly, this policy has been considered under the terms of the Human Rights Act 1998, and was deemed compatible with the European Convention Rights contained in the Act.

10.0 ALTERNATIVE FORMATS

This document can be made available on request in alternative formats, e.g. plain English, Braille, disc, audiocassette and in other languages to meet the needs of those who are not fluent in English.

11.0 COPYRIGHT

The supply of information under the Freedom of Information does not give the recipient or organisation that receives it the automatic right to re-use it in any way that would infringe copyright. This includes, for example, making multiple copies, publishing and issuing copies to the public. Permission to re-use the information must be obtained in advance from the Trust.

12.0 PROCEDURE FOR RAISING CONCERNS AT WORK

There are a range of options from which you can choose if you wish to raise a concern.

Concerns are best raised in writing. You should set out the background and history of the concerns, giving where possible:

- names,
- dates,
- places, and
- the reasons why you are particularly concerned about the situation.

If you do not feel able to put the concern in writing, you can of course raise your concern via telephone or in person. A statement can be taken of your concern which can be recorded for you to verify and sign.

12.1 How to raise a concern <u>internally</u>

Staff should raise any concern internally using one of the options listed below:

➢ **Option 1**

Managers have a vital role to play in ensuring that you and your colleagues are able to make constructive contributions and to feel that your ideas are welcomed, appreciated and where appropriate, acted upon in a positive manner.

You are therefore encouraged in the first instance to raise concerns with your line manager. You may wish to involve a Trade Union representative or colleague to advise or assist you. As soon as you have a concern, you should make an immediate note of it. You should write down all the relevant details – what was said or done, date, time, names etc.

➢ **Option 2**

If, for any reason, you feel unable to raise the concern with your line manager, please raise the matter with another senior person you can trust. This might be another manager or a Senior HR representative and again you may wish to involve a Trade Union representative or colleague.

➢ ***Option 3***

If you feel that the concern is so serious that it cannot be discussed with any of the above you can contact:-

➢ Director of Human Resources & OD	direct line	[redacted]
➢ Chief Executive	direct line	[redacted]
➢ Non –Executive Director (See Appendix 2 for names)	contacted through the Chair's office direct line	 [redacted]

The contact address for any of the above is: -

Southern HSC Trust Headquarters, Craigavon Area Hospital, Lurgan Road, PORTADOWN, BT63 5QQ

12.2 Response required from internal managers / Director to whom concerns are reported

Stage 1

ALL whistleblowing concerns MUST be notified by internal managers to the Director of Human Resources & Organisational Development for logging and investigation. The Director of Human Resources & Organisational Development will ensure that the Head of Employee Engagement & Relations is notified of the concern to ensure support can be provided to the employee.

The manager / Director should be clear on the range of other Trust policies and procedures in the event that the concern raised might be more appropriately dealt with under another policy / procedure e.g. Grievance Procedure, Working Well Together Procedure, Maintaining High Professional Standards (Medical & Dental staff). Advice from Employee Engagement & Relations may help to clarify this at any early stage.

Any internal manager / Director to whom a concern is raised must then arrange to meet with the employee to discuss the concern without delay along with a representative from the Employee Engagement & Relations team.

The manager / Director and HR representative should establish the background and history of the concerns, including names, dates, places, where possible, along with any other relevant information. The manager should also explore the reason why the employee is particularly concerned about the matter.

A record should be made of all discussions at this stage by the manager and Employee Engagement & Relations.

It may be necessary with anonymous allegations to consider whether it is possible, based on limited information provided in the complaint, to take any further action. Where it is decided that further action cannot be justified, the reasons for this decision should be documented and retained by the Employee Engagement & Relations Department.

Stage 2

Once the preliminary facts / issues of concern have been established, the approach to investigating the concern must be discussed and agreed. A record should be made of the decisions and/or agreed actions which should be signed and dated.

Stage 3

Within 10 working days of the concern being received, the manager receiving the concern must write to the employee:

- Acknowledging that the concern has been received;
- Indicating how the matter will be dealt with;
- Providing an estimate as to how long it will take to provide a final response; and/or
- Telling the employee whether any initial enquiries have been made; and
- Telling the employee whether further investigations will take place and if not why not; and /or
- Letting the employee know when s/he will receive further details if the situation is not yet resolved; and
- Providing the employee with details of whom to contact should s/he be dissatisfied with this response (see 10.4 below)

Advice from Employee Engagement & Relations should be sought when drafting the letter of response.

11.3 How to raise a concern externally

If you are unable to raise the matter internally as outlined above in Options 1 to 3, or if you feel it has not been dealt with properly, we would rather you raise it with an appropriate external agency, detailed in Option 4 below, than not at all.

- **Option 4.**

Provided that you are acting in good faith and have evidence to back up the concern, your concern may also be raised with: -

  - Relevant Professional / Regulatory Bodies (e.g. Nursing & Midwifery Council, General Medical Council, Northern Ireland Social Care Council, Health Care Professions Council etc.)

  - Statutory Bodies (e.g., Mental Health Commission, Regulation & Quality Improvement Authority (RQIA))

  - The Health and Safety Executive for N. Ireland

  - Department of Health, Social Services and Public Safety.

Contact addresses and telephone numbers are included in Appendix 1.

11.4 If You Remain Dissatisfied

If you are unhappy with the response you receive when you use this procedure, remember you can go to the other levels and bodies detailed in Section 10.3. While we cannot guarantee that we will always respond to all matters in the manner you might wish, we will do our best to handle the matter fairly and properly. By using this procedure, you will help us to achieve this.

12.0 SOURCES OF INDEPENDENT ADVICE AND FURTHER INFORMATION

You may also wish to access independent advice for example,

- A Trust JNCF Trade Union representative or any other recognised Trade Union official*;*

  or

- The independent charity *Public Concern at Work*
  - telephone 0207 404 6609 where lawyers can give free confidential advice at any stage about how to raise a serious concern.

Appendix 1

Northern Ireland Social Care Council
7th Floor Millennium House
Great Victoria Street
BELFAST
BT2 7AQ
028 90 417600

Regulation & Quality Improvement Authority (RQIA)
9th Floor Riverside Tower
5 Lanyon Place
BELFAST
BT1 3BT
028 90 517500

Health Professions Council
184 Kennington Park Road
LONDON
SE11 4BU
020 78409814

Health & Safety Executive for Northern Ireland
83 Ladas Drive
BELFAST
BT6 9FR
028 90243249 (Free phone 0800 0320 121)

Nursing & Midwifery Council
23 Portland Place
LONDON
W1B 1PZ
020 76377181

General Medical Council
20 Adelaide Street
BELFAST
BT2 8GD
028 90 517022

Department of Health, Social Services & Public Safety (DHSSPSNI)
Castle Buildings
Stormont
BELFAST
BT4 3SJ
028 90 520500

Mental Health Commission for Northern Ireland
4th Floor – Lombard House
10-20 Lombard Street
BELFAST
BT1 1RD

DHSSPS Fraud Hotline
Tel 08000 963396

Appendix 2

List of Non-Executive Directors with whom a concern can be raised

Mrs Deirdre Blakely

Mr Edwin Graham

Mrs Siobhan Rooney

Mrs Hester Kelly

Mrs Elizabeth Mahood

Mr Raymond Mullan

Mr Roger Alexander

Contact can be made with any of the above Non-Executive Directors through the Office of the Chair on [redacted].

Southern Health
and Social Care Trust

Quality Care - for you, with you

Nursing and Midwifery
Accountability and Assurance Framework

Heather Trouton
Interim Executive Director of Nursing, Midwifery & AHPs
August 2019
Version 4

APPENDIX 1 – FRAMEWORK LOGIC MODELS

1. PURPOSE

The Accountability and Assurance Framework for Nursing and Midwifery (hereafter referred to as the ‘Framework’) has been developed to ensure there are clear and effective lines of accountability and assurance for the professional governance of the Nursing and Midwifery workforce in the Southern Health and Social Care Trust (hereafter referred to as the ‘Trust’).

The Framework sets out the arrangements which assure the standards of practice, conduct and professionalism of the workforce. It enables the Trust, through the Executive Director of Nursing, Midwifery and AHPs (EDoN) to assure itself that effective governance systems are in place to enable the achievement of the professional standards and regulation requirements that nurses and midwives must uphold in order to be registered to practice (NMC, 2015; NMC 2016) and that services provided by the Nursing and Midwifery workforce are safe and of a high quality.

The Framework creates an environment which enables nurses and midwives to:

- Practice in accordance with The Code (NMC, 2015), the organisational vision and corporate objectives to ensure the best possible care and treatment experience for service users and families.
- Maintain the standards of conduct of practice and to provide high-quality services and promote public trust and confidence in Nursing and Midwifery services.
- Be responsible for their continuous learning and development.
- Highlight and address areas of concern and risk if required.

The Framework details the professional nursing structure and supporting mechanisms essential to the governance of the Nursing and Midwifery workforce. It may evolve in light of experience, learning and service reconfiguration or development.

2. STRATEGIC CONTEXT

HSC Trusts have corporate accountability for maintaining and improving the quality of services in the form of Clinical and Social Care Governance. The responsibility of oversight and assurance for the quality of Nursing and Midwifery is devolved to the Executive Directors of Nursing and Midwifery. Individually, nurses and midwives are professionally accountable to the Nursing and Midwifery Council (NMC) but they also have a contractual accountability to their employer and are accountable, in law, for their actions.

This Framework sets out how the EDoN provides assurance to the Chief Executive, Trust Board and the Chief Nursing Officer (CNO) on the quality and professionalism of Nursing and Midwifery. When implemented, the Framework provides evidence that structures and processes are in place to provide the right level of support, scrutiny and assurance across all Nursing and Midwifery services.

This Framework reflects the five standards outlined in the Assurance Framework for Professional Nursing and Midwifery Practice in Northern Ireland (2019, draft version 5)

Standard 1: There must be explicit and effective lines of nursing and midwifery accountability from every registrant in every care and service setting to the EDoN and through to CNO.

Standard 2: There must be collective professional leadership across every care and service setting that maximises the unique contribution of Nursing and Midwifery to safe and effective care.

Standard 3: Person-centred practice must be prioritised and embedded across every care and service setting.

Standard 4: Practice environments must be conducive to promoting positive health and well-being in every care and service setting.

Standard 5: The Nursing and midwifery workforce must be supported and equipped for practice across every care and service setting.

3. PROFESSIONAL REQUIREMENTS

As an aid to using the Professional Assurance Framework some of the underlying terminology is clarified below.

3.1 Accountability and Responsibility

The terms ‘responsibility’ and ‘accountability’ should not be used interchangeably.

Responsibility can be defined as a set of tasks or functions that an employer, professional body, court of law or some other recognised body can legitimately demand.

Accountability can be defined as demonstrating an ethos of being answerable for all actions and omissions, whether to service users, peers, employers, standard-setting / regulatory bodies or oneself.

3.2 Scope of Practice

Nurses and midwives must work within the parameters of their designated role and capability. This was formerly known as the Scope of Professional Practice but guidance on this has subsequently been incorporated into the NMC Code.

3.3 Delegation Framework for Nursing & Midwifery Practice (NIPEC 2017)

The purpose of delegation is to ensure the most appropriate use of skills within a health and social care team to achieve **person-centred outcomes**.

Delegation is defined as the process by which a nurse or midwife (delegator) allocates clinical or non-clinical tasks and duties to a competent person (delegatee).
The delegator remains accountable for the overall management of practice (NIPEC, 2019).

4. FRAMEWORK INTERVENTIONS

The Trust has a range of mechanisms in place to support assurance and accountability of the Nursing and Midwifery workforce.

Governance Structures, Roles and Responsibilities

Audit, Assurance and Compliance Arrangements

Learning, Development and Support

Workforce

Registration / Revalidation

Raising and Handling Concerns

Nursing Quality in the Independent Sector

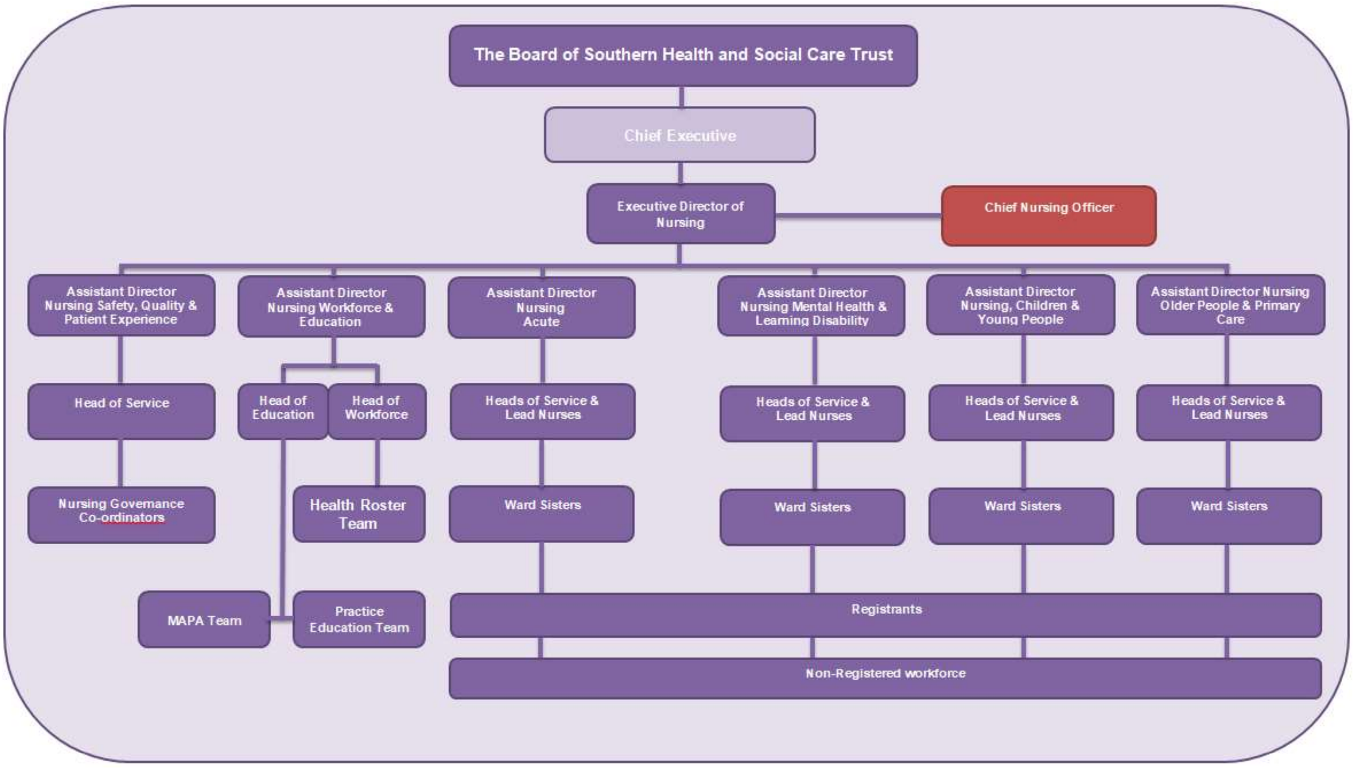
Figure 1: Accountability and Assurance Interventions

Each of the interventions is explored in detail in the following chapters.

5. GOVERNANCE STRUCTURES, ROLES AND RESPONSIBILITIES

The professional Nursing and Midwifery accountability and leadership structures within the SHSCT are as outlined below.

PROFESSIONAL GOVERNANCE MANAGEMENT STRUCTURE



The above configuration has potential for change depending on the agreed Nursing structure in operational directorates

5.1 Professional Accountability Roles and Responsibilities

Trust Board

The Board of the Southern Health and Social Care Trust has a responsibility to ensure that safe, high-quality care is provided and is underpinned by the public service values of accountability, probity and openness (Southern Health and Social Care Trust, 2017).

Chief Executive

The Chief Executive is the accountable officer of the Trust and holds ultimate accountability for the delivery of clinical, care and professional governance and adherence to the guidance issued by the Department of Health (DoH) in respect of governance.

Executive Director of Nursing, Midwifery & AHPs

The EDoN is responsible to Trust Board for providing robust triangulated evidence regarding the quality of professional nursing and midwifery practice, associated workforce issues and patient experience. This is done so that the Trust Board may make informed and sound decisions in fulfilling their joint responsibility regarding quality assurance and patient safety. That evidence should also include issues regarding escalation so that the Trust Board are informed of the risks and challenges the organisation faces. In addition, the EDoN is directly accountable to the CNO in respect of professional nursing and midwifery practice within the Trust.

In order to do this effectively, the EDoN is responsible for ensuring that there are robust and effective assurance structures and processes in place from every care and service setting through to the EDON. These structures and processes should drive improvement in the quality of nursing care and address any identified suboptimal standards of care.

The EDoN is responsible for ensuring that nursing care provided to patients is of a high standard meeting recognised professional standards and statutory requirements.

The EDoN provides professional leadership by ensuring professional issues are considered as part of strategic professional and operational service delivery.

Corporate Nursing Team

Assistant Director of Nursing and Midwifery (Safety, Quality & Patient Experience)

The Assistant Director of Nursing and Midwifery (Safety, Quality & Patient Experience) reports to the EDoN and is responsible for providing assurances that the Trust has robust arrangements in place to achieve high standards of professional governance to support the delivery of quality Nursing and Midwifery care. He / she works closely with the nursing operational Assistant Directors / Directorate Nurses to provide assurances.

The Assistant Director has oversight of established triggers and processes for the escalation of concerns about practitioner conduct, capability and / or fitness to practice and advise on legislation, rules, standards and guidance pertaining to nursing and midwifery. In addition, the Assistant Director develops and reviewing policies, procedures and protocols to ensure that these promote best Nursing and Midwifery practice and the delivery of high quality care.

The Assistant Director is responsible for ensuring that the EDoN is able to fulfil her / his role at Trust Board. This includes ensuring that robust assurance processes are implemented and their effectiveness monitored. He / she is responsible for ensuring that the EDoN is briefed about each clinical area and that issues of concern are escalated accordingly.

The Assistant Director will formulate a quarterly assurance paper that summarises the overall position in relation to Nursing and Midwifery assurance, including any action planned to address risks and areas of concern. This will be submitted to the Performance Committee via SMT.

He / she will ensure that the risk register accurately reflects the risk associated with the challenges nursing and midwifery are currently facing.

The Assistant Director is responsible for ensuring that nursing care provided to patients is of a high quality, meeting national standards and statutory requirements. Where significant quality and safety issues are identified, he / she in conjunction with the operational Nursing Assistant director / Directorate Nurse will initiate a thorough assessment of the clinical / service area and formulation of an improvement plan and ensure that the EDoN is briefed regarding the situation.

The Assistant Director is responsible for leading on the improvement of patient experience in line with regional priorities and in response to patient / client experience feedback.

Head of Nursing (Safety, Quality and Patient Experience)

This Head of Nursing (Safety, Quality and Patient Experience) is responsible for providing professional leadership and has managerial responsibility for the safety and quality of nursing and patient experience across the Trust.

The Head of Nursing (Safety, Quality and Patient Experience) works collaboratively across operational directorates to ensure high standards of patient experience and compassionate care, whilst promoting compliance with relevant standards and indicators of the safety and quality of nursing and midwifery.

He/she supports the Assistant Director of Nursing Safety, Quality and Patient Experience in strategic development of nursing and midwifery standards, policies and procedures, quality initiatives and the development and implementation of key performance indicators.

He/she is responsible for all aspects of the operational management of the Nurse Governance Team, Nurse Revalidation Team, Bereavement Co-ordinator, Head of Research and Development for Nurses, Midwives and AHPs, Patient and Client Experience/10,000 Voices Facilitator and Information Analysist, in addition to any temporary staff aligned to the team to support regional or local initiatives. He/she will provide clear leadership to all staff within their sphere of responsibility and will be responsible for effective financial management and the efficient use of all resources.

Assistant Director of Nursing and Midwifery, Workforce Development and Training

The Assistant Director of Nursing and Midwifery, Workforce Development and Training is responsible for all aspects of the Trust's arrangements for post registration Nursing and Midwifery training and education and for the Nursing and Midwifery pre-registration clinical placement oversight function. This requires the development and maintenance of partnership working with Department of Health (DoH), Public Health Agency (PHA), Health and Social Care Board (HSCB), universities, colleges and other training providers. They have a commissioning, performance management and quality assurance role for training which will be provided both internally and externally to the Trust.

The Assistant Director of Nursing and Midwifery Workforce Development and Training contributes to the Trust's corporate workforce planning and development. This involves engaging with colleagues from human resources and other disciplines in designing and putting in place various training programmes and arrangements including Qualifications and Credit Framework (QCF).

Head of Nursing and Midwifery Education and Workforce Development

The Head of Nursing and Midwifery Education and Workforce Development is responsible for the development of a learning and assessment education governance framework to ensure the NMC requirements are met; providing strong professional leadership, and facilitating learning and development through effective education strategies. This includes leading on Trust-wide training needs analyses; coordinating post registration education requirements, pre-registration education requirements and the education and development of Nursing and Midwifery support staff with all internal and external stakeholders.

They are also responsible for leading and coordinating workforce development initiatives related to the Nursing and Midwifery workforce.

Head of Nursing and Midwifery Workforce Planning and Utilisation

The Head of Workforce Planning and Utilisation is responsible for the planning and utilisation of the Nursing and Midwifery Workforce across the Trust. He / she leads workforce planning and utilisation of the nursing and midwifery workforce using appropriate and relevant strategies for workforce measurement and appropriate use of skill mix, as well as contribute to the Trust's corporate workforce planning and development agenda. They provide support and leadership to Directorates in changing working practices in nursing roles to ensure the nursing and midwifery workforce is dynamic, responsive and adaptive to the needs of patients / clients and the public and will help to build capacity and capability to support workforce innovation and new role development. Working with a wide range of stakeholders key actions as outlined in the Trust's Nursing and Midwifery Workforce Action Plan (SHSCT 2019) will be completed through the implementation of effective workforce strategies.

Operational Nursing Teams

Nursing Operational Assistant Directors / Directorate Nurses

Operational Assistant Directors who are registered nurses / midwives are directly accountable and responsible for the professional nursing and midwifery practice within their Division / Directorate. They will report directly to the EDoN and work in conjunction with the Assistant Director of Nursing (Safety, Quality and Patient Experience) to provide assurances regarding nursing and midwifery practice within their areas of responsibility.

Nursing Heads of Service

Heads of Service who are registered nurses / midwives are accountable and responsible for the professional nursing and midwifery practice within their service areas. They will report directly to the Operational Assistant Directors within their Division / Directorate and work in conjunction with the Directorate Nurse if applicable and the Assistant Director of Nursing (Safety, Quality and Patient Experience) and Head of Nursing (Safety, Quality and Patient Experience) to provide assurances regarding nursing and midwifery practice within their areas of responsibility.

Lead Nurses / Nurse Managers / Ward Sisters / Charge Nurses / Team Leads

This group of senior nurses will provide clinical, professional and managerial leadership to ensure the objectives and quality standards of the Framework are met. They will inspire, motivate and empower nurses, midwives and wider health care teams to continually improve the patient experience and provide effective nursing care to enhance patient safety.

They are responsible for the quality of nursing / midwifery care in their area and will deliver on this by ensuring that their staff are inducted and trained to effectively and safely carry out their duties, facilitate supervision and the implementation of staff support policies. They will escalate concerns regarding practitioners' conduct, capability or fitness to practice as required, following discussion, they will progress actions agreed, monitor and feedback.

Nursing and Midwifery Staff

All Nursing and Midwifery registrants are responsible for meeting the regulatory standards of conduct and practice as set out for their profession by the Nursing and Midwifery Council (NMC) professional regulatory body. They are individually responsible to ensure they maintain their professional registration. They must comply with Trust policies and procedures and their on-going professional development designed to support them in the delivery of safe and effective care.

Nursing Assistants

Nursing Assistants are required to meet the Standards for Nursing Assistants (DoH, 2018) and, to comply with Trust policies and procedures designed to support them in delivering safe and effective care.

5.1 Supporting Arrangements

Nursing Governance Team

The Nursing Governance Team support and facilitate teams to achieve improvements in Nursing and Midwifery care through a variety of approaches including quality improvement and practice development.

Practice Education Team

This team consists of Practice Education Facilitators, led by a Practice Education Coordinator. Under the direction of the Assistant Director of Nursing and Midwifery Workforce Development and Training, the team's remit is to develop and sustain an effective learning culture, infrastructure and environment for Nursing and Midwifery students on a Trust-wide basis within a NMC approved governance framework. They also evaluate the effectiveness of pre and post-registration learning and education activities to provide enhanced value added benefits reflected in improved quality of care of patients and clients. Another of the team's remit is to lead on the implementation, monitoring and evaluation of the Trust's new registrant Induction, Rotation and Preceptorship programmes.

Revalidation Team

The Nursing and Midwifery Revalidation Team support operational directorates and the corporate nursing team to provide the EDoN with oversight and assurance with regards to Nursing and Midwifery revalidation. The remit of this team will be extended to provide assurances around other aspects of the framework, including supervision.

5.2 Professional Governance Forums

There are a number of professional fora across directorates which support the EDoN in providing assurances regarding the quality of professional nursing and midwifery practice. These fora promote an ethos of awareness, continuous learning, accountability and improvement. They are essential in supporting corporate governance arrangements, specifically in relation to promoting continuous professional education and development and ensuring professional standards and regulatory requirements are in place and adhered to. They ensure professional processes are monitored and reviewed and that all risks related to the nursing and midwifery workforce are considered and where necessary mitigated against through timely and effective action planning and dissemination of learning.

6. AUDIT, ASSURANCE AND COMPLIANCE ARRANGEMENTS

The Trust monitors Nursing and Midwifery professional governance through a suite of performance and quality indicators designed to ensure that the care, treatment and support are of a consistently high quality throughout the system. These are communicated down through professional nursing and midwifery structures and action plans developed as required to provide assurance.

6.1 Accountability Reporting

The EDoN compiles an Executive Director of Nursing and Midwifery report twice yearly to Trust Board to provide assurances regarding professional nursing and midwifery practice. In addition, the EDoN will table a performance report to the Performance Committee on a quarterly basis.

6.2 Monitoring Arrangements

Nursing and Midwifery practice is reviewed and monitored through a range of processes and fora as outlined in the table below.

Key Performance / Quality Indicator and Reports	Description	Frequency of Review	Reviewed / Monitored through
Executive Director of Nursing, Midwifery and AHPs Reporting	A summary of activity and developments within the Nursing and Midwifery profession.	Twice Yearly reports to Trust Board reports Quarterly reports to the Performance Committee	• Senior Nursing and Midwifery Governance Forum (SNMGF) • Trust Senior Management Team • Performance Committee • Trust Board
Induction status reporting	Compliance with Trust Nursing and Midwifery Induction Requirements - New registrants - Registrants - Role specific	Biannual	• Directorate Nursing and Midwifery Governance Fora. • Senior Nursing and Midwifery Governance Forum (SNMGF) • Performance Committee
Preceptorship requirements reporting	Compliance Nursing and Midwifery preceptorship requirements	Quarterly	• Directorate Nursing and Midwifery Governance Fora. • Senior Nursing and Midwifery Governance Forum (SNMGF) • Trust Senior Management Team • Performance Committee

Key Performance / Quality Indicator and Reports	Description	Frequency of Review	Reviewed / Monitored through
Audit of Compliance with Mandatory Training	Scorecards of mandatory training performance	Quarterly	• Local and Directorate management meeting • Directorate Nursing and Midwifery Governance Fora. • Senior Nursing and Midwifery Governance Forum (SNMGF)
Nursing and Midwifery Supervision Audit	Audit of supervision practice against Supervision Standards.	Quarterly	• Directorate Nursing and Midwifery Governance Fora. • Senior Nursing and Midwifery Governance Forum (SNMGF) • Trust Performance Committee
Audit of Compliance with Annual KSF and Personal Development Plans	Sample audit of Personal Development Plan completion	An annual audit of PDP completion	• Directorate Nursing and Midwifery Governance Fora. • Senior Nursing and Midwifery Governance Forum (SNMGF)
Compliance with Standards for Learning and Assessment in Practice (NMC, 2008)	Mentor register reports Placement evaluation reports Educational Audits	Biannual Biannual Biannual	• Practice Education Team • Directorate Nursing and Midwifery Governance Fora. • Senior Nursing and Midwifery Governance Forum (SNMGF) • Performance committee
Post registration Education service level agreement usage , including DNA rate	Post registration Education service level agreement usage , including DNA rate	Bi annual	• Operational director • SNMGF • Performance committee
Audit of Compliance with Normative Staffing	Monitoring report Phases 1-6	Biannual	• Directorate Nursing and Midwifery Governance Fora. • Office of Chief Executive and Executive Director of Nursing
Revalidation and Registrations Status Reporting	Compliance with NMC registration requirements	Quarterly	• Directorate management and governance Fora • Directorate Nursing and Midwifery Governance Fora • Senior Nursing and Midwifery Governance Forum (SNMGF) • Trust Performance committee
Fitness to Practice	Summary of Nursing and Midwifery staff referred to NMC	Bi annual	• Performance committee • SNMGF • Operational Directorates
Compliance with regional and locally agreed clinical NQI's and KPIs including PACE and Patient Safety Thermometer data.	Compliance with regional clinical NQI Bundles and other relevant safety / practice indicators	Monthly	• Ward Sisters / Charge Nurses • Lead Nurses
		Quarterly	• Directorate Nursing and Midwifery Governance Fora • Operational Director • Senior Nursing and Midwifery Governance Forum (SNMGF) • Trust Performance Committee

Key Performance / Quality Indicator and Reports	Description	Frequency of Review	Reviewed / Monitored through
Patient Experience Feedback	Utilise the feedback of service users and / or carers to improve services. Includes 10,000 voices feedback.	Monthly	• Directorate Governance Fora • Operational Director
		Quarterly	• Trust Senior Management Team • Patient and Client Experience Steering Group • Trust Patient and Client Experience Committee
Nursing Quality in the Independent Sector	Monitored via the Trust Independent Sector Governance Forum	Bi annual	• Operational Director • Trust performance committee

6.3 Information Systems

To support the Nursing and Midwifery Accountability and Assurance Framework there are a number of information systems alongside the need to manually collate information:

- HRPTS Workforce Information System
- DATIX Complaints and Incident Management System
- Allocate Health Rostering System
- Easy Information Management System (EIMS) – Mentor Register
- E-CATS – Health Visiting and District Nursing
- Filemaker
- HCAT System
- Revalidation register

7. LEARNING, DEVELOPMENT AND SUPPORT

There are systems in place to monitor workforce volumes, highlight issues and to ensure that the Nursing and Midwifery workforce have the appropriate knowledge, skills and support needed to provide high-quality care.

Corporate Induction

The Trust Induction Policy (SHSCT, 2013a) requires all newly appointed staff to attend a Corporate Induction (in addition to a Departmental Induction / orientation). The programme comprises of information of common interest across all staff groups and contributes to building a commonality of understanding amongst the workforce. New employees are required to attend Corporate Induction ideally within three months of commencement but no longer than six months following appointment.

Nurse Induction for New Registrants

A Nurse Induction programme is delivered biannually to all new Nursing registrants. The programme is delivered in a blended approach by Clinical Education Centre, Practice Education Team and in-house SHSCT staff over a period of 3 days. It combines Corporate and Professional Induction, elements of Mandatory Training, a range of e-learning, and preceptorship training. All new registrants are given the option at recruitment phase to undertake a Rotational Programme to facilitate consolidation of knowledge and skills across a range of care settings.

Currently there is work ongoing to develop a Regional Induction Programme for Nursing Assistants.

Specialty / Departmental Induction

The Trust Induction Policy (2013a) requires all new employees to undertake specialty / departmental induction to ensure they have the information they may need to undertake the requirements of the post and to undertake the requirements of the job / professional role.

Preceptorship Programme

The Practice Education Team delivers a Preceptorship Programme to new registrants.

The duration of the programme is six months and runs concurrently with induction and the probationary period. A Preceptorship procedure (SHSCT, 2018) details the requirements for the Preceptorship Programme. The Trust reports annually to the Chief Nursing Officer (CNO) and quarterly to Trust Board regarding compliance with the Preceptorship Framework (DHSSPS, 2013).

Nursing and Midwifery Supervision & Annual Appraisal

The learning and development requirements of the Nursing and Midwifery workforce are identified through the Trust supervision and appraisal systems. The Trust considers the implementation of supervision and KSF processes as a critical priority in valuing staff and supporting their development to help achieve the key objective of safe, high-quality health and social care. The outcome of supervision activities informs the individual's KSF and Personal Development Plans, including identification of training requirements.

Mandatory Training

The Trust Corporate Mandatory Training Policy (Southern Health and Social Care Trust, 2013) details the Corporate Mandatory Training for Nursing and Midwifery staff groups. The policy denotes the mandatory training requirements for nursing, midwifery and nursing assistant staff groups.

Role Specific Training

All clinical areas ensure Nursing and Midwifery staff undertake role specific training to deliver safe and effective care. This is managed locally by the Ward Sister / Charge Nurse / Team Lead and all registrants.

Continuous Professional Development (CPD) Maintenance

All nursing and midwifery registrants have access to educational programmes provided through the Clinical Education Centre Level Agreement and the Education Commissioning Plan which provides them with opportunities to maintain Post Registration Training and Learning and gain recognition for learning.

Clinical Education Centre (CEC) – Service Level Agreement (SLA)

All nursing and midwifery registrants have access to the CEC which provides them with a range of programmes to maintain continuous professional development. Monitoring and uptake is ongoing throughout the financial year through monthly reports from the CEC. The procedure for the Management of the Nursing and Midwifery SLA with the CEC provides guidance on all courses available and with the CEC (SHSCT, 2016a)

Education Commissioning Cycle – Training Needs Analysis

As part of the Regional Education Commissioning Group chaired by the DoH funds are allocated for education to each HSC Trust. The completion of an annual Training Needs Analysis facilitates Nursing and Midwifery staff to undertake further education including stand-alone modules, short courses and specialist practice to facilitate the development of skills, knowledge and expertise for practitioners. The procedure for the Management of Nursing and Midwifery Post-Registration Education Commissioning provides guidance on all aspects of the Nurse Education Commissioning process (SHSCT, 2016b)

8. WORKFORCE

The Trust recognises that ensuring appropriate nurse staffing is a key element in influencing the quality of care. Given this, a comprehensive Nursing and Midwifery Workforce Action Plan 2019 – 21 has been developed and the action plan is being progressed through 3 work streams. Progress is reported through to SMT and Trust Board.

8.1 Recruitment

Active recruitment of Nursing and Midwifery staff occurs on an ongoing basis via an open advertisement with the Business Services Organisation (BSO). Targeted recruitment via International Nurse Recruitment, UK wide recruitment fairs and local recruitment is managed by the HR Trust's recruitment team and the Corporate Nursing Team in a planned process. Monthly vacancy reports are reviewed by Directorates and escalation processes are in place to address staff shortages.

8.2 Delivering Care Project (Normative Staffing)

The Delivering Care Project continues to be implemented (DHSSPS, 2014). It aims to support the provision of high quality care which is safe and effective in hospital and community settings, through the development of a framework to determine staffing ranges for the Nursing and Midwifery workforce in a range of major specialties. Although funding has only been approved for phase 1, biannual reporting is completed to the HSCB of all agreed phases.

9. REGISTRATION / REVALIDATION

The Trust has developed an infrastructure to support the registration of the Nursing and Midwifery workforce which enhances the professional regulation of the workforce and reinforces the individual's responsibility to provide quality Nursing and Midwifery services.

Monitoring at Operational Level

While the responsibility to maintain registration lies with the registrant, line managers are responsible for ensuring that registered nurses and midwives have a valid registration and are on the NMC Register (SHSCT, 2017c).

HRPTS Oversight & NMC Registration Employer Centralised Oversight

The Trust has a dedicated Revalidation Team which record and monitor Nursing and Midwifery workforce registration and renewal status. The regional HRPTS system is used for central recording and monitoring of workforce registration and renewal status. Monthly reports are issued to managers on registration and renewal status.

Pre-Employment Checks

The Trust Recruitment and Selection Procedure (SHSCT, 2010) stipulates a pre-recruitment phase which involves the development and approval of personnel specifications and a range of checks to be undertaken pre- employment.

NMC Registration and Renewal Processes

The Trust Policy on the Validation and Monitoring of Registration with a Professional Regulatory Body (SHSCT, 2017d) defines the approach for registration and the maintenance of Nursing and Midwifery professional registration.

10. RAISING AND HANDLING CONCERNS

The Trust has a range of mechanisms for raising and handling concerns which are designed to ensure the Nursing and Midwifery workforce achieve and maintain appropriate standards of conduct, performance and behaviour.

Identification of Poor or Variable Performance

Concerns about poor or variable performance are identified through supervision, probationary reviews, incidents, complaints, patient feedback, whistleblowing and managerial engagement with front-line teams. Depending on the severity and potential impact of the issues identified a line manager may seek to resolve locally through identification of further training and development needs, increased supervision or enact the Trust's management of probationary, capability or disciplinary procedures.

Probationary

All Nursing and Midwifery appointments are subject to a probationary period which is normally 6 months duration, during which time progress is monitored. In the event of unsatisfactory progress, despite appropriate support and / or counselling, employment will be terminated with appropriate notice either during or at the end of the probationary period in accordance with the Trust's procedure for probationary periods (SHSCT, no year).

Management of Capability, Conduct or Health Concerns

The Trust Capability Procedure (SHSCT, 2015a) has been designed for use in situations where there is evidence of '*a genuine lack of capability rather than a deliberate failure on the part of the employee to perform to the standards of which he / she is capable*'.

The Trust Disciplinary Procedure (SHSCT, 2015b) is designed to help and encourage all employees to achieve and maintain appropriate standards of conduct, performance and behavior.

Line managers work very closely with the Trust Occupational Health Department and Attendance Management Team to appropriately manage health concerns related to the Nursing and Midwifery workforce.

Management of Fitness to Practice Referrals to NMC and NMC Investigation Process

Trust Procedures for initiating and managing a referral to a Professional Regulatory Body and the Independent Safeguarding Authority and Requesting the DHSSPS to issue an ALERT (SHSCT, 2015c) outline the processes to be followed should this be required. All referrals to NMC for fitness to practice and requested for an alert to be issued should be discussed with and quality assured by the Assistant Director of Nursing (Safety, Quality and Patient Experience) and approved by the EDoN.

The corporate nursing team will support nurses and midwives involved in NMC investigations and hearings.

Nursing and Midwifery Human Resources Interface Forum

The Trust Nursing and Midwifery Human Resource Interface Forum has formalised interfaces between the Assistant Director of Nursing (Safety, Quality and Patient Experience), Assistant Directors of Human Resources (Directorate) and Head of Employee Relations in relation to conduct, capability or fitness to practice of Nursing and Midwifery staff.

11. NURSING QUALITY IN THE INDEPENDENT SECTOR

There are robust processes in place for assuring the quality and safety of services commissioned from third or independent sector providers.

Contracts

Where externally provided services are commissioned by the Trust, the same high levels of compliance with Trust safety and quality standards are required to be implemented by the Provider through adherence to robust, descriptive contracts. The contracts stipulate clear arrangements for monitoring that these standards are met. Advice and guidance can be sought from the Operational Assistant Directors or Assistant Directors of Nursing as required.

If concerns are identified regarding the conduct, capability or fitness to practice of a registrant not employed by the Trust the Trust Procedures for initiating and managing a referral to a Professional Regulatory Body and the Independent Safeguarding Authority and Requesting the DHSSPS to issue an ALERT (SHSCT, 2015c) should be followed.

Contract Management and Monitoring

There are identified contract managers who undertake both formal and informal contract management and monitoring. At a minimum, an Independent / 3rd Party Contractor is subject to an annual formal Contract Management meeting.

The majority of Independent / 3rd Party Contractors engaged with by the Trust are registered with RQIA and subject to their ongoing monitoring and inspection.

12. REFERENCES

Department of Health Social Services and Public Safety and Northern Ireland Practice Education Council (2013) Preceptorship Framework for Nursing, Midwifery and Specialist Community Public Health Nursing in Northern Ireland, Belfast: NIPEC.

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Southern Health and Social Care Trust (2013) *Corporate Mandatory Training Policy*

Southern Health and Social Care Trust (2013a) *Trust Induction Policy*

Southern Health and Social Care Trust (2015) *Policy for the Management of Complaints (Working Draft)*

Southern Health and Social Care Trust (2015a) *Capability Procedure*

Southern Health and Social Care Trust (2015b) *Disciplinary Procedure*

Southern Health and Social Care Trust (2015c) *Trust Procedures for initiating and managing a referral to A Professional Regulatory Body and The Independent Safeguarding Authority and Requesting the DHSSPS to issue an ALERT*

Southern Health and Social Care Trust (2016) *Policy for Supporting Nursing & Midwifery Students in Practice*

Southern Health and Social Care Trust (2016a) *Procedure for the Management of the Nursing and Midwifery Service Level Agreement with the Clinical Education Centre*

Southern Health and Social Care Trust (2016b) *Procedure for the Management of Nursing and Midwifery Post-Registration Education Commissioning*

Southern Health and Social Care Trust (2018) *Preceptorship Procedure for Nurses, Midwives and Specialist Community Public Health Nurses*

Southern Health and Social Care Trust (2017) *Board Assurance Framework*

Southern Health and Social Care Trust (2017a) *Procedure on the Identification, Management and Monitoring of Practice Placements for Students who are undertaking NMC approved programmes.*

Southern Health and Social Care Trust (2017b) *Procedure for Maintaining the Trust Register.*

Southern Health and Social Care Trust (2017c) *Policy on the Validation and Monitoring of Registration with a Regulatory Body*

Southern Health and Social Care Trust (2017d) *Professional Registration Policy*

Southern Health and Social Care Trust (2019) *Nursing and Midwifery Workforce Action Plan 2019-21*

Appendix 1

Southern Health
and Social Care Trust

Quality Care - for you, with you

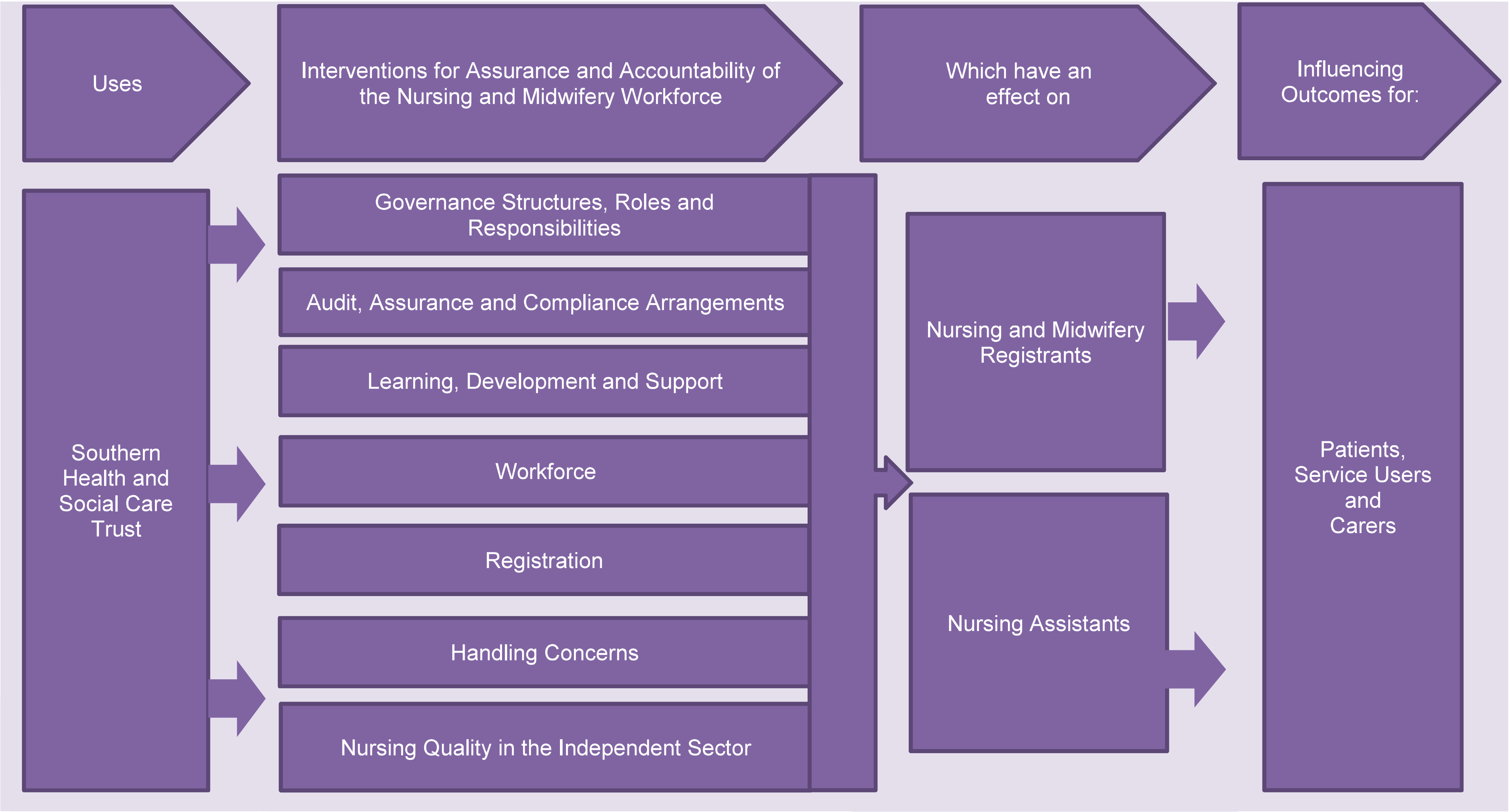
Nursing and Midwifery Accountability and Assurance

Logic Models

Southern Health and Social Care Trust

Quality Care - for you, with you

Accountability and Assurance Framework
Nursing and Midwifery



Uses

Interventions for Assurance and Accountability of the Nursing and Midwifery Workforce

Which have an effect on

Influencing Outcomes for:

Southern Health and Social Care Trust

Governance Structures, Roles and Responsibilities

Audit, Assurance and Compliance Arrangements

Learning, Development and Support

Workforce

Registration

Handling Concerns

Nursing Quality in the Independent Sector

Nursing and Midwifery Registrants

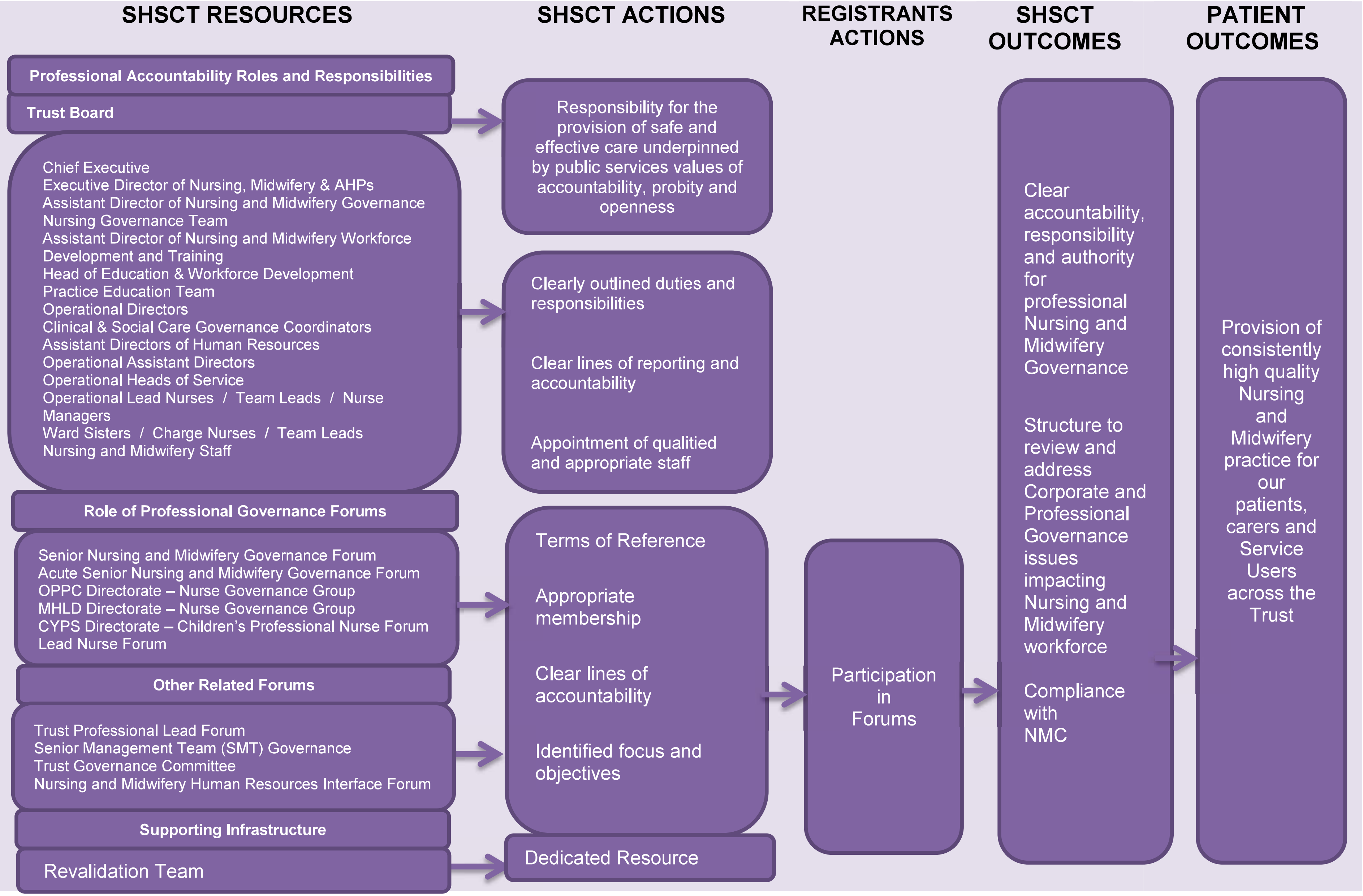
Nursing Assistants

Patients, Service Users and Carers

Southern Health and Social Care Trust
Quality Care - for you, with you

Accountability and Assurance Framework
Nursing and Midwifery

Governance Structures, Roles and Responsibilities



SHSCT RESOURCES

Professional Accountability Roles and Responsibilities

Trust Board

Chief Executive
Executive Director of Nursing, Midwifery & AHPs
Assistant Director of Nursing and Midwifery Governance
Nursing Governance Team
Assistant Director of Nursing and Midwifery Workforce Development and Training
Head of Education & Workforce Development
Practice Education Team
Operational Directors
Clinical & Social Care Governance Coordinators
Assistant Directors of Human Resources
Operational Assistant Directors
Operational Heads of Service
Operational Lead Nurses / Team Leads / Nurse Managers
Ward Sisters / Charge Nurses / Team Leads
Nursing and Midwifery Staff

Role of Professional Governance Forums

Senior Nursing and Midwifery Governance Forum
Acute Senior Nursing and Midwifery Governance Forum
OPPC Directorate – Nurse Governance Group
MHLD Directorate – Nurse Governance Group
CYPS Directorate – Children's Professional Nurse Forum
Lead Nurse Forum

Other Related Forums

Trust Professional Lead Forum
Senior Management Team (SMT) Governance
Trust Governance Committee
Nursing and Midwifery Human Resources Interface Forum

Supporting Infrastructure

Revalidation Team

SHSCT ACTIONS

Responsibility for the provision of safe and effective care underpinned by public services values of accountability, probity and openness

Clearly outlined duties and responsibilities

Clear lines of reporting and accountability

Appointment of qualitied and appropriate staff

Terms of Reference

Appropriate membership

Clear lines of accountability

Identified focus and objectives

Dedicated Resource

REGISTRANTS ACTIONS

Participation in Forums

SHSCT OUTCOMES

Clear accountability, responsibility and authority for professional Nursing and Midwifery Governance

Structure to review and address Corporate and Professional Governance issues impacting Nursing and Midwifery workforce

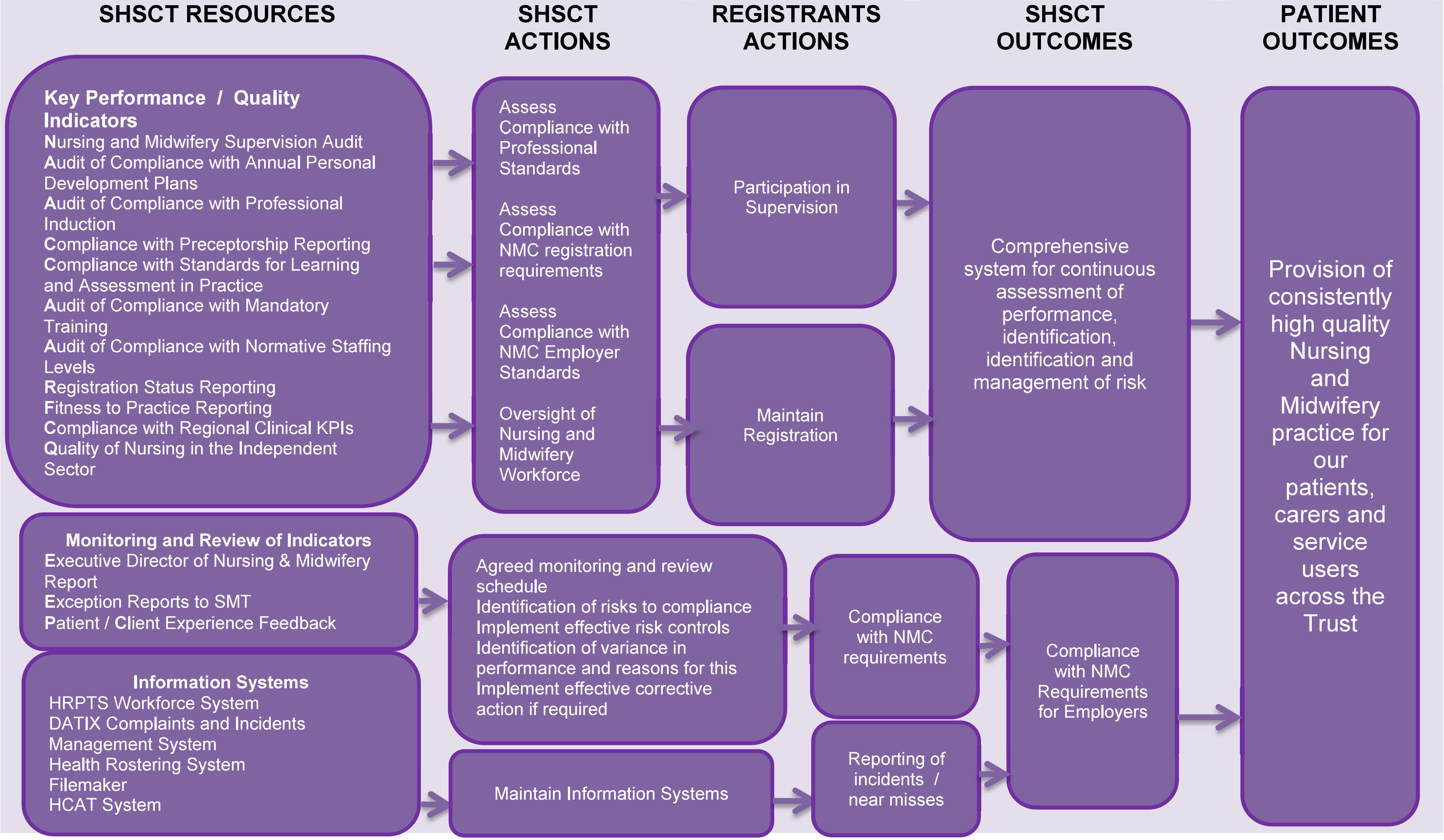
Compliance with NMC

PATIENT OUTCOMES

Provision of consistently high quality Nursing and Midwifery practice for our patients, carers and Service Users across the Trust

Accountability and Assurance Framework
Nursing and Midwifery

Audit, Assurance and Compliance Arrangements



SHSCT RESOURCES

Key Performance / Quality Indicators
Nursing and Midwifery Supervision Audit
Audit of Compliance with Annual Personal Development Plans
Audit of Compliance with Professional Induction
Compliance with Preceptorship Reporting
Compliance with Standards for Learning and Assessment in Practice
Audit of Compliance with Mandatory Training
Audit of Compliance with Normative Staffing Levels
Registration Status Reporting
Fitness to Practice Reporting
Compliance with Regional Clinical KPIs
Quality of Nursing in the Independent Sector

Monitoring and Review of Indicators
Executive Director of Nursing & Midwifery Report
Exception Reports to SMT
Patient / Client Experience Feedback

Information Systems
HRPTS Workforce System
DATIX Complaints and Incidents Management System
Health Rostering System
Filemaker
HCAT System

SHSCT ACTIONS

Assess Compliance with Professional Standards

Assess Compliance with NMC registration requirements

Assess Compliance with NMC Employer Standards

Oversight of Nursing and Midwifery Workforce

Agreed monitoring and review schedule
Identification of risks to compliance
Implement effective risk controls
Identification of variance in performance and reasons for this
Implement effective corrective action if required

Maintain Information Systems

REGISTRANTS ACTIONS

Participation in Supervision

Maintain Registration

Compliance with NMC requirements

Reporting of incidents / near misses

SHSCT OUTCOMES

Comprehensive system for continuous assessment of performance, identification, identification and management of risk

Compliance with NMC Requirements for Employers

PATIENT OUTCOMES

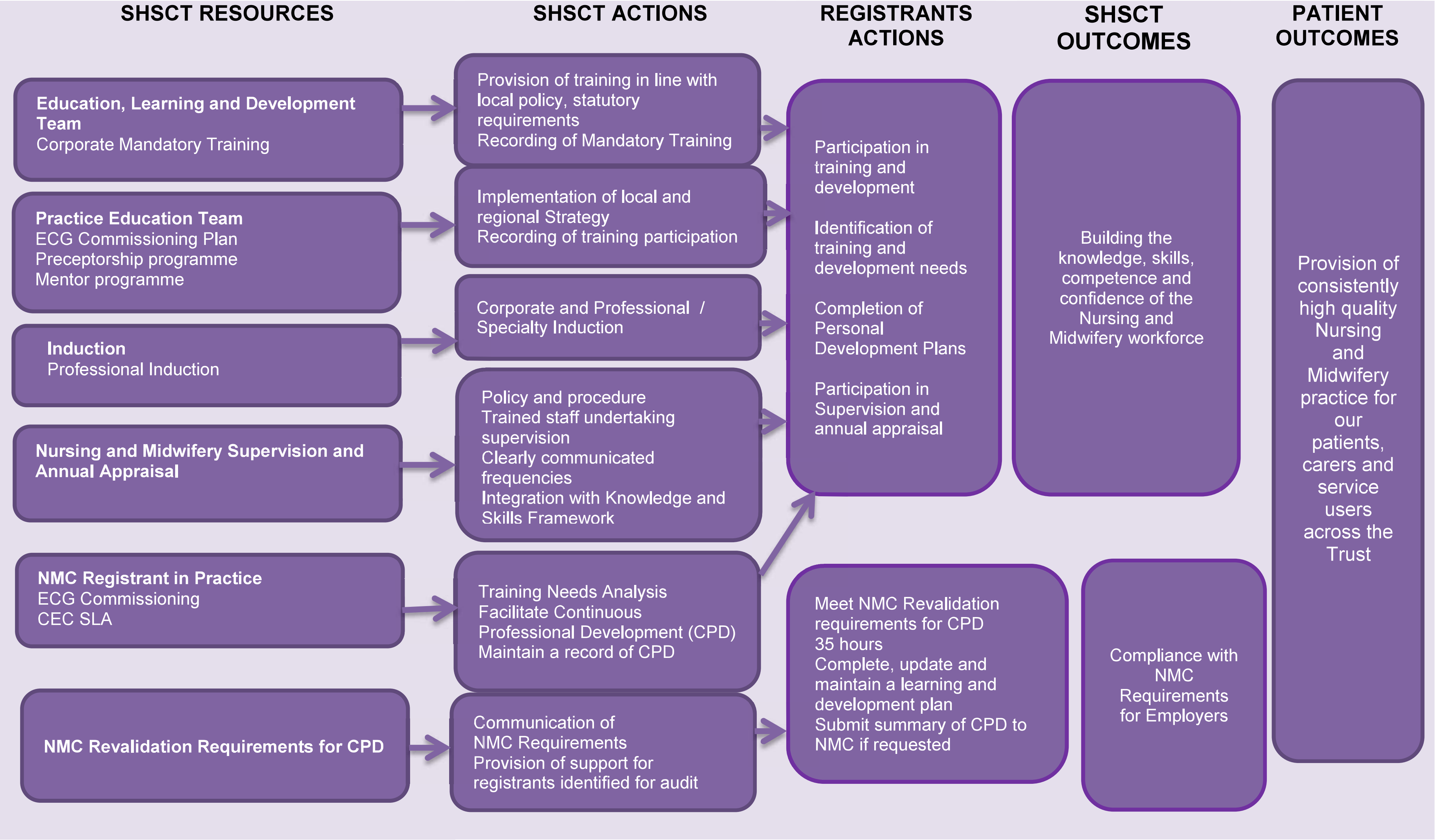
Provision of consistently high quality Nursing and Midwifery practice for our patients, carers and service users across the Trust

Southern Health
and Social Care Trust

Quality Care - for you, with you

Accountability and Assurance Framework
Nursing and Midwifery

Learning, Development and Support



SHSCT RESOURCES

Education, Learning and Development Team
Corporate Mandatory Training

Practice Education Team
ECG Commissioning Plan
Preceptorship programme
Mentor programme

Induction
Professional Induction

Nursing and Midwifery Supervision and Annual Appraisal

NMC Registrant in Practice
ECG Commissioning
CEC SLA

NMC Revalidation Requirements for CPD

SHSCT ACTIONS

Provision of training in line with local policy, statutory requirements
Recording of Mandatory Training

Implementation of local and regional Strategy
Recording of training participation

Corporate and Professional / Specialty Induction

Policy and procedure
Trained staff undertaking supervision
Clearly communicated frequencies
Integration with Knowledge and Skills Framework

Training Needs Analysis
Facilitate Continuous Professional Development (CPD)
Maintain a record of CPD

Communication of NMC Requirements
Provision of support for registrants identified for audit

REGISTRANTS ACTIONS

Participation in training and development

Identification of training and development needs

Completion of Personal Development Plans

Participation in Supervision and annual appraisal

Meet NMC Revalidation requirements for CPD 35 hours
Complete, update and maintain a learning and development plan
Submit summary of CPD to NMC if requested

SHSCT OUTCOMES

Building the knowledge, skills, competence and confidence of the Nursing and Midwifery workforce

Compliance with NMC Requirements for Employers

PATIENT OUTCOMES

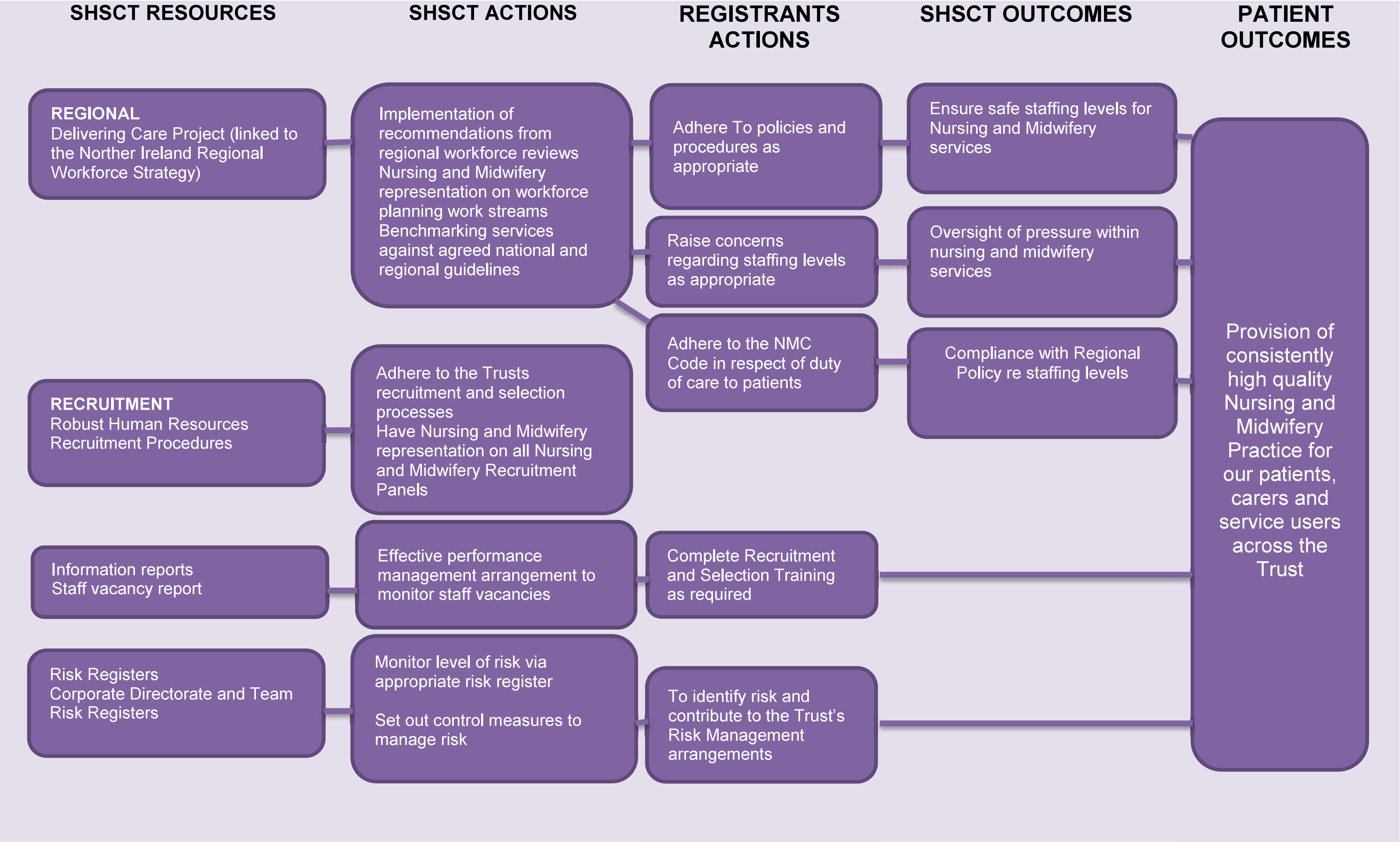
Provision of consistently high quality Nursing and Midwifery practice for our patients, carers and service users across the Trust

Southern Health and Social Care Trust

Quality Care - for you, with you

Accountability and Assurance Framework
Nursing and Midwifery

Workforce



SHSCT RESOURCES

REGIONAL
Delivering Care Project (linked to the Northern Ireland Regional Workforce Strategy)

RECRUITMENT
Robust Human Resources Recruitment Procedures

Information reports
Staff vacancy report

Risk Registers
Corporate Directorate and Team Risk Registers

SHSCT ACTIONS

Implementation of recommendations from regional workforce reviews
Nursing and Midwifery representation on workforce planning work streams
Benchmarking services against agreed national and regional guidelines

Adhere to the Trusts recruitment and selection processes
Have Nursing and Midwifery representation on all Nursing and Midwifery Recruitment Panels

Effective performance management arrangement to monitor staff vacancies

Monitor level of risk via appropriate risk register

Set out control measures to manage risk

REGISTRANTS ACTIONS

Adhere To policies and procedures as appropriate

Raise concerns regarding staffing levels as appropriate

Adhere to the NMC Code in respect of duty of care to patients

Complete Recruitment and Selection Training as required

To identify risk and contribute to the Trust’s Risk Management arrangements

SHSCT OUTCOMES

Ensure safe staffing levels for Nursing and Midwifery services

Oversight of pressure within nursing and midwifery services

Compliance with Regional Policy re staffing levels

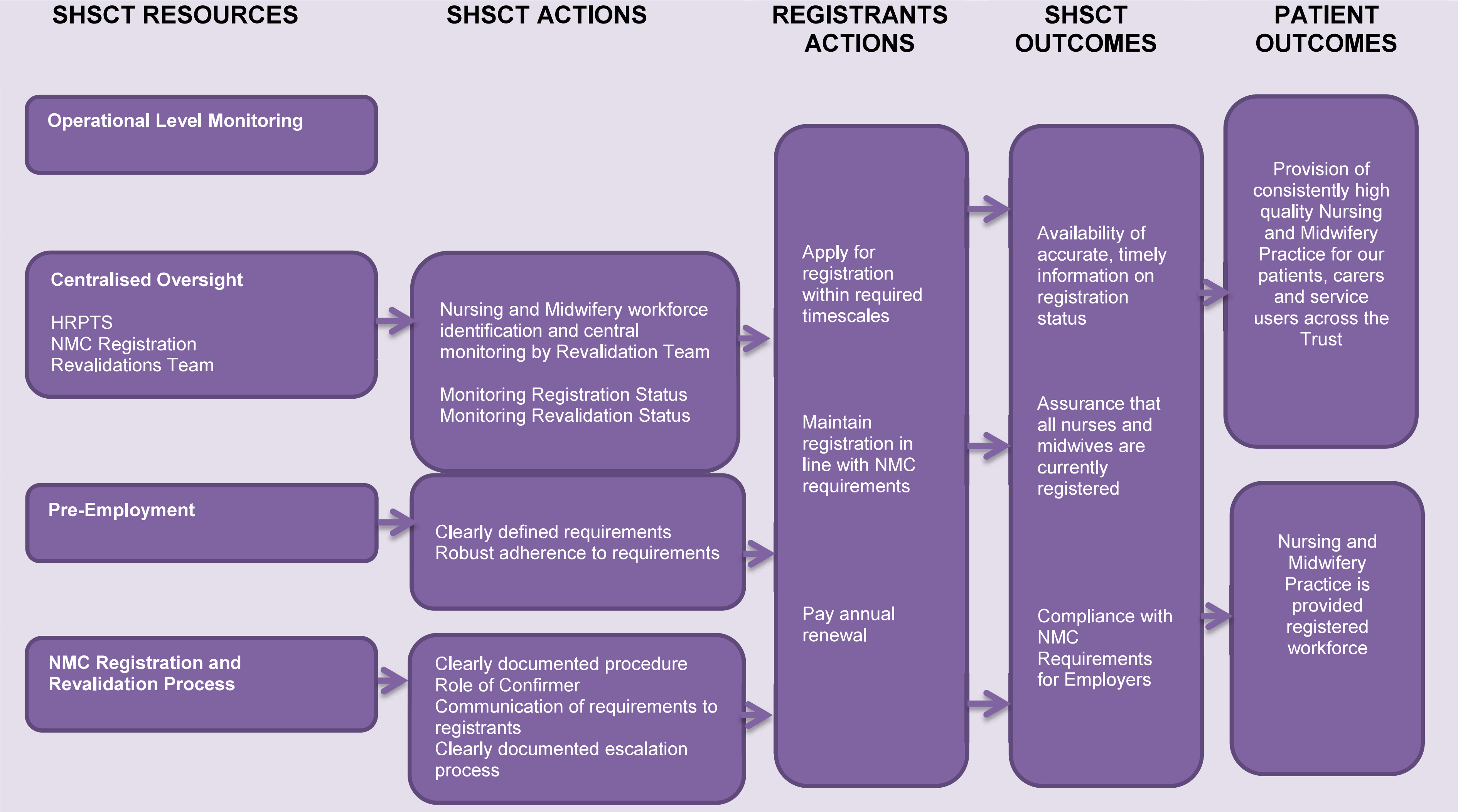
PATIENT OUTCOMES

Provision of consistently high quality Nursing and Midwifery Practice for our patients, carers and service users across the Trust

Southern Health
and Social Care Trust
Quality Care - for you, with you

Accountability and Assurance Framework
Nursing and Midwifery

Registration



SHSCT RESOURCES

Operational Level Monitoring

Centralised Oversight

HRPTS
NMC Registration
Revalidations Team

Pre-Employment

NMC Registration and Revalidation Process

SHSCT ACTIONS

Nursing and Midwifery workforce identification and central monitoring by Revalidation Team

Monitoring Registration Status
Monitoring Revalidation Status

Clearly defined requirements
Robust adherence to requirements

Clearly documented procedure
Role of Confirmer
Communication of requirements to registrants
Clearly documented escalation process

REGISTRANTS ACTIONS

Apply for registration within required timescales

Maintain registration in line with NMC requirements

Pay annual renewal

SHSCT OUTCOMES

Availability of accurate, timely information on registration status

Assurance that all nurses and midwives are currently registered

Compliance with NMC Requirements for Employers

PATIENT OUTCOMES

Provision of consistently high quality Nursing and Midwifery Practice for our patients, carers and service users across the Trust

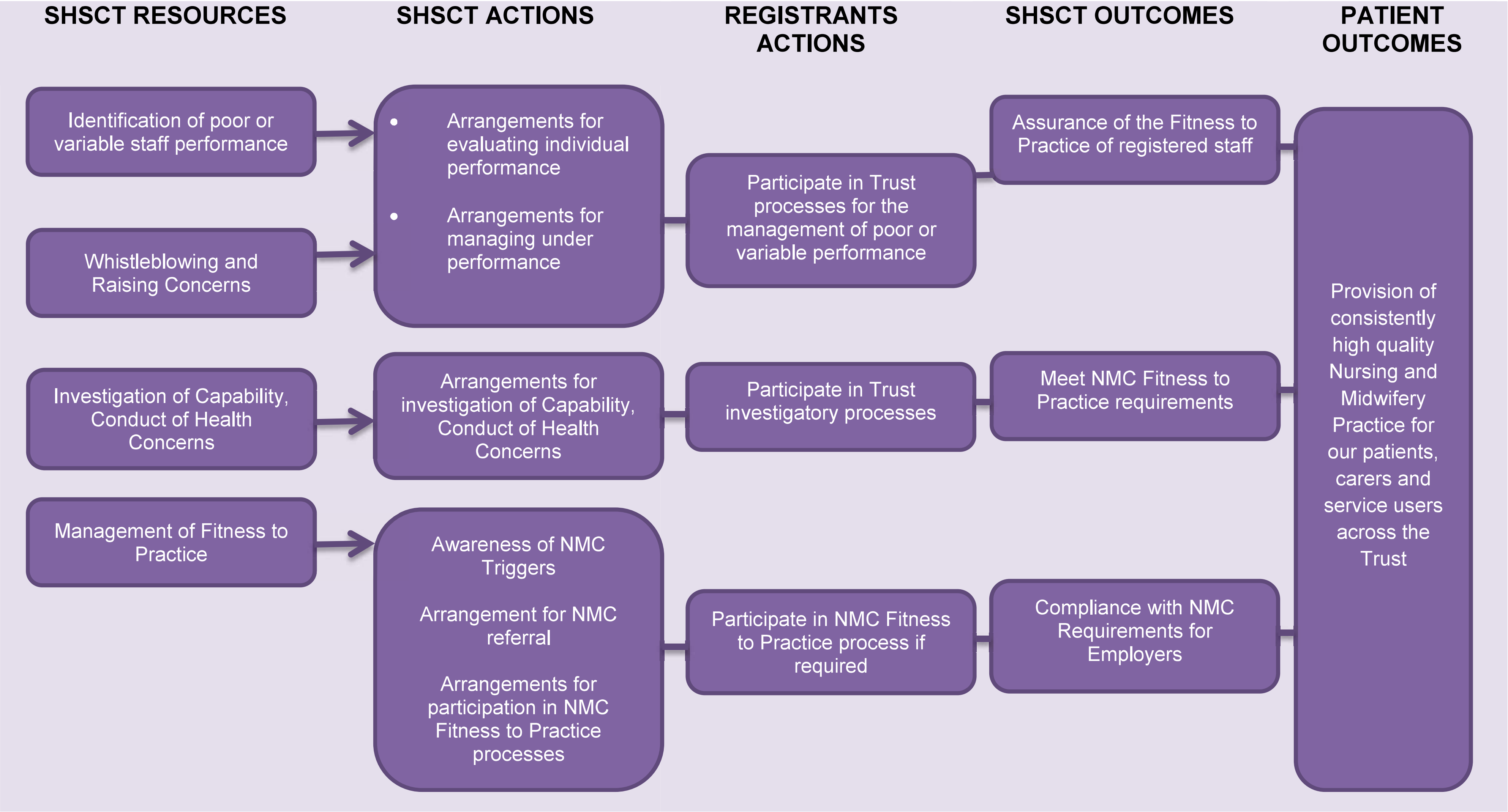
Nursing and Midwifery Practice is provided registered workforce

Southern Health and Social Care Trust

Quality Care - for you, with you

Accountability and Assurance Framework
Nursing and Midwifery

Handling Concerns



SHSCT RESOURCES

Identification of poor or variable staff performance

Whistleblowing and Raising Concerns

Investigation of Capability, Conduct of Health Concerns

Management of Fitness to Practice

SHSCT ACTIONS

- Arrangements for evaluating individual performance
- Arrangements for managing under performance

Arrangements for investigation of Capability, Conduct of Health Concerns

Awareness of NMC Triggers

Arrangement for NMC referral

Arrangements for participation in NMC Fitness to Practice processes

REGISTRANTS ACTIONS

Participate in Trust processes for the management of poor or variable performance

Participate in Trust investigatory processes

Participate in NMC Fitness to Practice process if required

SHSCT OUTCOMES

Assurance of the Fitness to Practice of registered staff

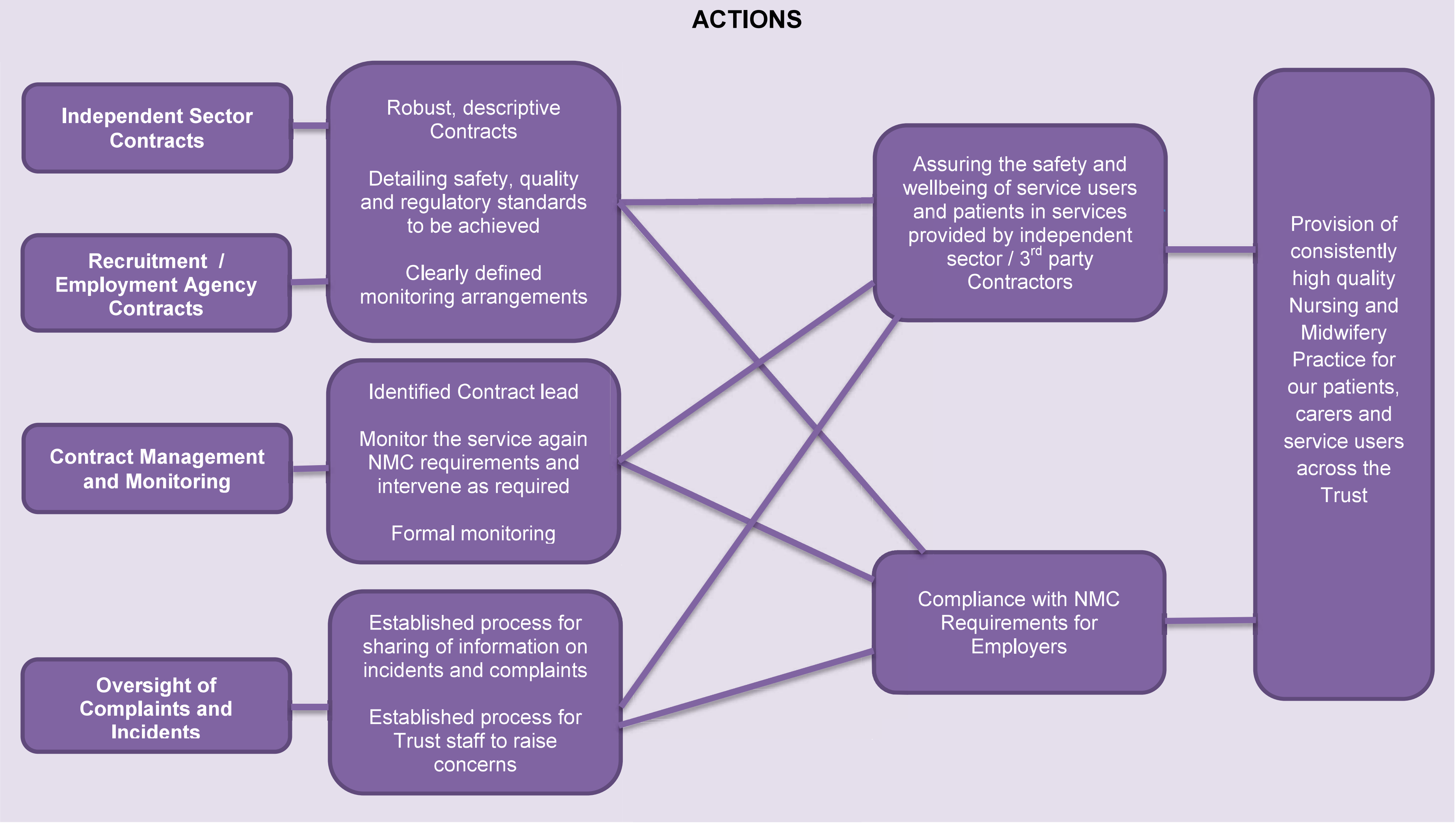
Meet NMC Fitness to Practice requirements

Compliance with NMC Requirements for Employers

PATIENT OUTCOMES

Provision of consistently high quality Nursing and Midwifery Practice for our patients, carers and service users across the Trust

Accountability and Assurance Framework
Nursing and Midwifery
Quality of Nursing in the Independent Sector



SHSCT RESOURCES

SHSCT ACTIONS

REGISTRANTS ACTIONS

SHSCT OUTCOMES

PATIENT OUTCOMES

Independent Sector Contracts

Recruitment / Employment Agency Contracts

Contract Management and Monitoring

Oversight of Complaints and Incidents

Robust, descriptive Contracts

Detailing safety, quality and regulatory standards to be achieved

Clearly defined monitoring arrangements

Identified Contract lead

Monitor the service again NMC requirements and intervene as required

Formal monitoring

Established process for sharing of information on incidents and complaints

Established process for Trust staff to raise concerns

Assuring the safety and wellbeing of service users and patients in services provided by independent sector / 3rd party Contractors

Compliance with NMC Requirements for Employers

Provision of consistently high quality Nursing and Midwifery Practice for our patients, carers and service users across the Trust

Southern Health and Social Care Trust

WORKING WELL TOGETHER POLICY

Author	Regional HR Policy Group
Directorate responsible	Human Resources & Organisational Development
Date	July 2009
Review date	July 2012

CONTENTS *PAGE No.*

Working Well Together Policy

Procedure for dealing with issues of conflict

SOUTHERN HEALTH AND SOCIAL CARE TRUST

WORKING WELL TOGETHER POLICY

1.0 INTRODUCTION

1.1 The Trust recognises its staff are its greatest resource and aims to promote a working environment that is safe, productive and characterised by fair treatment, strong teamwork, open communication, personal accountability and development opportunities. This is essential to the well being of all staff and also the patients/clients with whom staff come into contact with.

1.2 Positive interpersonal behaviour is key to working well together. It is not a requirement to like or be friendly with work colleagues, however it is essential that staff behave appropriately and treat each other with respect. It is about fostering a climate of dignity and respect by and for all staff at and between all levels. This will help create the sort of organisation that staff want to be part of and feel proud to work in.

2.0 PURPOSE AND AIMS

2.1 The purpose and aims of this policy and associated procedure are:

2.1.1 To affirm that a harmonious working environment, free from conflict, is something for which **all** staff have responsibility.

2.1.2 To outline to managers their responsibilities to create and maintain a harmonious, positive and enabling environment for all staff.

2.1.3 To provide a mechanism for promptly addressing any issues which may arise.

3.0 POLICY STATEMENT

3.1 The Trust recognises the diversity within its workforce and is committed to the principle that the dignity of all staff must be respected and that all staff should feel valued within the workplace. The Trust will work towards creating a harmonious environment that is characterised by fair treatment.

3.2 It is recognised that on occasions poor working relationships between staff can develop. The Trust therefore will ensure that there are mechanisms in place to address these situations effectively and promptly.

3.3 Conflict can take many forms. It can range from adverse comments, destructive criticism, ignoring someone at work to bullying behaviour and can have a negative impact not only on the staff involved but also on the wider working environment. Issues of conflict, which affect the ability of the staff to work well together, will be taken seriously and addressed. They may require formal investigation, which subsequently may result in disciplinary action being taken.

4.0 SCOPE

4.1 This policy applies to:

4.1.1 **All** employees of the Trust

4.1.2 Conduct both within the workplace and outside the workplace in circumstances that are considered to be work-related and includes social events.

4.2 This policy is intended to compliment existing Trust policies and procedures in relation to promoting dignity at work for staff. Where one or more of the nine equality dimensions listed in section 75 of the Northern Ireland Act 1998 is alleged to underpin workplace conflict between two or more parties, the issue will be dealt with under the Trust's Policy and Procedure for Dealing with Harassment in the Workplace.

5.0 RESPONSIBILITIES

5.1 Director of Human Resources and Organisational Development,

5.1.1 The Chief Executive has appointed the Director of Human Resources and Organisational Development as Lead Director with responsibility for monitoring the implementation and operation of this policy.

5.2 Managers

5.2.1 Managers and supervisors have a responsibility to lead by example and develop a working environment which ensures all staff respect and treat each other with dignity.

5.2.2 Opportunities for creating positive working relationships should be implemented and supported:

Examples:

Recognition to staff for a job well done
Encouragement and positive feedback
Seeking opportunities to engage and involve staff
Multi-disciplinary team working
Regular team meetings
Open, honest and transparent communication
Celebration of achievement

5.2.3 Managers have a specific duty to be vigilant to the behaviour of staff within their team and are responsible for addressing actions that might cause offence to others.

5.2.4 Managers must make every effort to ensure that conflict does not arise within their teams, or promptly deal with it if it does. Any remedial action must be taken speedily and the issues dealt with until resolution is achieved.

5.2.5 Staff should be informed, by managers, of the requirement under this policy to 'work well together'. This should form part of the individual's induction programme at both corporate and departmental levels.

5.3 All employees

5.3.1 Staff have a responsibility to ensure that they treat their colleagues, including managers, with dignity and respect and help create a harmonious environment where conflict is unacceptable.

5.3.2 Staff should help to support their colleagues who may be experiencing conflict and alert their manager of their concerns.

5.3.3 Staff should effectively participate in team working within their department.

5.3.4 Staff who find themselves in a conflict situation should seek to resolve it immediately either themselves or by seeking support from a manager, Trade Union representative or work colleague. It is important that staff seek to raise such issues at an early stage before they have an opportunity to develop further.

5.3.5 Staff must not allow situations of misunderstanding to develop into conflict and should seek assistance to address the situation.

5.4 Trade Union Representatives

5.4.1 Trade Union representatives will be proactive in developing a working environment where all are treated with dignity and respect and where conflict is unacceptable.

5.4.2 Representatives will work with managers in contributing towards developing and maintaining a positive and harmonious working environment.

5.4.3 Representatives will encourage and support staff to seek an early resolution to a conflict situation.

6.0 COMMUNICATION

6.1 This policy will be communicated to all staff so that they:

(i) understand the Trust's commitment to eliminating unacceptable behaviour at work, and

(ii) know how to make complaints and are confident that these will be handled effectively.

6.2 Copies of the policy are available from the Trust's Intranet site, the Employee Engagement and Relations Department or from your line manager.

7.0 SUPPORT

7.1 Resolution of a complaint is likely to be a distressing experience for all concerned. Therefore, all cases will be handled with the highest degree of sensitivity.

7.2 All parties in any complaint may seek the help and support of a Trade Union representative or work colleague who may be present, at the request of the member of staff, at any or all stages of the process.

7.3 All parties may access the Confidential Counselling Services offered by the Trust's Occupational Health Department and Care Call Scheme.

8.0 MONITORING AND REVIEW

8.1 The Trust will monitor complaints to assess trends and the operational effectiveness of this policy. This policy will be reviewed periodically in consultation by the HSC (NI) Joint Negotiation Forum.

9.0 EQUALITY AND HUMAN RIGHTS COMPLIANCE

9.1 This policy has been screened for equality implications as required by Section 75 and Schedule 9 of the Northern Ireland Act 1998. Equality Commission guidance states that the purpose of screening is to identify those policies which are likely to have a significant impact on equality of opportunity so that greatest resources can be devoted to these.

9.2 Using the Equality Commission's screening criteria, no significant equality implications have been identified. The policy will therefore not be subject to an equality impact assessment.

9.3 Similarly, this policy has been considered under the terms of the Human Rights Act 1998, and was deemed compatible with the European Convention Rights contained in the Act.

10.0 ALTERNATIVE FORMATS

10.1 This document can be made available on request in alternative formats, e.g. plain English, Braille, disc, audiocassette and in other languages to meet the needs of those whose first language is not English.

11.0 COPYRIGHT

11.1 The supply of information under the Freedom of Information does not give the recipient or organisation that receives it the automatic right to re-use it in anyway that would infringe copyright. This includes, for example, making multiple copies, publishing and issuing copies to the public. Permission to re-use the information must be obtained in advance from the trust.

12.0 GENERAL INFORMATION/SOURCES OF ADVICE

12.1 Further information about this policy may be obtained in the supporting procedure / guidelines or by contacting the Employee Engagement and Relations Department.

WORKING WELL TOGETHER POLICY

PROCEDURE FOR DEALING WITH ISSUES OF CONFLICT

1.0 INTRODUCTION

1.1 The Trust affirms its commitment to ensuring that the dignity of all individuals is respected in the workplace and that a harmonious environment free from conflict is created and maintained. It is recognised that from time to time, working relationships can be less effective than they should be and this can lead to conflict or tension.

1.2 This procedure has been developed in order to detail how the Trust deals with issues of work related conflict.

2.0 STAGE 1: INFORMAL PROCESS

2.1. Best practice indicates that early and informal intervention is the most effective method of dealing with issues of conflict. An informal approach often serves to reduce the impact of conflict on the individuals concerned, thereby reducing the risk of interruption to the service.

2.2 A **member of staff** should seek to resolve matters by considering the following:

2.2.1 Approaching the other individual involved at an early stage and making it clear that their behaviour is offensive, not welcome and should stop; or

2.2.2 Seeking support from a manager, Trade Union representative or work colleague to address the matter.

2.2.3 Asking for a facilitated meeting with the other individual in order to move towards an informal resolution.

2.3 If an individual wishes to raise an issue about their immediate line manager and feels they cannot approach that person directly, they should seek advice or support from the next higher level of management in their department.

2.4 **Managers** should seek to resolve matters by:

2.4.1 Ensuring that they take the matters raised by the member of staff seriously and deal with them without delay and in a fair manner.

2.4.2 Facilitating discussion with the parties involved but outside of any formal action. This may be initially through individual meetings or at a later stage in the process through a facilitated round table discussion.

2.4.3 Retaining notes of the issues raised and how they were resolved. This should also be put in writing to the individuals concerned so that they have a record.

2.4.4 Following up with individuals after issues have been resolved to ensure that all is well.

2.5 Mediation can be offered in cases where the potential exists for the issue(s) to be resolved informally.

3.0 STAGE 2: FORMAL PROCESS

3.1. Stage 2 cannot be initiated until Stage 1 has been exhausted and the matters remain unresolved.

3.2. Where the matters remain unresolved following informal Stage 1, a formal investigation can be initiated by the complainant.

3.3. An investigating team will be appointed to establish the facts relating to the conflict. The investigating team will have the authority to interview all relevant persons and examine all documentation relating to the case.

3.4. The investigation should normally be completed as quickly as possible, normally within 8 – 12 weeks. If this is not possible, for any reason, both parties will be informed of the revised timetable.

3.5. Confidentiality should be maintained as far as is compatible with thorough investigation and the effective handling of the case.

3.6. Both parties may be accompanied by a work based friend or trade union representative during any interviews.

3.7. If deemed necessary, appropriate action will be taken to avoid contact between the parties involved.

3.8. Where a case of serious misconduct has been alleged by one party against the other, consideration may be given to a precautionary suspension, on full pay, before the investigation proceeds further.

3.9. Witnesses may be interviewed if deemed necessary.

3.10. During all interviews, notes will be taken and interviewees will be given the opportunity to examine these notes and will be asked to sign them to confirmed that they are an accurate reflection of the interview.

3.11. If any of the parties involved or witnesses are absent from work due to sickness, arrangements may be made, following advice from the Trust's Occupational Health Department, to interview such persons at home or at a suitable neutral location. This is to ensure that matters can be brought to a conclusion within a reasonable timeframe.

3.12. At every stage in the investigation, it will be stressed to all those involved, that the matter must be treated in the strictest confidence.

3.13. The investigating team will then prepare a full report, summarising the evidence gathered during the investigation and findings.

3.14. The report will be considered by a senior Human Resources Representative who will decide on any appropriate action which is needed to remedy the situation, in conjunction with the relevant service manager.

3.15. Both parties will be advised in writing of the conclusions to the investigation and any action to be taken.

4.0 REQUEST FOR REVIEW

4.1. Either party may submit a request for review within 14 days of receiving the outcome of the investigation. A review will only be permitted on the grounds that it is considered by either party that the process of investigation has been unfairly or poorly carried out.

4.2. The managers considering the review should not previously have been involved in the case.

5.0 CONSIDERATION OF REDEPLOYMENT

5.1. In the event of a total breakdown of relationships, consideration may be given to requests or the need for redeployment.

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Policy Checklist

Name of Policy:	**Nursing Supervision Policy**
Purpose of Policy:	To ensure that a culture of Nursing Supervision is embedded in the Southern Health and Social Care Trust and that the processes through which Supervision is carried out are integral to the organisational arrangements for the delivery of safe and effective care.
Directorate responsible for Policy	Executive Director of Nursing
Name & Title of Author:	Margaret Marshall, Assistant Director of Nursing Governance Paula Fearon, Nursing Governance Co-ordinator
Does this meet criteria of a Policy?	Yes
Trade Union consultation?	Yes
Equality Screened by:	NA
Date Policy submitted to Policy Scrutiny Committee:	9th July 2018
Members of Policy Scrutiny Committee in Attendance: Electronically by membership of Policy Scrutiny Committee	
Policy Approved/Rejected/ Amended	19th July 2018
Policy Implementation Plan included?	N/A – reviewed policy
Any other comments:	
Date presented to SMT	N/A – reviewed policy
Director Responsible	Director of Nursing and AHP’s
SMT Approved/Rejected/Amended	N/A
SMT Comments	

POLICY DOCUMENT – VERSION CONTROL SHEET	
Title	Nursing Supervision Policy Version 3 July 2018
Supersedes	Version 2_0_August 2011
Originator	Margaret Marshall, Assistant Director of Nursing Governance
Scrutiny Committee & SMT approval	Referred for approval by: Margaret Marshall Date of Referral:10th July 2018 Scrutiny Policy Committee Approval 9th July 2018 SMT approval (Date)
Circulation	Issue Date: 20th July 2018 Circulated By: Assistant Director of Nursing Governance
Review	Review Date: September 2019 Responsibility Margaret Marshall, Assistant Director of Nursing Governance

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POLICY TITLE:	**Nursing Supervision Policy**
ACCOUNTABLE DIRECTOR:	Heather Trouton, Interim Executive Director of Nursing
POLICY AUTHOR:	Margaret Marshall, Assistant Director of Nursing Governance
CO-ORDINATOR FOR IMPLEMENTATION PLAN:	Heather Trouton, Interim Executive Director of Nursing
DATE APPROVED BY POLICY SCRUTINY COMMITTEE:	9th July 2018
DATE APPROVED BY SMT:	N/A – Policy Review

Contents *Page No.*

Appendices

1.0 Introduction

The importance of effective Supervision has been highlighted in regional critical incident inquiries such as the Lewis Review (2003)[1], Murtagh Review (2005)[2], and McCleery Report (2006)[3]. The Quality Standards for Health and Social Care (DHSSPS 2007)[4] recommend an effective system for Supervision across Health and Social Care (HSC) to help organisations meet each of the Clinical and Social Care Governance Standards.

It is recognised that effective Supervision processes improve: recruitment and retention of nursing staff; job satisfaction; professional autonomy; and reduces absenteeism[5].

1.1 This revised policy and "*Guidance on Nursing Supervision*" (Appendix 1) have been produced to support the continuing development and maintenance of a robust system of Supervision for nursing staff who work within the Southern Health and Social Care Trust (SHSCT).

1.2 The Review of Clinical Supervision for Nursing in the Health and Personal Social Services (Ireland and UK) (HPSS) (2007)[6] recommended action to enhance and promote professional Supervision for Nursing in Trusts throughout Northern Ireland.

The report defined Supervision as:
'a process of professional support and learning, undertaken through a range of activities, which enables individual registrant nurses to develop knowledge and competence, assume responsibility for their own practice and enhance service-user protection, quality and safety'.

Following this the Chief Nursing Officer (CNO) published Standards for Supervision for Nursing[7] which contained 2 Regional Standards.

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[1] Lewis, RJ, Cole, D, Williamson, A (2003). Review of Health and Social Services in the case of David and Samuel Briggs. Belfast, DHSSPS

[2] Regional Quality Improvement Authority (2005). Review of the lessons arising from the death of the Late Janine Murtagh, Belfast, RQIA

[3] McCleery Inquiry Panel (2006). Executive Summary and Recommendations from the report of the Inquiry Panel (McCleery) to the Eastern Health and Social Services Board, Belfast, DHSSPS

[4] Department of Health, Social Services and Public Safety (2007). The Quality Standards for Health and Social Care. Belfast, DHSSPS

Hyrkäs, K., Appelqvist-Schmidlechner, K. and Haataja, R. (2006). Efficacy of clinical Supervision: Influence on job satisfaction, burnout and quality of care. *Journal of Advanced Nursing*.55(4), 521-535

http://www.nipec.hscni.net/download/projects/current_work/highstandards_practice/framework_for_Supervision_in_nursing_and_miwifery/documents/Supervision-in-Nursing-in-NI-Review-of-Current-Processes.pdf

Chief Nursing Officer for Northern Ireland (2007) *Standards for Supervision for Nursing*. Belfast, DHSSPS

1.3 Other outcomes were : a Regional Policy and Procedure document, a Frequently Asked Questions Leaflet ; standardised record keeping resources including contracts for supervisors and supervisees; a regional approach to the preparation of supervisors and supervisees.

A Supervision Regional Forum was charged with directing and supporting the implementation of the Standards. This was facilitated by Northern Ireland Practice and Education Council for Nursing and Midwifery (NIPEC). The Standard Statements were revised as follows:-

Standard Statement 1 *Supervision will contribute to the delivery of safe and effective care when practitioners have access to appropriate systems that facilitate the development of knowledge and competence through a culture of learning by reflection.*

Standard Statement 2 *An organisational framework supporting effective leadership and performance management will ensure that Supervision will become an effective tool to improve the safety and quality of care.*

1.4 NIPEC annually evaluates Supervision process and perceived impact on practice. Each Trust receives a confidential report. The Chief Nursing Officer (CNO) monitors Trust compliance with the Standards through annual reports from each HSC Trust's Executive Director of Nursing (EDoN).

1.5 In June 2016 the CNO and Central Nursing and Midwifery Advisory Committee (CNMAC) agreed to the development of a single regional overarching Nursing and Midwifery Supervision Framework. The new model must provide professional accountability assurances to the CNO, Executive Directors of Nursing and the public. NIPEC is facilitating this development and has reviewed the current Supervision processes. It had been hoped the Framework would be completed by 2017, however work, although near completion, is ongoing. Progress can be tracked via the following link:
http://www.nipec.hscni.net/download/projects/current_work/highstandards_practice/framework_for_Supervision_in_nursing_and_miwifery/documents/Supervision-in-Nursing-in-NI-Review-of-Current-Processes.pdf

As an interim measure, the previously agreed Regional Nursing Supervision Policy (SHSCT) has been reviewed and revised here-in.

2.0 Aim of the Policy

This policy identifies Supervision in Nursing as a key organisational objective for all Health and Social Care (HCS) Trusts in Northern Ireland. The aim of this policy is to ensure that a culture of Nursing Supervision is embedded in the SHSCT and that the processes through which Supervision is carried out are integral to the organisational arrangements for delivery of safe and effective care in the Trust.

2.1 The implementation of an effective system of Supervision for Nursing will help ensure:-

- The promotion and maintenance of Nursing Care Standards,
- A competent and skilled workforce,
- Delivery of safe and effective care; and
- A supportive professional environment for nursing staff.

2.2 Senior management teams in the SHSCT must ensure that appropriate measures are in place to enable Supervision activities for both clinical and non-clinical teams.

3.0 Policy Statement

The SHSCT acknowledges the importance of Nursing Supervision in ensuring the delivery of safe and effective nursing care and the essential role it plays in protecting the public.

The SHSCT stipulates that all nurses it employs should have access to and avail of, a minimum of two Supervision sessions per year. The Trust must ensure there are effective systems in place to support Supervision processes. All supervisors must be supported to acquire the appropriate knowledge and skills to competently undertake this role.

4.0 Definition and Scope of the Policy

The Department of Health, Social Services and Public Safety (DHSSPS) adopted the following definition of Supervision for Nursing following *The Review of Clinical Supervision for Nursing in the HPSS* undertaken by NIPEC in 2006:

'Supervision is defined as a process of professional support and learning, undertaken through a range of activities, which enables individual registrant nurses to develop knowledge and competence, assume responsibility for their own practice and enhance service-user protection, quality and safety', NIPEC 2006[8]

4.1 The SHSCT requires all registered nurses to have a minimum of two formal Supervision sessions per year. Registrants are likely to engage in other activities which could also support the Supervision process. The Regional Forum acknowledged that a variety of diverse approaches and activities could be employed in implementing Supervision. Some examples are included in Appendix 2.

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[8] Northern Ireland Practice and Education Council (2007) The Review of Clinical Supervision for Nursing in the HPSS 2006 on Behalf of the DHSSPS. Belfast, NIPEC.

4.2 It should be noted that the scope of Safeguarding Children Supervision differs from Supervision referred to in this Policy. Safeguarding Children is separate from, but complimentary to, other forms of Supervision. Safeguarding Children Supervision provides specialist professional advice, case management and support to staff in their safeguarding of children. This includes children in need of protection; children in need; looked after children and families of concern.

The **Safeguarding Children Nursing Supervision** process includes the assessment of staff performance, professional development in relation to safeguarding children and families and quality assurance of practice to ensure compliance with best practice guidelines.

Further information is available via:

- DHSSPS Safeguarding Children Supervision Policy for Nurses (2011).
- https://www.health-ni.gov.uk/sites/default/files/publications/dhssps/safeguarding-children-supervision-policy.pdf
- *The SHSCT Policy, Procedures and Guidance for Registered Nurses, Midwives and Specialist Community Public Health Nurses on Safeguarding Children and Young People (Revised May 2018).* This is available on the Trust Intranet and SharePoint http://sharepoint/gov/home/Policies%20and%20Procedures/Forms/AllItems.aspx?RootFolder=%2Fgov%2Fhome%2FPolicies%20and%20Procedures%2FPolicies&FolderCTID=0x0120002BE1109E37E47349B3DE6A07F51171ED&View=%7B39B022B7%2DEAF5%2D4CE3%2D8BC9%2D6EE55B567DC4%7D

4.3 Midwifery Supervision in Northern Ireland

The awaited Framework for the overarching Supervision of Midwifery, Nursing and Safeguarding Children will be introduced on the completion of the CNO-commissioned NIPEC work. Whilst this work is ongoing, Midwifery (as well as Nursing and Safeguarding) Supervision will continue in Northern Ireland.

Northern Ireland has taken forward legislative changes to the Nursing and Midwifery Order 2001 effective from 31st March 2017. Northern Ireland has taken forward legislative changes to the Nursing and Midwifery Order 2001 effective from 31st March 2017. This removed Supervision from its statutory regulation components. Until the review of supervision is completed by NIPEC midwifery supervision will continue in the agreed format as determined by the Midwifery Working group September 2016.

Details of the arrangements from April 2017 until the overarching Supervision of Midwifery, Nursing and Safeguarding Children can be found via the following link: https://www.health-ni.gov.uk/articles/changes-midwife-Supervision-uk

5.0 Supervision and Appraisal

It is important that Supervisors and Supervisees in the SHSCT recognise and differentiate Supervision activity from other processes such as appraisal. Whilst Supervision activity informs and is informed by the Agenda for Change Knowledge and Skills Framework Annual Review Process, neither activity should be substituted for the other, each activity having a different purpose.

6.0 Responsibilities

In the SHSCT there are key individuals in posts with responsibility for ensuring Nursing Supervision is implemented. They are: -

6.1 Chief Executive

The Chief Executive of the SHSCT accepts responsibility and accountability for quality service provision at Trust Board level which includes systems, such as Supervision in Nursing, which support clinical and social care governance.

6.2 Executive Director of Nursing

The Executive Director of Nursing, in conjunction with the Operational Directors in the SHSCT is accountable to the Chief Executive for the implementation and maintenance of Supervision in Nursing. The Executive Director of Nursing presents the Trust Report to both the Trust Board and the Chief Nursing Officer for Northern Ireland on an annual basis. In addition, s/he may act as a supervisor for Assistant Directors and other senior professional roles when appropriate.

6.3 Directors

All Directors have responsibility for ensuring that arrangements are in place within their directorate to evidence compliance with this policy and that resources are available to support Nursing Supervision, monitoring and reporting processes.

6.4 Assistant Director of Nursing Governance

The Assistant Director of Nursing Governance has responsibility to co-ordinate, facilitate, evaluate and maintain a system of Supervision in the Nursing workforce. S/he is accountable to the Executive Director of Nursing and for presenting information relevant to the quantity and quality of SHSCT Supervision activity in governance reports or accountability reviews.

6.5 Operational Assistant Directors

Operational Assistant Directors have responsibility to co-ordinate and facilitate implementation and maintenance of Supervision for nurses within their individual directorates. They are responsible for agreeing the models of Supervision to be employed within the division/directorate and must ensure appropriate resources are in place to enable nurses to undertake at least two formalised sessions of Supervision annually. They are responsible for monitoring the ongoing level of Supervision activity within individual directorates and will facilitate the Assistant Director of Nursing Governance in collation of reports

6.6 Heads of Service/Nurse Managers/Lead Nurses

Heads of Service/Nurse Managers/Lead Nurses have a responsibility to promote, co-ordinate and facilitate implementation and maintenance of Supervision for nurses within their individual directorates/divisions. They are accountable to the Operational Assistant Director and can act as supervisors for Ward Managers/Team Leaders within their own division/directorate.

6.7 Ward Managers/Team Leaders

Ward Managers/Team Leaders have a responsibility to role-model and facilitate implementation and maintenance of Supervision for nurses within their staff teams. They are accountable to the Heads of Service. They can act as supervisors for other members of staff, either within or outside their own team.

6.8 Supervisors

Supervisors have a responsibility to maintain and develop their own skills and competencies relative to Supervision activity, contribute to the models of learning and to the approaches used. They must seek and undertake Supervision themselves, maintaining records for both their personal Supervision and professional Supervision of others. They must provide at least two formal sessions of Supervision annually for each supervisee, whether group or individual. They must adhere to ground rules identified and conduct Supervision sessions within the principles and process identified in these procedures. They are accountable to their line managers for this activity.

6.9 Supervisees

Supervisees have a responsibility to engage fully in the nursing supervision process, adhering to identified ground rules. They have a responsibility to prepare for, and participate in, a minimum of two formal Supervision sessions per year, keeping accurate records of relevant actions. Activities undertaken between sessions should be used to inform formal Supervision sessions. Supervisees are accountable to their line manager to engage in a minimum of two formal supervision sessions annually.

7.0 Legislative Compliance, Relevant Policies, Procedures

This policy should be read in conjunction with the:-

- Southern Trust Policy, Procedure and Guidance on Record Keeping as outlined in the content and appendices of this document.
- Safeguarding Board for Northern Ireland (SBNI) Regional Core Child Protection Policy and Procedures (2017).
- DHSSPS Safeguarding Children Supervision Policy for Nurses and Midwives (2011) - currently under Regional review

http://vsrintranet.southerntrust.local/SHSCT/HTML/PandP/documents/RecordsManagementProcedures_001.pdf

https://www.nmc.org.uk/globalassets/sitedocuments/nmc-publications/nmc-code.pdf

http://sharepoint/gov/home/NMC1/NMC%20Standards%20for%20Competence/NMC%20Standards%20for%20competence%20for%20Registered%20Nurses.pdf

http://sharepoint/gov/home/NMC1/NMC%20Standards%20for%20Competence/NMC%20Standards%20for%20Competence%20for%20Registered%20Midwives.pdf

http://revalidation.nmc.org.uk/

https://www.health-ni.gov.uk/articles/changes-midwife-Supervision-uk

https://www.ombudsman.org.uk/publications/midwifery-Supervision-and-regulation-recommendations-change/current-midwifery-Supervision-and-regulation-nursing-and-midwifery-councils-role

8.0 Equality and Human Rights Considerations

This policy has been screened for equality implications as required by Section 75, Schedule 9, of the Northern Ireland Act, 1998. Equality Commission for Northern Ireland Guidance states that the purpose of screening is to identify those policies which are likely to have a significant impact on equality of opportunity so that greatest resources can be targeted at them.

Using the Equality Commission's screening criteria, no significant equality implications have been identified. This policy will therefore not be subject to an Equality Impact Assessment.

This policy has been considered under the terms of the Human Rights Act 1998, and was deemed to be compatible with the European Convention Rights contained in that Act.

9.0 This policy will be included in the Trust's Register of Screening Documentation and maintained for inspection whilst it remains in force.

This document can be made available on request in alternative formats, e.g. Braille, disc, audio cassette, and in other languages to meet the needs of those who are not fluent in English.

The SHSCT audit this Policy every two years and make appropriate changes where necessary.

GUIDANCE ON NURSING SUPERVISION

Purpose of Nursing Supervision

The main purpose of Nursing Supervision is to support: -

- Nurses to develop the necessary knowledge, competencies and skills within a role or clinical area, to enhance safe and effective practice and person centeredness;
- Nurses in both clinical and non-clinical roles by providing an opportunity to discuss issues pertinent to the delivery of safe and effective care and / or professional issues;
- Nurses through difficult circumstances such as challenging patient caseloads or difficult interpersonal contact with other team members;
- Nurses to realise personal and professional growth through reflection and facilitation.

Supervision Processes

Frequency of Supervision

Formalised Supervision sessions for nursing staff should take place at least twice per year.

Nursing and Midwifery Mandatory Requirements

The Nursing and Midwifery Council (NMC) has recognised the importance of reflection and subsequent discussion as integral to professional development of nurses and midwives. It has included reflective discussion as a mandatory requirement for Revalidation. http://revalidation.nmc.org.uk/

Nurses can access guidance on reflection and keeping a portfolio with corresponding templates:-
https://www.nmc.org.uk/globalassets/sitedocuments/revalidation/reflective-discussion-guidance.pdf

The pre-requisite Reflective Template can be completed by staff in preparation for Supervision:-
http://revalidation.nmc.org.uk/download-resources/forms-and-templates/

Preparation for Supervision

Registered nurses should reflect on their own practices as they engage in ongoing learning and development activities in their working environment. This experience should be used to inform the Supervision sessions. There are many ways to reflect on practice and approach supervision-some examples are included in Appendix 2.

In order to benefit from Supervision, nurses should prepare appropriately. Preparation will include becoming familiar with and agreeing to, the Ground Rules for the Supervision session. (Appendix 3) Preparation will also include a review of the current Supervision action plan and reflection on the learning activities that have been undertaken between sessions. A Supervision Preparation template to help structure this process can be found at Appendix 4.

General information and guidance on Nursing Supervision is available in the Health and Social Care Trust (HSC) *'Nursing Supervision Information Leaflet - Frequently Asked Questions (updated 2016).*

Issues of Concern

Where an issue of unsafe, unethical or illegal practice is identified, it should be dealt with supportively via appropriate procedures. All parties must be informed of the intention to disclose, before revealing confidential information.

Use of Patient /Client Records

If necessary, patient/client records maybe used for the purposes of Supervision activity. The NMC states that where this happens, principles of access and confidentiality apply, namely:-

- Patients'/clients' health records should only be accessed where necessary;
- The patient/client reserves the right to refuse access to, or limit the information from his/her records; this should be respected.

The SHSCT Records Management Policy[10] and associate procedures should be adhered to. http://vsrintranet.southerntrust.local/SHSCT/HTML/PandP/documents/RecordsManagementProcedures_001.pdf

The NMC no longer have standalone guidance on record keeping, this has been incorporated into the NMC Code.
https://www.nmc.org.uk/standards/code/record-keeping

Recording Supervision

It is essential that written notes of individual sessions are taken, remain confidential and record clearly any agreed actions. Individual sessional notes are the responsibility of the supervisee. The supervisor should, however, keep brief notes and maintain quarterly Sessional Records information which is submitted to the Ward Manager/Team Leader or the appropriate line manager. Copies of the Record of Supervision form can be found in Appendix 5.

Each formalised Supervision session must have a written record signed by both supervisor and supervisee(s).

Storage of Records

The SHSCT Policy for the safe storage of records must be adhered to however, each registrant should also be mindful of his/her professional accountability with regard to the principle of confidentiality of information. Nurses must, therefore, take responsibility for making sure that the system used is managed in such a way that it is appropriately protected to ensure the security of confidential information.

Monitoring and Evaluation

Monitoring and evaluation of Supervision activity are essential to ensure that resources required for professional Supervision are managed effectively. It is also necessary to monitor the benefit to individual registrants, as the quality of Supervision activities can influence professional and clinical effectiveness.

The SHSCT may seek qualitative information periodically from individual registrants to assist in the ongoing evaluation of Supervision processes.

Individual supervisors must record quarterly the number of sessions they engage in and make these returns available to line managers for collation. This information will, in turn, be collated by directorate managers and communicated to the Assistant Director of Nursing Governance, who is responsible for monitoring Nursing Supervision within the Trust.

Formal Supervision sessions (2 per year) must be recorded on the *"KSF Form for use by NMC Registrants – Part B*" and forwarded to the SHSCT Nursing Revalidation Team at the time of yearly appraisal

Part B of the Annual Personal Development Plan can be found on the Trust Intranet under Knowledge and Skills Framework section – *KSF Form for use of NMC Registrants Only*
http://vsrintranet.southerntrust.local/SHSCT/HTML/KSF/documents/KSFFormforNMCRegistrants_001.docx

APPENDIX 2

Range of Supportive Activities

A range of activities can support Supervision in the Nursing workforce. Whichever activity is used each registrant must ensure he/she has the appropriate skills and competencies required to engage in the activity.

Nurses should use the many learning opportunities within their work environments to reflect on their own practice. These *informal* experiences can be used to inform *formal* Supervision sessions.

Examples of activities which support Supervision can be found in Table 1 – overleaf.

Many activities inform Supervision processes; it should, therefore, be noted that this is not a definitive list of activities, merely examples to guide professional teams.

Table 1: Range of Supportive Activities

Reflective Practice Reflective practice is the process of thinking about your own practice and that of others in a structured way; this leads to new and better ways of working and helps you develop new levels of knowledge and competence. You will learn to think critically about your practice and about what you need to do to improve it and the care you provide. Reflection allows you to describe your experience, think about it, and evaluate the outcomes. This should help you to have new understandings and insights. Reflection is what turns experience into meaningful learning, making sense of the world around you, and building on what is happening. You may also find it helpful to use one of the many reflective tools that have been developed.	**Work-Based Learning** A work-based learning programme is provided by an education institution, using a negotiated, project-led approach; this is managed by you and provides the best opportunities for learning and professional development in the workplace. Work-based learning acknowledges that everyone learns in different ways. It gives you control over how and when you learn and takes learning out of the classroom into the workplace. The learning is gained through work-related projects. Work-based learning opens your eyes to the fact that you can learn from anything. Work-based learning in multi-professional teams, making full use of modern technology, can produce benefits to you, the organisation and the profession. Successful completion of the programme will provide you with accredited learning and lead to an academic qualification. It is concerned with helping you to bridge the practice/theory gap.	**Post Incident Review** This happens when an incident has occurred in the workplace that has caused you and/or other members of the healthcare team a level of distress. The incident has usually resulted in a miss or near-miss, where there has or could have been damage to a patient or client. A post-incident review involves the reviewing of specific incidents, either individually or as a team, within a setting that provides emotional support to each person. The incident is analysed with your involvement and the involvement of all team members, using reflection, self-evaluation and/or facilitated learning to establish how the incident happened and how it could be avoided in the future. If you are involved in a post-incident review, it should result in good support from your team members and outcomes and actions for yourself and the team, with possible organisational implications. The final outcome must provide a clear description of risk factors and required action. You should also use the review process to identify personal action plans and required development. This is a learning event for all involved, with the objective of learning to improve practice.
Learning Sets The term refers to a group of people who meet regularly to work and learn together, using a structured format. The learning set can comprise of uni- or multi-professional groups and the focus is on self-directed learning; the participants decide the particular issues to be addressed. This provides you with a confidential forum in which to test issues that concern you, discuss new ideas and help you and the others to challenge working practices in new and creative ways. It is important to set ground rules to deal with issues such as confidentiality. Each member of the group is facilitated and supported by the others in the solving of issues and problems.	**Critical Incident Review** A critical incident is a significant event or experience that has occurred in your workplace and that you feel has had an impact on you or the people you work with. This could be negative or positive; it could be a personal experience or it could result from observing how other people work. You need to examine the incident through a process of reflection, using an evidence-based approach, to identify lessons to be learned. This could also take place with a group of practitioners working together. This should result in new learning for you and/or the group you are working with and result in a short action plan to bring about improvement in practice.	**Group Supervision** This is a valuable learning activity as it helps to develop critical thinking and collaborative working and brings about improvements in Nursing practice. Group Supervision needs to be set up within a structured format to ensure that nurses have the required skills and are supported by experienced colleagues.
Supervised Practice for Competency Development This is a negotiated period of supervised practice, with agreed learning and competency outcomes and may be provided for you if you require to develop specific, identified competencies. It is also likely to be arranged for you if you have poor or failing clinical competence in an area of practice. This is a period of practice where you are supervised and monitored by an experienced practitioner. The length of the supervised practice and the required outcome are set before the exercise begins. You are required to work closely with your supervisor throughout the entire period of practice. You will also be assessed at the end of the supervised practice to demonstrate that you have the necessary knowledge and competence.	**Preceptorship / Mentoring** A mentor is someone who has skills of working with individuals who can provide guidance and support to help you achieve your potential. Your mentor may not be from your own field of practice but should be a person with mentoring experience. Mentoring is achieved through a process of relationship building between yourself and your mentor and takes place over a period of time. The purpose of the mentoring process is to enable you to recognise your own skills and capabilities and maximise the development opportunities available to you.	**Opportunistic Experiences** Often in the course of a working day there is the opportunity to learn from other people or situations in which you might find yourself participating. These experiences are not planned but provide us with a rich learning ground. Examples of these could be: a medicine round where you learn about a new drug regimen; a community patient visit with a tissue viability nurse; discussing the difficulties a palliative patient in your care is experiencing with a colleague; supporting a colleague who has experienced challenging behaviour from a client. All of these situations provide learning which we often reflect on without recording. It is important to make a brief note of the learning provided by these experiences as it can inform other more formal processes in the future.

GROUND RULES FOR 1:1 SUPERVISION

Prior to Supervision session the SUPERVISEE will have: -

- Read all relevant/associated policies, procedures and guidance
- Prepared for the session and will have considered and identified practice areas for open discussion
- Undertaken relevant action(s) as agreed at previous Supervision session(s)

During each Supervision session both **SUPERVISOR** and **SUPERVISEE** will: -

- Maintain mutual respect
- Have an attitude of open learning
- Maintain strict confidentiality
- Be open to constructive feedback
- Engage in reflective practice
- Deal appropriately with areas of disagreement according to the Ground Rules
- Ensure that identified unsafe, unethical or illegal practice is dealt with supportively via appropriate procedures
- All parties must be informed of the intention to disclose, before revealing confidential information
- Explore the supervisee's expectations appropriately using appropriate knowledge, skills and experience

At the end of the Supervision session both **SUPERVISOR** and **SUPERVISEE** will: -

Agree a suitable time and venue for the next session

After the session the **SUPERVISEE** will: -

- Engage in learning and development activities that will inform subsequent Supervision sessions
- Record and reflect on significant activities using a portfolio approach
- Evaluate the perceived benefit of the session
- Maintain and store records in line with Trust Policy

After the session the **SUPERVISOR** will: -

- Complete the Trust's Sessional form(s)
- Maintain and store records in line with Trust policy
- Provide the supervisee with a copy of the session if not already provided
- Evaluate the perceived benefit of the session to the supervise

GROUND RULES FOR GROUP SUPERVISION

Prior to Supervision session the SUPERVISEES will have: -

- Read all relevant/associated policies, procedures and guidance
- Prepared for the session and will have considered and identified practice areas for open discussion
- Undertaken relevant action(s) as agreed at previous Supervision session(s)

During each Supervision session both **SUPERVISOR** and **SUPERVISEES** will: -

- Be sensitive to the needs of individuals and the overall dynamics within the group
- Maintain strict confidentiality by not disclosing or discussing information provided by any other members of a group
- Be supportive of other members of the group
- Listen to and allow other members of the group to speak
- Maintain mutual respect
- Have an attitude of open learning
- Be open to constructive feedback
- Engage in reflective practice
- Deal appropriately with areas of disagreement according to the ground rules
- Ensure that identified unsafe, unethical or illegal practice is dealt with supportively via appropriate procedures
- All parties must be informed of the intention to disclose, before revealing confidential information
- Explore the supervisee's expectations appropriately using appropriate knowledge, skills and experience

At the end of the Supervision session both **SUPERVISOR** and **SUPERVISEES** will: -

Agree a suitable time and venue for the next session

After the session the **SUPERVISEES** will: -

- Engage in learning and development activities that will inform subsequent Supervision sessions
- Record and reflect on significant activities using a portfolio approach
- Evaluate the perceived benefit of the session
- Maintain and store records in line with Trust policy

After the session the **SUPERVISOR** will: -

- Complete the Trust's Sessional form(s)
- Maintain and store records in line with Trust policy
- Provide the supervisees with a copy of the session if not already provided
- Evaluate the perceived benefit of the session to the supervisees

APPENDIX 4

PREPARATION FOR SUPERVISION

NAME ____

DATE ____ / ____ / ____ **VENUE** _________________ **TIME from** ______ **to** ______

Agreed actions from previous session	Progress on action points
Reflection on Learning from previous session	
Issues to be brought forward and discussed at the next meeting	

APPENDIX 5

RECORD OF 1:1 SUPERVISON

Date ____/______/______ Venue ___________________ Time from ______ to _______

SUPERVISEE
PRINT NAME: **SIGNATURE**
SUPERVISOR
PRINT NAME: **SIGNATURE**
Review of Action Points from Previous Supervision Session
Issues / Topics for Discussion
Key Points from Discussion
Agreed Action Plan for Supervisee

Actions	**Timescale**

APPENDIX 5

RECORD OF GROUP SUPERVISION

Date ____ /____/_____ Venue _______________ Time from _____ to _____

SUPERVISEES	**SIGNATURE**
SUPERVISOR(S)	**SIGNATURE**

Review of Action Points from Previous Supervision Session

Issue / Topic for Discussion

Agreed Action Plan for Supervisor (if applicable)		
Actions		**Timescale**
If a significant issue requires onward reporting, record below outline of issues for onward reporting, to who and when it will be reported		
Issue	**Report to**	**Timescale**
Issues / areas of disagreement		
Date and Time of Next Session		
Date		**Time**
Session Evaluation		

Copy to supervisee ☐ **Date ____/____/_____**

APPENDIX 5

Agreed Action Plan for Supervisees	
Actions	**Timescale**

Agreed Action Plan for Supervisor (if applicable)	
Actions	**Timescale**

If a significant issue requires onward reporting, record below outline of issues for onward reporting, to who and when it will be reported Issues / area of disagreement		
Issue	**Report to**	**Timescale**

Issues / areas of disagreement

Date and Time of Next Session			
Date		**Time**	
Session Evaluation			

Copy to supervisees ☐ **Date ____/____/_____**

NHS England

Acute Oncology Service - Peer Review Report

Trust Name: **Southern Health and Social Care Trust**	**Date of Review: Friday 23 November 2018**

Structure and Process

Number	Indicator	SD	PR	Comments
AO-18-001	Single Acute Oncology Group (AOG)	Y	N	The AOG is chaired by the Head of Cancer Services. No clinical oncologist or lead for MSCC
AO -18-002	There is an acute oncology team	N	N	No oncologist currently supporting service due to long term absences. Service not commissioned for haemato-oncology
AO-18-003	There are acute oncology rotas for advice and assessment	N	N	Service is commissioned for weekdays only – therefore nursing cover not provided seven days a week
AO-18-004	Information on Acute Oncology for healthcare professionals	Y	Y	Available on Trust intranet site
AO-18-005	There is a process for immediate essential patient information retrieval	Y	Y	Regional electronic patient records system
AO-18-006	There are agreed patients pathways	Y	N	Agreed regional pathways have

				not been adapted to include local contact details.
AO -18-007	There are clinical guidelines in place.	Y	Y	NICaN Clinical guidelines are in place; these are reviewed and updated centrally.

The Southern Health and Social Care Trust (SHSCT) is an integrated Trust, providing acute and community hospital services together with a range of community health and social services to a population of approximately 360,000. Acute services provided include diagnostics/MRI, emergency care, theatres, day procedures, endoscopy, and inpatient acute care with intensive care services available in the main Craigavon Hospital site. The Acute Oncology Service (AOS) is commissioned at Craigavon Hospital only.

The Daisy Hill Hospital site is thirty miles away from the Craigavon Area Hospital and has inpatient beds plus an Emergency Department (ED) but with no on site MRI. Craigavon Area Hospital is designated as the Cancer Unit for the Southern area of the province providing ambulatory systemic anti-cancer therapy/chemotherapy services. Patients with cancer are not treated with standard multi-modality cancer therapies at the Daisy Hill Hospital but do present via the ED; where they are triaged, treated and or then transferred to Craigavon Hospital. Patients are referred to the Trust with all of the common cancers for diagnostic and surgical treatment; this includes breast, colorectal, gynaecology, urology, lung, upper GI and thyroid. Some of the rarer cancers are managed on a shared arrangement and proceed to the Cancer Centre in Belfast for surgery such as lung and gynaecology. Paediatric and orthopaedic related primary cancers are directly referred to the cancer centre. Patients have access to site specific Clinical Nurse Specialists (CNS) for each of the following tumour sites; lung, colorectal, breast, gynae, upper GI, skin, haematology, urology plus head and neck.

The oncology consultant service is delivered as an outreach service by the Belfast Health and Social Care Trust (BHSCT) with visiting oncologists providing outpatient clinics enabling onsite chemotherapy. Radiotherapy treatment is provided by BHSCT.

The Mandeville chemotherapy unit is based at the Craigavon Hospital and provides a telephone helpline for patients attending for chemotherapy treatment. Out-of-hours, the helpline is available through the haematology ward. The Trust has recently piloted a three-month trial whereby a band 3 member of the healthcare team triages the calls received, as many were found to be in relation to request for changes in appointments times rather than calls requiring clinical help and support. Historically, the Mandeville unit has provided a service for the management of paracentesis and pleural effusion but with no current speciality doctor provision; this service has been relocated to another Trust. This change in location of service provision will have had a detrimental impact on the ease, speed of access and continuity of care for local patients. During the review discussion, the Head of Cancer Services reported that this service could be re-established as a nurse led service if appropriate nursing resources were available.

The Acute Oncology Service (AOS) was established in 2013 with agreed funding for 1.0 whole time equivalent (WTE) Acute Oncology Consultant and 1.5 WTE Acute Oncology CNSs with 0.5 WTE Support Worker. There is also a 1.0 WTE Oncology Speciality doctor based in the Mandeville Unit.

The reviewers were pleased to meet the Acute Oncology CNSs, Chemotherapy Sister, Macmillan General Practitioner, Research Nurse, Administration Manager, Specialist Palliative Care Consultant, ED Consultant/Clinical Director, Head of Cancer Services and Macmillan Cancer Service Improvement Lead which facilitated an open and honest review of the local service.

There is an Acute Oncology Group (AOG) which is currently led and chaired by the Head of Cancer Services. The group has named core membership from haemato-oncology, specialist palliative care, primary care, clinical nurse specialists with named secretarial support. The AOG has named extended members who attend meetings on an ad-hoc basis when their particular expertise is needed. The GP representative who attended the review meeting reported that the group had been pro-active in involving primary care, and they complimented the hard work and competence of current AOS CNSs. There are agreed Terms of Reference for the AOG which include the frequency of meeting, with three having been held within the last year. Copies of AOG minutes showed good attendance. There are established escalation procedures in place for highlighting issues and registering risks at Board level. However the AOG is not quorate as there is currently no named oncologist nor is there an identified lead for Metastatic Spinal Cord Compression (MSCC); this will impact on service development and delivery of the AOS. The lack of a named lead for MSCC within the Trust is further compromised by the lack of a regional coordinator. The reviewers were informed that there are often delays in the AO team being advised on whether MSCC patients referred to the spinal team are suitable for surgical treatment or not. The reviewers were concerned that these potential delays may seriously compromise patient experience and best clinical outcome.

The reviewers were informed that recruitment for oncologists including locums is a real challenge and the management team have been unsuccessful on a number of times in their attempts to recruit to this role. The lack of an Oncologist is exacerbated by the long-term absence of the speciality doctor which means the service is further compromised as there is limited support for the nursing team. The head of cancer services stated that the team are hopeful that they may be able to recruit a locum GP with special interest. The reviewers were concerned that this lack of consultant oncologist/specialist doctor input to the AOS has the potential to impact on the timely triage, care and treatment of patients.

The commissioned service model for the Acute Oncology provision currently is for a single site and does not take in to account that cancer patients have the potential to be admitted to each of the Trust`s sites via the two EDs; while the service model does not allow nursing resource to be physically present on both sites; the AO nursing team at Craigavon Area Hospital provide advice during week days on request to staff in Daisy Hill Hospital. The reviewers were concerned that this has the potential for inequality of a face to face assessment service for patients. The reviewers were advised that there is also an increased demographic of older people accessing services on the Daisy Hill campus. Due to the limited number of WTE hours by the AOS CNSs and the current team`s medical staffing challenges, there is restricted or no time to fully support the cohort of cancer patients over five days and certainly not for an expanded seven day service.

The team reported good working relationships with palliative care team with one of the AO CNS attending the weekly MDT meetings which are held on a Monday; this is further enhanced by the co-location of the office accommodation which is shared by other site specific CNS. The good communication skills were reported to help deliver patient centred care.

The Emergency Department leadership from the clinical director committed to improving timely Neutropenic Sepsis management is commended.

They have, in conjunction with the AOS CNSs, developed a patient hand held alert card. All oncology patients are educated to carry the card with them should they attend the hospital, especially via the ED. The “red card” explains to the emergency department receptionist, triage nurse and doctors within ED that prompt action is required in terms of assessing and treating the patient. The card also has the details of the nurse led telephone helpline which patients are encouraged to use if they have any concerns or become unwell. There is a separate 24/7 oncology advice line hosted by Belfast Health and Social Care Trust which is specifically for other healthcare professional staff from across the region. .

The AOT facilitate the diagnostic pathways for patients presenting with either Cancer of Unknown Primary or Malignancy of Unknown Origin and the team appreciated the need for rapid transfer of care to the site specific MDT or Specialist Palliative Care team.

The Trust isn’t designated as a MSCC Centre; the AOT including the ED clinical Director were passionate in acknowledging their frustrations and the effort required to access MSCC surgical opinion from the spinal service within the Royal Victoria Hospital in Belfast; which they expressed was far from satisfactory with the potential for delays. MRI was only available 6 days a week on the Craigavon Hospital site with patients having to be transferred from the Daisy Hill Campus to Craigavon or directly to the Cancer Centre in Belfast. The team feel the pathway will be improved with the appointment of new northern Ireland MSCC co-ordinator with improved speed and rapid access to appropriate diagnostics and treatment for patients presenting with suspected or confirmed MSCC.

The AO service benefits from highly skilled nurses who lead the service on a day to day basis. The senior of the two nursing staff has completed the NICaN AOS nursing competencies and has completed advanced health assessment and non-medical prescribing training. The second nurse who is currently covering the AO service has been seconded to cover the substantive post holder who is currently covering a vacancy in another speciality. The nurse is currently undertaking her Degree in Specialist Practice and will be completing her competencies for the AO service. Both of the CNSs are members of the Macmillan Community of Practice Programme which was a forum for networking and sharing good practice across the region as well as attend the bi annual clinical supervision which is available to all cancer CNSs. The AOS CNSs in conjunction with the chemotherapy sister support the competency assessment and ongoing updating of nurses who manage the telephone helpline using the UK Oncology Nurses (UKONs) triage assessment tool.

The reviewers were impressed by the patient’s informatics systems. The regional Electronic Care Record and new regional Information System for Oncology and Haematology (RISOH) which is available across all Trusts and healthcare professionals working within primary care. Locally there is no flagging system to inform the staff within ED or elsewhere in the hospital that a patient is currently receiving oncology treatment. The team are aware of a pilot in the Northern Trust that alerts admitting staff to patients’ chemo / cancer status on admission and would like to see it implemented in their own organisation. Consideration should also be given as to an electronic alerts system to notify the members of the AO team when patients have been admitted; currently the AO CNSs look through patients’ records to see who has been admitted overnight/during weekend to see if there are any patients who require assessment. General Practitioners have developed an alert on their electronic patient record system which lets them know patients who are receiving chemotherapy or radiotherapy; this again enables appropriate triage, support and advice from primary care with onward secondary care. The primary care lead highlighted his ambition to use the UKONs toxicity screening tool in primary care to look at reducing the “time to door” for suspected neutropenic patients.

The AOT use the NICaN developed pathways, however these still need to be localised with Trust contact details and onward referral points to the Cancer Centre when appropriate. This information would be especially important for out of hour's staff who may be unfamiliar with the pathways or infrequently treat cancer patients.

The NICaN guidelines are accessible on the trust intranet and hard copies are available on all wards, the team recognised that these need regular version control. There is an electronic application which can be downloaded to telephone and other hand –held electronic devices with the NICaN guidelines which all staff are encourage use. The team has undertaken education and training of nursing and medical staff across the two acute sites and contribute to the medical staff induction programme. The AOT attempt to attend the ED weekly on a Wednesday at change over to capture as many healthcare staff as possible as well as taking every opportunity to train individuals when patients are being assessed on the ward.

Patient Experience

Number	Indicator	SD	PR	Comments
AO-18-201	Patient feedback is obtained and used to evaluate the service	**Y**	**Y**	A survey was completed

The team has undertaken an informal patient feedback exercise involving a relatively small number of patients; it was reported that the comments received were positive and so no further action plans have been developed. The reviewers encourage the team to consider other ways to obtain feedback which may result in more meaningful information which the team could use to further develop the service. There is a dedicated patients and families suggestion box located on the chemotherapy unit; but the volume of patients utilising this mechanism of feedback is very low with on average only one comment posted per month.

The AOT are also considering asking the Trust's Cancer Service User Group' to assist in gaining feedback together with the 10,000 Voices project which looks at patient's stories as a way of informing service improvement. There is a Macmillan Information and Support centre situated in the main entrance of the Craigavon Hospital which may be another means of gaining feedback from patients.

The Trusts has participated in the 2018 National Cancer Patient Experience Survey: however, at the time of the review meeting the results had not yet been shared.

Clinical Outcomes

Number	Indicator	SD	PR	Comments
AO -18-101	The service is collecting and reviewing the acute oncology minimum dataset	Y	Y	Commended for continuing to collect given staffing issues

AO -18-102	The service is collecting and reviewing the MSCC minimum dataset (Applicable only to hospitals agreed by the network as definitively treating cases of MSCC with surgery and/or radiotherapy.)	N/A	N/A	Not designated as a MSCC treatment centre.

The Trust has continued to collect the minimum dataset as set out by NICaN with support from the administrative team. The data is currently verified by the AOS CNS. The reviewers commend the team for continuing to collect this data through recent staffing issues.

The AOT collected quarterly information on neutropenic sepsis and from July – September 2017 there has been an improvement in the door to needle times in Emergency Department for 75% of patients receiving treatment within one hour and the remaining 25% within 2 hours. The team consider the improved time from the previous quarter had been as a result of the close working relation between the ED teams, ED Clinical Director and AOS CNSs. The team acknowledged the challenges of ED staff turnover and further continued work was needed to sustain and improve this. Patients presenting to the Mandeville unit were included in the audit for July and September period, there were seven patients admitted; of which three patients were seen within the 60 minutes, three patients were seen within 1-2 hours and one patient was seen more than three hours; the delays in treatment were associated with the unit`s capacity and associated activity.

Good Practice

Regular AOG meetings in 2018 with good attendance.

Committed, respected and strong nurse led service.

Expanded scope. expertise and advanced skills of the AOT CNSs.

Macmillan Information and Support Centre in the main entrance.

Emergency Department Leadership and commitment to improve timely Neutropenic Sepsis management.

Patient held alert Card which outlines the role of ED staff if they attend hospital due to unexpected difficulties.

Improvement to door to needle times in Emergency Department to 75% within 1 hour.

Primary Care/GP Practice Alert System for use in all GP practice by health care professionals.

Continued commitment to NICaN data collection and quality assurance despite staffing challenges.

The Macmillan Community of Practice for CNSs.

Specify Immediate Risks
Refer to the guidance on identifying concerns. Any immediate risks or serious concerns must be brought directly to the attention of the zonal team.
An "Immediate Risk" is an issue that is likely to result in harm to patients or staff or have a direct impact on clinical outcomes and therefore requires immediate action.

None identified

Specify Serious Concerns
A "Serious Concern" is an issue that, whilst not presenting an immediate risk to patient or staff safety, could seriously compromise the quality or clinical outcomes of patient care, and therefore requires urgent action to resolve.

1. The service model for the Acute Oncology provision currently commissioned is for a single site and doesn't take in to account that cancer patients have the potential to be admitted to each of the Trust`s sites via their two EDs; this has the potential for inequality of service to patients.
2. There is currently no oncologist with any named cover to take the lead for AOS or agreed replacement plan for a locum; this will impact on service development and delivery for AOS, MSSC and radiotherapy.
3. There is no speciality doctor to support the nursing team which has the potential to impact on the timely triage, care and treatment of patients.
4. There is no named lead for MSCC within the Trust and this is further compromised by the lack of a regional coordinator which may seriously compromise patient experience and best clinical outcome.
5. There are only 1.5 wte Acute Oncology Clinical Nurse Specialists, which is insufficient to provide support and expertise for the commissioned five-day face to face service to the two hospital sites each with an emergency department. Due the level of cancer service provision across the Trust there is limited or no time to fully support the cohort of cancer patients and expanded seven-day nursing cover.

Areas for Improvement/Consideration/General concerns

Consider the development of a nurse led abdominal paracentesis and pleural aspiration service.

Increase the methodologies for feedback for cohort of patients surveyed for feedback on the AO service and consider obtaining feedback from families.

Update locally agreed pathways to include relevant contact information.

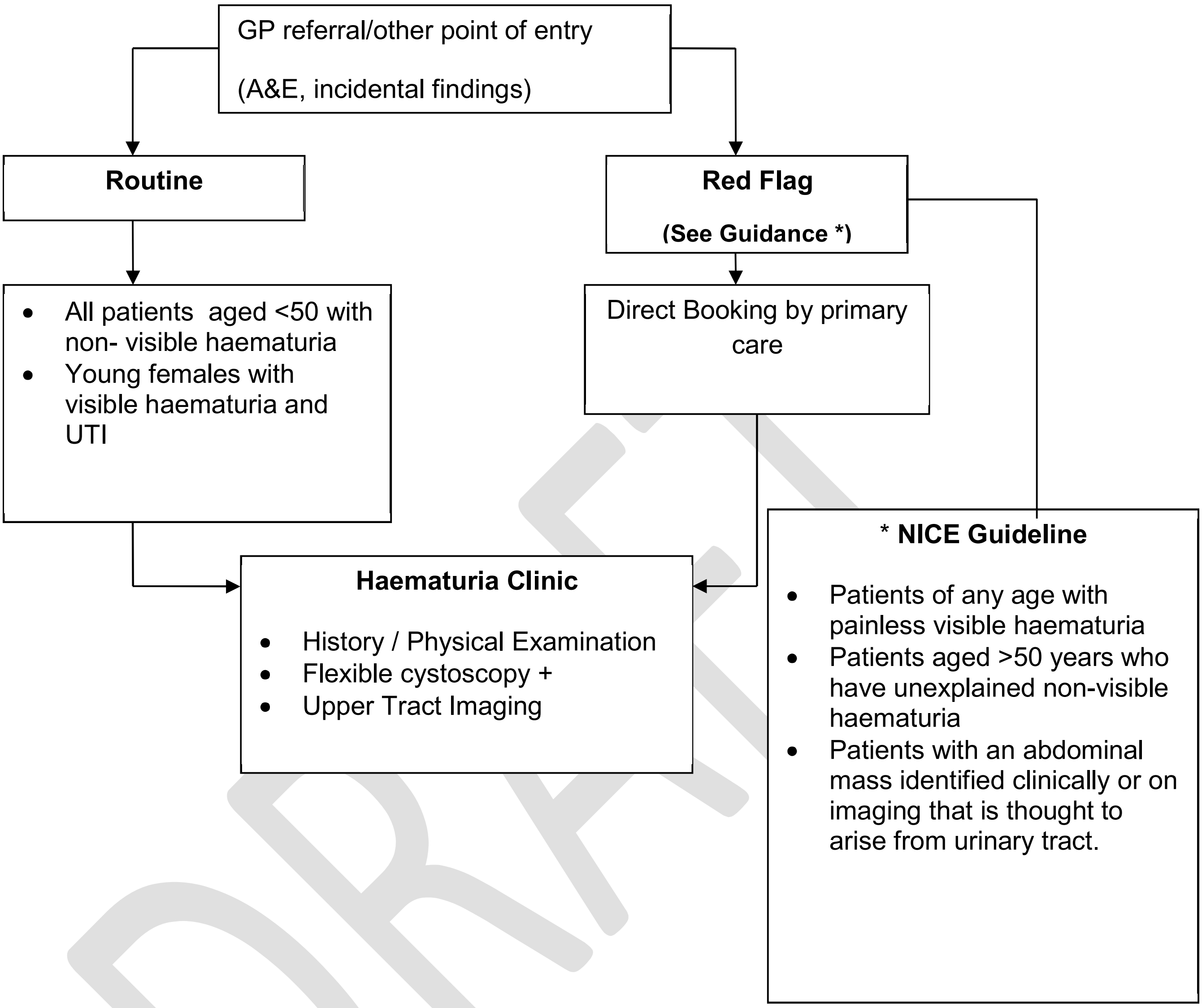
NICaN
Northern Ireland Cancer Network

Urology Care Pathways

Cancer Care Pathways outline the steps and stages in the patient journey from referral through to diagnostics, staging, treatment, follow up, rehabilitation and if applicable onto palliative care.

Timed effective care pathways are central to delivering quality and timely care to patients throughout their cancer journey and to the delivery of an equitable service. These pathways have been developed following with reference to available best practice guidance. They represent an 'ideal' pathway that can be adapted for local use. The timelines on the pathway are intended to facilitate the proactive management of patients within the access standards and it is to be noted that for some urological tumours, the patient will move much quicker through the pathway (e.g. testicular cancer).

Haematuria Referral Guideline



GP referral/other point of entry

(A&E, incidental findings)

Routine

- All patients aged <50 with non- visible haematuria
- Young females with visible haematuria and UTI

Red Flag

(See Guidance *)

Direct Booking by primary care

Haematuria Clinic

- History / Physical Examination
- Flexible cystoscopy +
- Upper Tract Imaging

*** NICE Guideline**

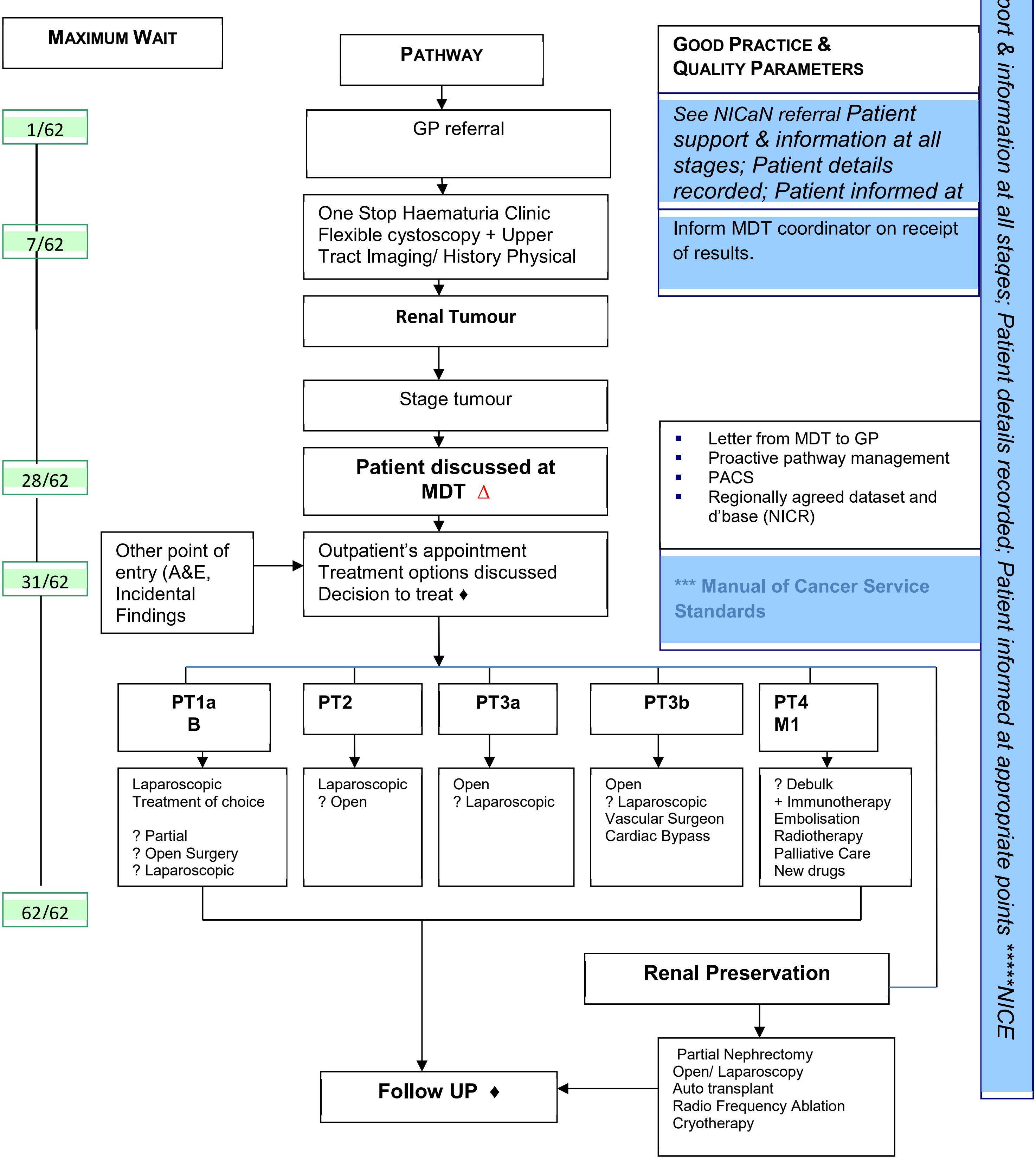
- Patients of any age with painless visible haematuria
- Patients aged >50 years who have unexplained non-visible haematuria
- Patients with an abdominal mass identified clinically or on imaging that is thought to arise from urinary tract.

NOTE: Please Consider Nephrology referral as well as referral to haematuria clinic if the patient has any of the following:

- Diabetes
- Proteinuria
- Hypertension

Appendix 3 of NICaN Urology Cancer Clinical Guidelines

Renal Tumour



MAXIMUM WAIT

1/62

7/62

28/62

31/62

62/62

PATHWAY

GP referral

One Stop Haematuria Clinic
Flexible cystoscopy + Upper Tract Imaging/ History Physical

Renal Tumour

Stage tumour

Patient discussed at MDT ∆

Other point of entry (A&E, Incidental Findings

Outpatient's appointment
Treatment options discussed
Decision to treat ♦

PT1a B
Laparoscopic Treatment of choice
? Partial
? Open Surgery
? Laparoscopic

PT2
Laparoscopic
? Open

PT3a
Open
? Laparoscopic

PT3b
Open
? Laparoscopic
Vascular Surgeon
Cardiac Bypass

PT4 M1
? Debulk
+ Immunotherapy
Embolisation
Radiotherapy
Palliative Care
New drugs

Renal Preservation

Partial Nephrectomy
Open/ Laparoscopy
Auto transplant
Radio Frequency Ablation
Cryotherapy

Follow UP ♦

GOOD PRACTICE & QUALITY PARAMETERS

See NICaN referral Patient support & information at all stages; Patient details recorded; Patient informed at

Inform MDT coordinator on receipt of results.

- Letter from MDT to GP
- Proactive pathway management
- PACS
- Regionally agreed dataset and d'base (NICR)

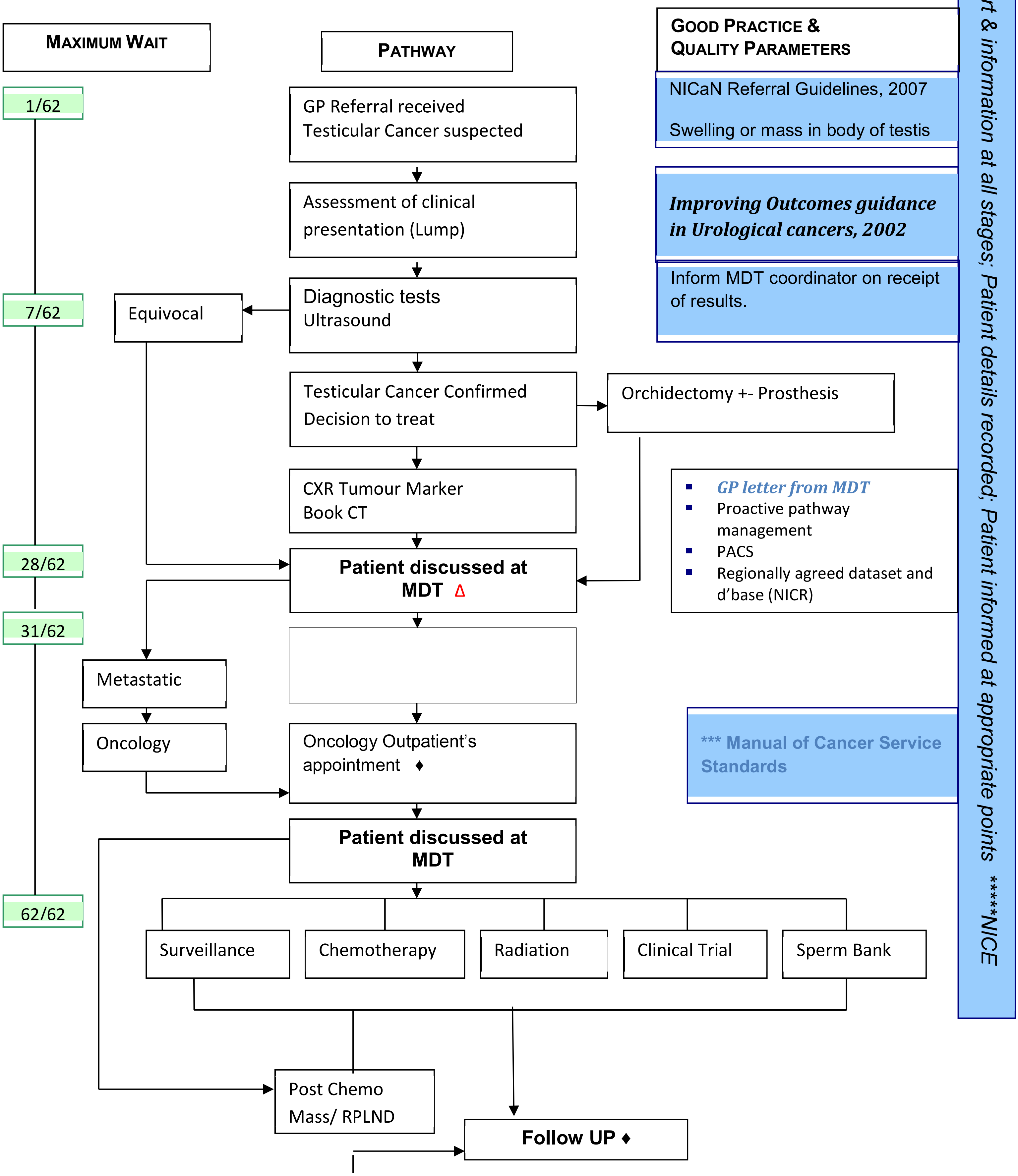
***** Manual of Cancer Service Standards**

*Patient support & information at all stages; Patient details recorded; Patient informed at appropriate points ****NICE*

♦ Indicates point of holistic assessment ∆ Inter-Trust transfer by Day 28

Appendix 3 of NICaN Urology Cancer Clinical Guidelines

Testicular Cancer Pathway



MAXIMUM WAIT

1/62

7/62

28/62

31/62

62/62

PATHWAY

GP Referral received
Testicular Cancer suspected

Assessment of clinical presentation (Lump)

Diagnostic tests
Ultrasound

Equivocal

Testicular Cancer Confirmed
Decision to treat

Orchidectomy +- Prosthesis

CXR Tumour Marker
Book CT

Patient discussed at MDT Δ

Metastatic

Oncology

Oncology Outpatient's appointment ♦

Patient discussed at MDT

Surveillance

Chemotherapy

Radiation

Clinical Trial

Sperm Bank

Post Chemo
Mass/ RPLND

Follow UP ♦

GOOD PRACTICE & QUALITY PARAMETERS

NICaN Referral Guidelines, 2007

Swelling or mass in body of testis

Improving Outcomes guidance in Urological cancers, 2002

Inform MDT coordinator on receipt of results.

- ***GP letter from MDT***
- Proactive pathway management
- PACS
- Regionally agreed dataset and d'base (NICR)

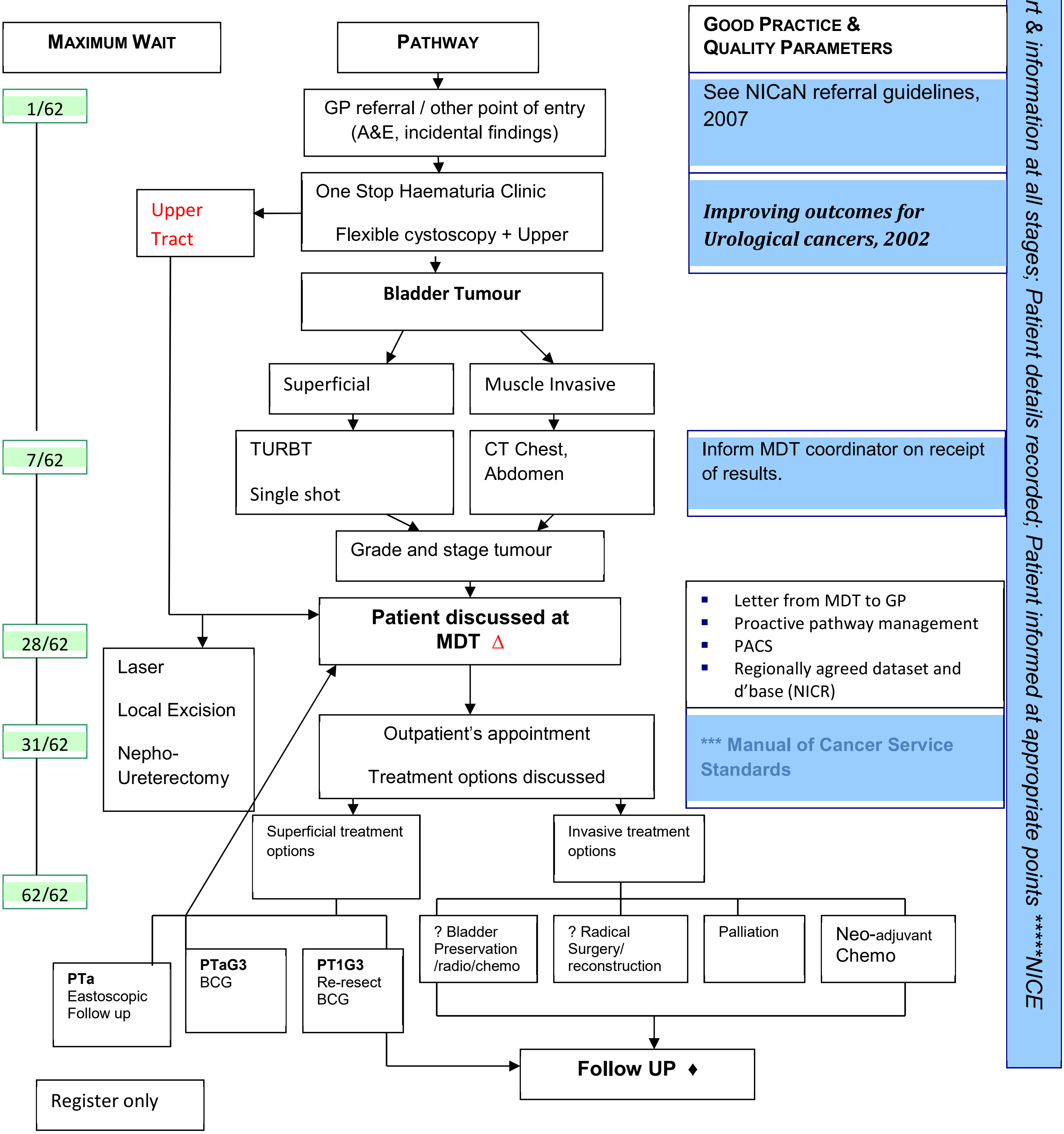
***** Manual of Cancer Service Standards**

*Patient support & information at all stages; Patient details recorded; Patient informed at appropriate points ****NICE*

♦ Indicates point of holistic assessment Δ Inter-Trust transfer by Day 28

Appendix 3 of NICaN Urology Cancer Clinical Guidelines

♦ Indicates point of holistic assessment   Δ Inter-Trust transfer by Day 28



MAXIMUM WAIT

1/62

7/62

28/62

31/62

62/62

PATHWAY

GP referral / other point of entry (A&E, incidental findings)

One Stop Haematuria Clinic

Flexible cystoscopy + Upper

Upper Tract

Bladder Tumour

Superficial

Muscle Invasive

TURBT

Single shot

CT Chest, Abdomen

Grade and stage tumour

Patient discussed at MDT Δ

Laser

Local Excision

Nepho-Ureterectomy

Outpatient's appointment

Treatment options discussed

Superficial treatment options

Invasive treatment options

PTa Eastoscopic Follow up

PTaG3 BCG

PT1G3 Re-resect BCG

? Bladder Preservation /radio/chemo

? Radical Surgery/ reconstruction

Palliation

Neo-adjuvant Chemo

Follow UP ♦

Register only

GOOD PRACTICE & QUALITY PARAMETERS

See NICaN referral guidelines, 2007

Improving outcomes for Urological cancers, 2002

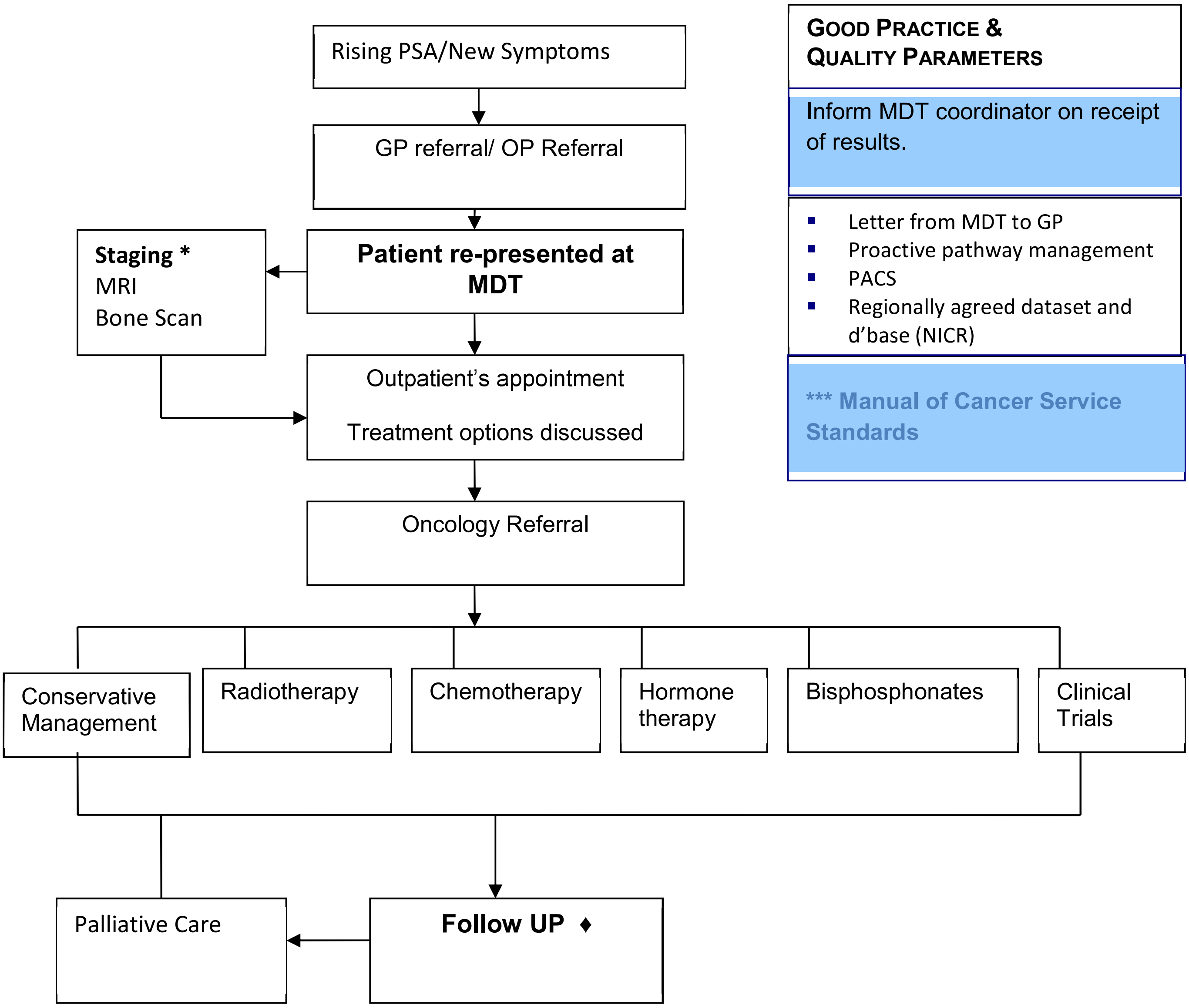
Inform MDT coordinator on receipt of results.

- Letter from MDT to GP
- Proactive pathway management
- PACS
- Regionally agreed dataset and d'base (NICR)

***** Manual of Cancer Service Standards**

*Patient support & information at all stages; Patient details recorded; Patient informed at appropriate points *****NICE*

Castration Resistant Prostate Cancer



GOOD PRACTICE & QUALITY PARAMETERS

Inform MDT coordinator on receipt of results.

- Letter from MDT to GP
- Proactive pathway management
- PACS
- Regionally agreed dataset and d'base (NICR)

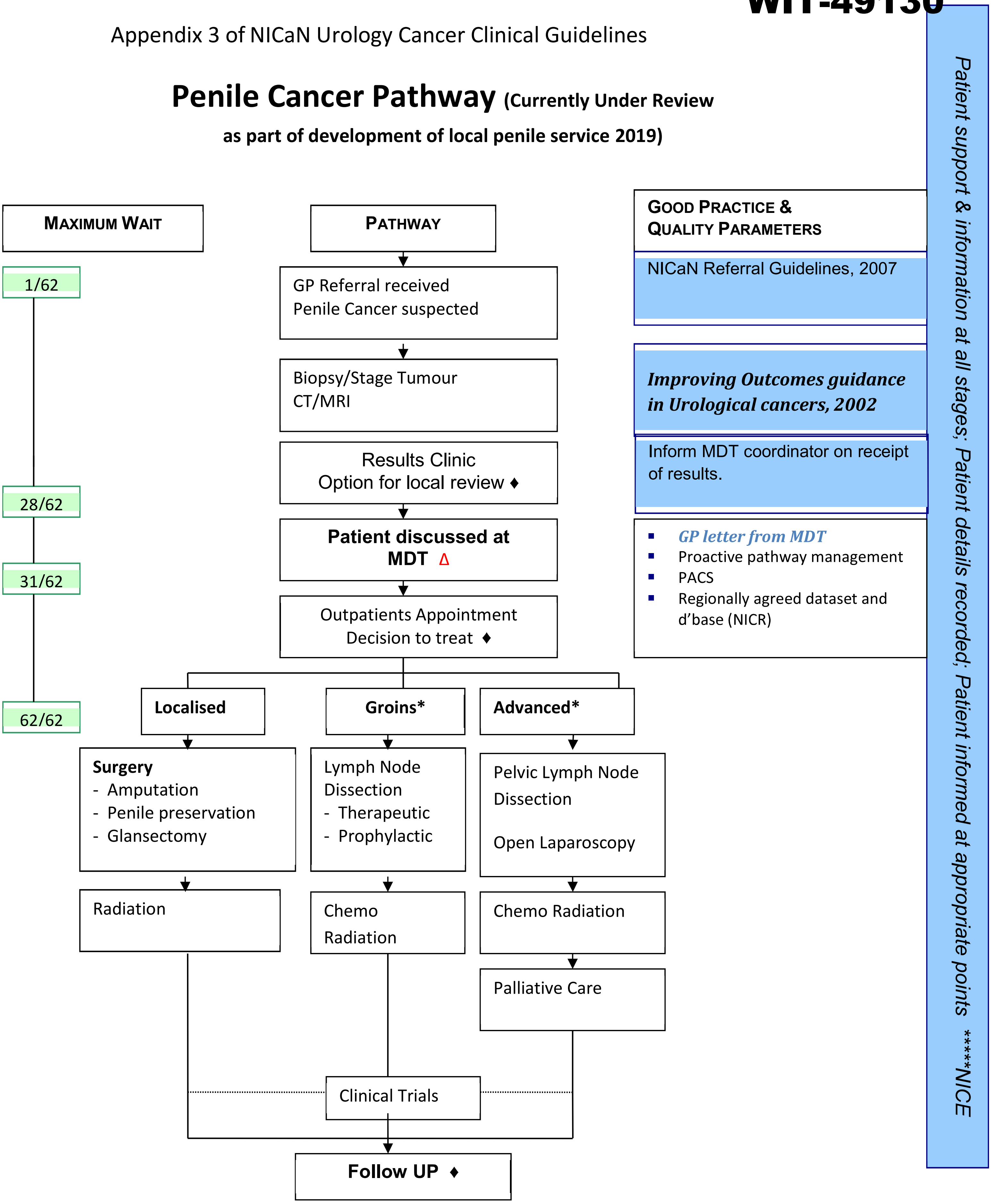
***** Manual of Cancer Service Standards**

*Patient support & information at all stages; Patient details recorded; Patient informed at appropriate points ****NICE*

* MRI/Bone Scan as clinically indicated

Appendix 3 of NICaN Urology Cancer Clinical Guidelines

Penile Cancer Pathway (Currently Under Review as part of development of local penile service 2019)



MAXIMUM WAIT

1/62

28/62

31/62

62/62

PATHWAY

GP Referral received
Penile Cancer suspected

Biopsy/Stage Tumour
CT/MRI

Results Clinic
Option for local review ♦

Patient discussed at MDT Δ

Outpatients Appointment
Decision to treat ♦

Localised

Surgery
- Amputation
- Penile preservation
- Glansectomy

Radiation

Groins*

Lymph Node Dissection
- Therapeutic
- Prophylactic

Chemo
Radiation

Advanced*

Pelvic Lymph Node Dissection

Open Laparoscopy

Chemo Radiation

Palliative Care

Clinical Trials

Follow UP ♦

GOOD PRACTICE & QUALITY PARAMETERS

NICaN Referral Guidelines, 2007

Improving Outcomes guidance in Urological cancers, 2002

Inform MDT coordinator on receipt of results.

- *GP letter from MDT*
- Proactive pathway management
- PACS
- Regionally agreed dataset and d'base (NICR)

Patient support & information at all stages; Patient details recorded; Patient informed at appropriate points *****NICE

♦ Indicates point of holistic assessment Δ Inter-Trust transfer by Day 28

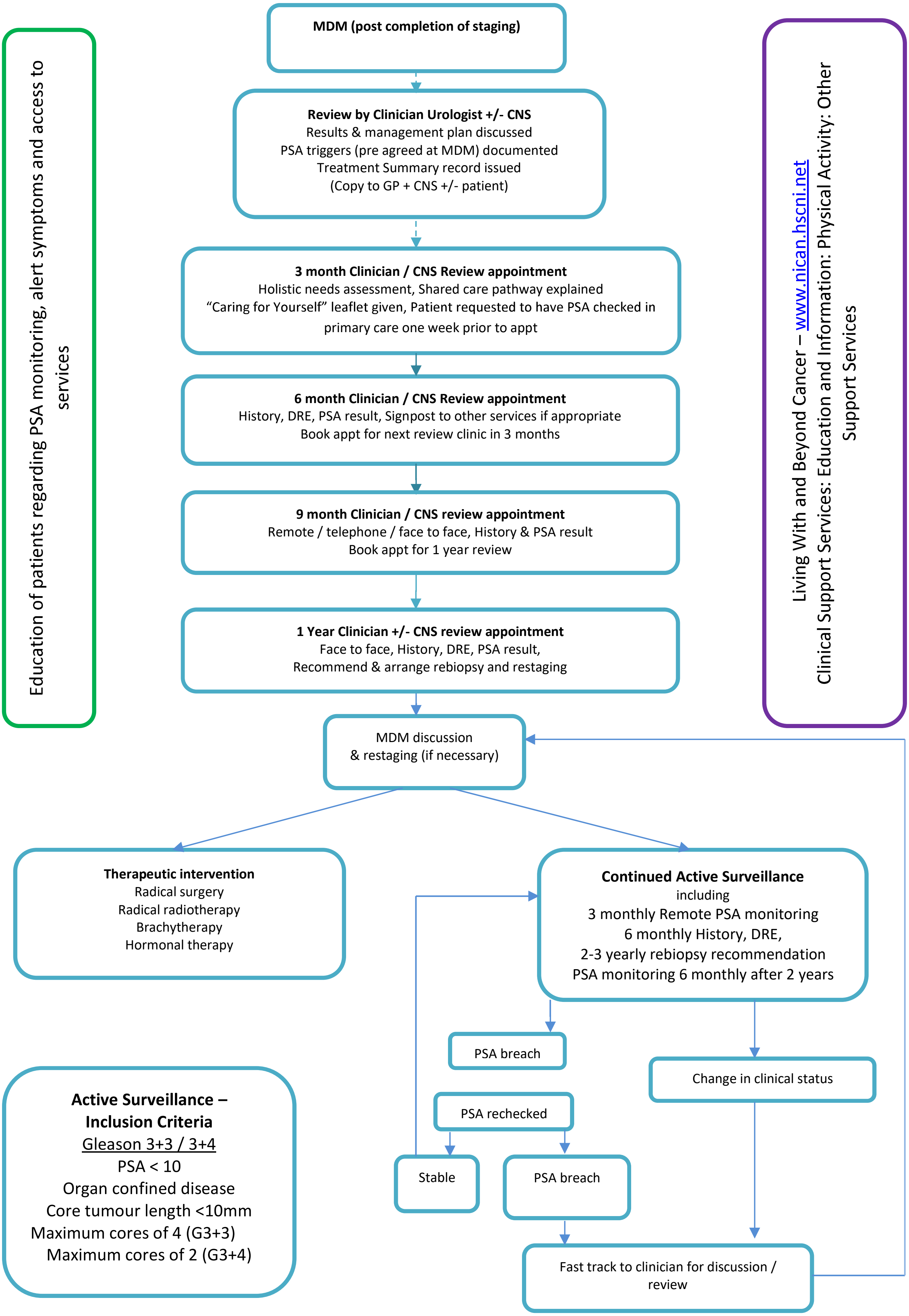
Appendix 3 of NICaN Urology Cancer Clinical Guidelines

Policy Code / Reference No:

Trust Logo

Appendix 3 of NICaN Urology Cancer Clinical Guidelines

Pathway 2 Prostate Cancer: Active Surveillance



Education of patients regarding PSA monitoring, alert symptoms and access to services

MDM (post completion of staging)

Review by Clinician Urologist +/- CNS
Results & management plan discussed
PSA triggers (pre agreed at MDM) documented
Treatment Summary record issued
(Copy to GP + CNS +/- patient)

3 month Clinician / CNS Review appointment
Holistic needs assessment, Shared care pathway explained
"Caring for Yourself" leaflet given, Patient requested to have PSA checked in primary care one week prior to appt

6 month Clinician / CNS Review appointment
History, DRE, PSA result, Signpost to other services if appropriate
Book appt for next review clinic in 3 months

9 month Clinician / CNS review appointment
Remote / telephone / face to face, History & PSA result
Book appt for 1 year review

1 Year Clinician +/- CNS review appointment
Face to face, History, DRE, PSA result,
Recommend & arrange rebiopsy and restaging

MDM discussion
& restaging (if necessary)

Therapeutic intervention
Radical surgery
Radical radiotherapy
Brachytherapy
Hormonal therapy

Continued Active Surveillance
including
3 monthly Remote PSA monitoring
6 monthly History, DRE,
2-3 yearly rebiopsy recommendation
PSA monitoring 6 monthly after 2 years

PSA breach

PSA rechecked

Stable

PSA breach

Change in clinical status

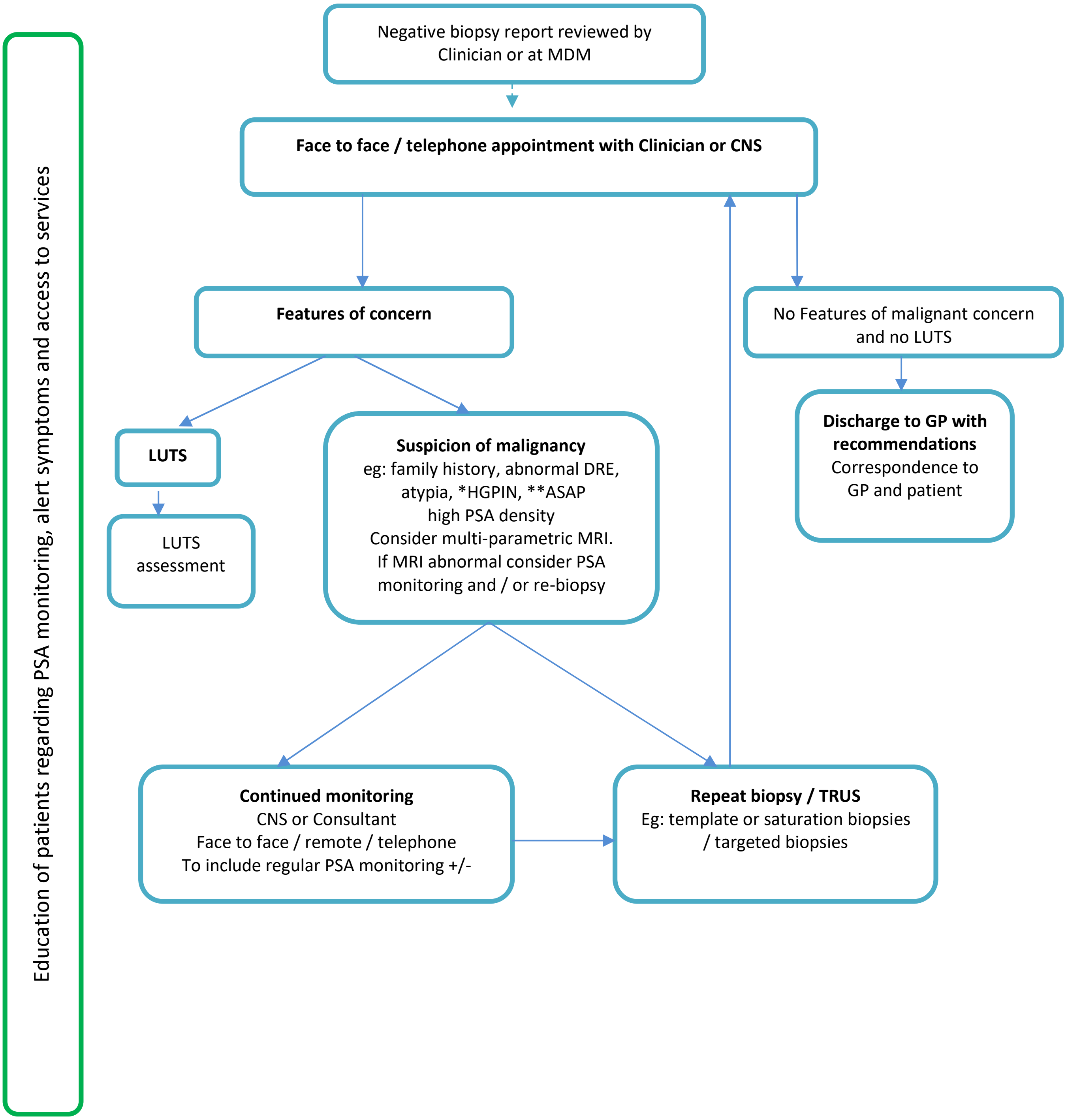
Fast track to clinician for discussion / review

Living With and Beyond Cancer – www.nican.hscni.net
Clinical Support Services: Education and Information: Physical Activity: Other Support Services

Active Surveillance – Inclusion Criteria
Gleason 3+3 / 3+4
PSA < 10
Organ confined disease
Core tumour length <10mm
Maximum cores of 4 (G3+3)
Maximum cores of 2 (G3+4)

Appendix 3 of NICaN Urology Cancer Clinical Guidelines

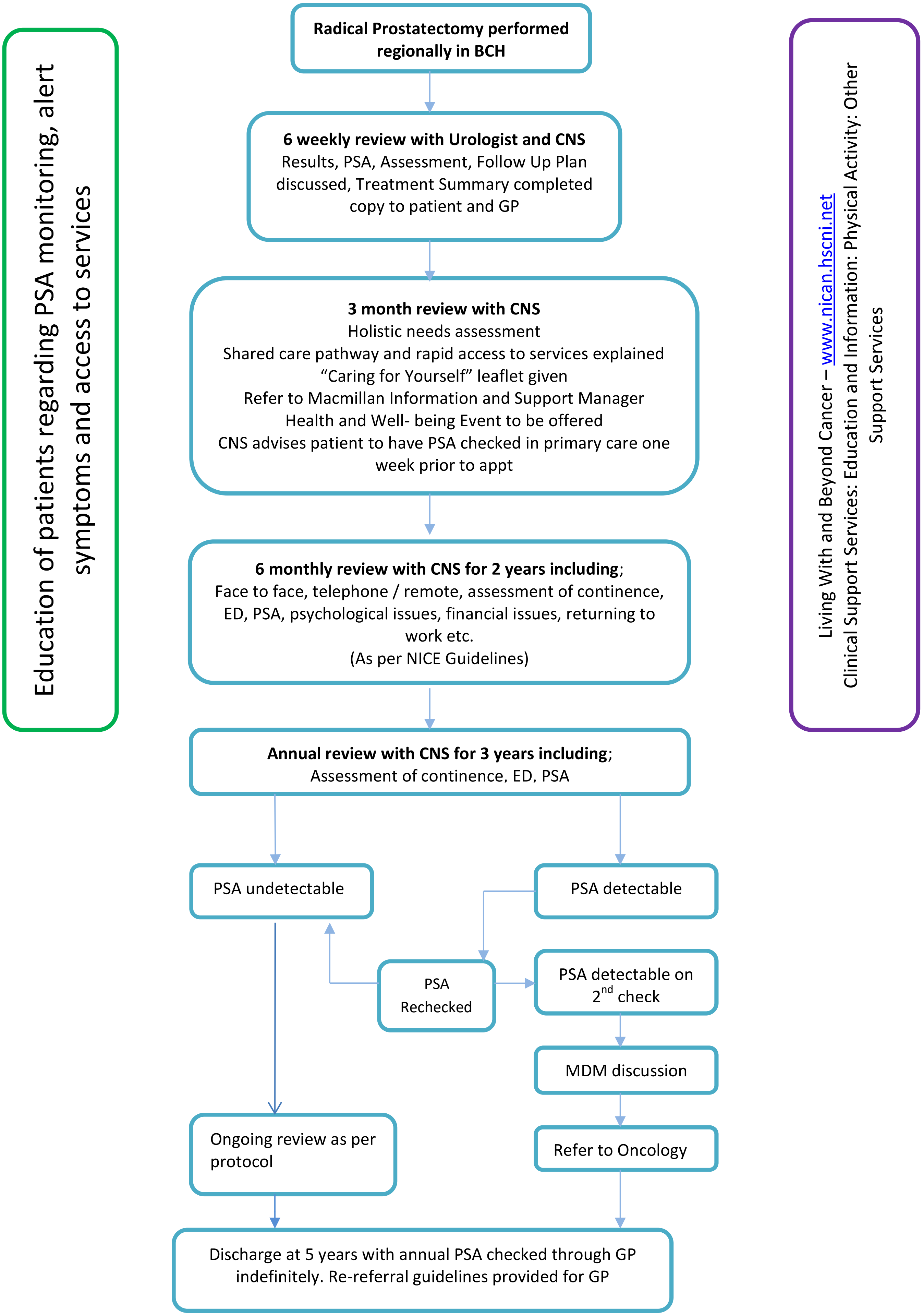
Pathway 3 Raised PSA & Negative Biopsy



*HGPIN – High grade prostatic intra-epithelial neoplasia
**ASAP – Atypical small acinar proliferation

Appendix 3 of NICaN Urology Cancer Clinical Guidelines

Pathway 4 Prostate Cancer: Radical Surgery – Negative margins



Education of patients regarding PSA monitoring, alert symptoms and access to services

Radical Prostatectomy performed regionally in BCH

6 weekly review with Urologist and CNS
Results, PSA, Assessment, Follow Up Plan discussed, Treatment Summary completed copy to patient and GP

3 month review with CNS
Holistic needs assessment
Shared care pathway and rapid access to services explained
"Caring for Yourself" leaflet given
Refer to Macmillan Information and Support Manager
Health and Well- being Event to be offered
CNS advises patient to have PSA checked in primary care one week prior to appt

6 monthly review with CNS for 2 years including;
Face to face, telephone / remote, assessment of continence, ED, PSA, psychological issues, financial issues, returning to work etc.
(As per NICE Guidelines)

Annual review with CNS for 3 years including;
Assessment of continence, ED, PSA

PSA undetectable

PSA detectable

PSA Rechecked

PSA detectable on 2nd check

MDM discussion

Refer to Oncology

Ongoing review as per protocol

Discharge at 5 years with annual PSA checked through GP indefinitely. Re-referral guidelines provided for GP

Living With and Beyond Cancer – www.nican.hscni.net
Clinical Support Services: Education and Information: Physical Activity: Other Support Services

Appendix 3 of NICaN Urology Cancer Clinical Guidelines

Pathway 5 Prostate Cancer: Permanent Prostate Brachytherapy (LDR)

Education of patients regarding PSA monitoring, alert symptoms and access to services

Permanent Prostate Brachytherapy
Implant performed
(Pt discharged)

Post implant AUR management if required

4week Post implant CT scan and QA/peer review
(PSA, IPSS, Dosimetry to database)

3month - Radiographer telephone review
(PSA to database)

6month - Consultant led clinical review
(PSA, IPSS,IIEF,EPIC to database)

6monthly Consultant led clinical review.
GP check PSA every 3-6months
(PSA, IPSS,IIEF,EPIC to database)
Transfer to annual review at 3years if PSA <1ng/ml & falling

12monthly clinical review
GP check PSA every 6 months
(PSA, IPSS,IIEF, EPIC to database)
Discharge to GP care at 5 years if PSA <1ng/ml & falling

GP information letter re biochemical and clinical triggers and re-referral pathway

Sigmoidoscopy by experienced practitioner at year 5, 10, 15 If deemed fit for procedure

Rising PSA Year 0 – 3 could be benign PSA bounce.
PSA 3monthly with clinical review.
MRI/CT/IBS if:
1 PSA level>10ng/ml
2 Clinically indicated

Living With and Beyond Cancer – www.nican.hscni.net
Clinical Support Services: Education and Information: Physical Activity: Other Support Services

Selection criteria for Permanent Prostate Brachytherapy

Clinical inclusion criteria:
Organ confined prostate cancer T1 or T2
Estimated life expectancy >10yrs
Gleason 6 and PSA <15ng/ml
Gleason 7 and PSA <15ng/ml

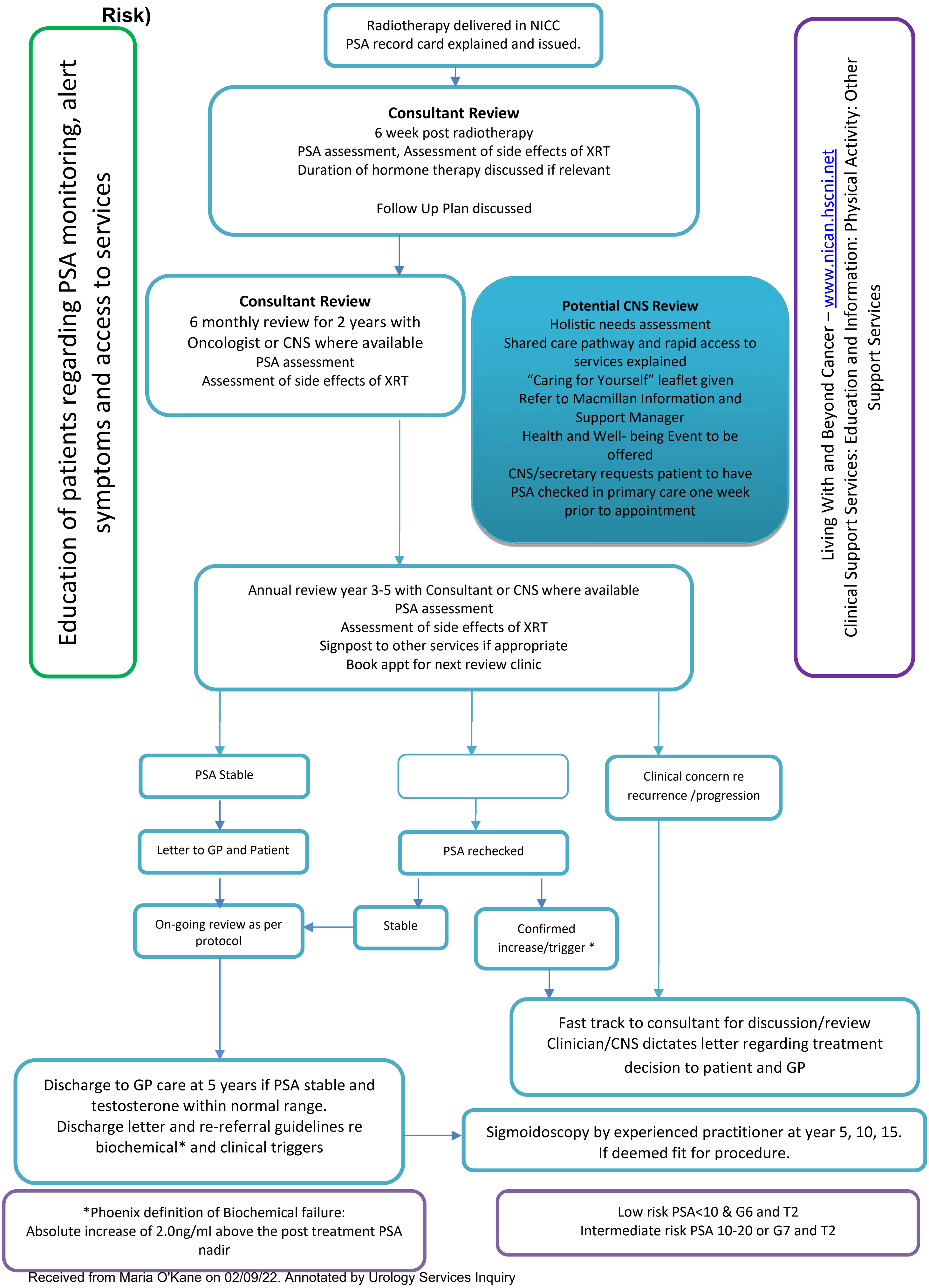
Clinical exclusion criteria for brachytherapy:
Prostate volume >50ml (> 65ml prior to hormonal cytoreduction)
IPSS >9. (Would consider for implant is <15 & Qmax >12ml/sec)
Life expectancy <5years
Large or poorly healed TURP defect
Unacceptable operative risk
Relative contraindications for brachytherapy:
Large median lobe

Selection criteria for combined Permanent Prostate Brachytherapy + EBRT

Selected men with:
High volume Gleason 7 or
Low volume Gleason >7 or
Early T3a disease
May be suitable for dose escalation with combination therapy and should be referred for discussion to central

Appendix 3 of NICaN Urology Cancer Clinical Guidelines

Pathway 6: Prostate Cancer: Radiotherapy+/-Hormones (Low Intermediate Risk)



Education of patients regarding PSA monitoring, alert symptoms and access to services

Radiotherapy delivered in NICC
PSA record card explained and issued.

Consultant Review
6 week post radiotherapy
PSA assessment, Assessment of side effects of XRT
Duration of hormone therapy discussed if relevant

Follow Up Plan discussed

Consultant Review
6 monthly review for 2 years with Oncologist or CNS where available
PSA assessment
Assessment of side effects of XRT

Potential CNS Review
Holistic needs assessment
Shared care pathway and rapid access to services explained
"Caring for Yourself" leaflet given
Refer to Macmillan Information and Support Manager
Health and Well- being Event to be offered
CNS/secretary requests patient to have PSA checked in primary care one week prior to appointment

Living With and Beyond Cancer – www.nican.hscni.net
Clinical Support Services: Education and Information: Physical Activity: Other Support Services

Annual review year 3-5 with Consultant or CNS where available
PSA assessment
Assessment of side effects of XRT
Signpost to other services if appropriate
Book appt for next review clinic

PSA Stable

Letter to GP and Patient

On-going review as per protocol

PSA rechecked

Stable

Confirmed increase/trigger *

Clinical concern re recurrence /progression

Fast track to consultant for discussion/review
Clinician/CNS dictates letter regarding treatment decision to patient and GP

Discharge to GP care at 5 years if PSA stable and testosterone within normal range.
Discharge letter and re-referral guidelines re biochemical* and clinical triggers

Sigmoidoscopy by experienced practitioner at year 5, 10, 15.
If deemed fit for procedure.

*Phoenix definition of Biochemical failure:
Absolute increase of 2.0ng/ml above the post treatment PSA nadir

Low risk PSA<10 & G6 and T2
Intermediate risk PSA 10-20 or G7 and T2

Concerns Checklist - identifying your concerns

Patient's name or label

Key worker: ____________________

Date: ____________________

Contact number: ____________________

This self assessment is optional. It has been designed to help us support you by identifying any concerns you may have and information you may require.

What do I need to do?

Select any areas that may have caused you concern recently and you would like to discuss with your key worker.

When selecting please score each concern between 1-10, with 1 being low level of concern and 10 the highest.

Key worker to complete

☐ Copy given to patient

☐ Copy to be sent to GP

Physical concerns

☐ Breathing difficulties
☐ Passing urine
☐ Constipation
☐ Diarrhoea
☐ Eating, appetite or taste
☐ Indigestion
☐ Swallowing
☐ Cough
☐ Sore or dry mouth or ulcers
☐ Nausea or vomiting
☐ Tired, exhausted or fatigued
☐ Swelling
☐ High temperature or fever
☐ Moving around (walking)
☐ Tingling in hands or feet
☐ Pain or discomfort
☐ Hot flushes or sweating
☐ Dry, itchy or sore skin
☐ Changes in weight
☐ Wound care
☐ Memory or concentration
☐ Sight or hearing
☐ Speech or voice problems
☐ My appearance
☐ Sleep problems
☐ Sex, intimacy or fertility
☐ Other medical conditions

Practical concerns

☐ Taking care of others
☐ Work or education
☐ Money or finance
☐ Travel
☐ Housing
☐ Transport or parking
☐ Talking or being understood
☐ Laundry or housework
☐ Grocery shopping
☐ Washing and dressing
☐ Preparing meals or drinks
☐ Pets
☐ Difficulty making plans
☐ Smoking cessation
☐ Problems with alcohol or drugs
☐ My medication

Emotional concerns

☐ Uncertainty
☐ Loss of interest in activities
☐ Unable to express feelings
☐ Thinking about the future
☐ Regret about the past
☐ Anger or frustration
☐ Loneliness or isolation
☐ Sadness or depression
☐ Hopelessness
☐ Guilt
☐ Worry, fear or anxiety
☐ Independence

Family or relationship concerns

☐ Partner
☐ Children
☐ Other relatives or friends
☐ Person who looks after me
☐ Person who I look after

Spiritual concerns

☐ Faith or spirituality
☐ Meaning or purpose of life
☐ Feeling at odds with my culture, beliefs or values

Information or support

☐ Exercise and activity
☐ Diet and nutrition
☐ Complementary therapies
☐ Planning for my future priorities
☐ Making a will or legal advice
☐ Health and wellbeing
☐ Patient or carer's support group
☐ Managing my symptoms
☐ Sun protection

☐ **I have questions about my diagnosis, treatments or effects**

MACMILLAN CANCER SUPPORT
RIGHT THERE WITH YOU

NHS

Ensuring Better Treatment

National Cancer Action Team
Part of the National Cancer Programme

Excellence in Cancer Care: The Contribution of the Clinical Nurse Specialist

WE ARE MACMILLAN.
CANCER SUPPORT

Contents

Foreword



Together we share an ambition to achieve the best cancer outcomes for patients in the UK, recognising that, at a time of tightened budgets, it is critical that NHS resources are deployed to best effect. Now more than ever, clinical nurse specialists (CNSs) have a vital role to play in delivering high quality and compassionate care, including care closer to home, and supporting a drive for efficiency that improves health outcomes and maximises resources.

Cancer CNSs have played an important role in the successful implementation of initiatives to improve NHS cancer services. Despite an increasing incidence of the disease and an ageing population, death rates from many cancers are dropping, survival rates are improving and many patients' experiences of care have been enhanced. CNSs are at the front line of cancer care; they are the main point of contact for patients and as a result help to shape services for each patient according to need and patient choice, which contributes to wider cancer priorities. For example, CNSs play an important role in enabling care to be delivered closer to home and in improving patients' and their families' ability to self-manage symptoms and side-effects of treatment.

CNSs contribute to increasing the quality of care provided by the NHS; indeed, in the face of rising patient expectations, more patients report being treated with dignity and respect and having trust and confidence in their care team. Increasingly, they have an ongoing role in supporting cancer survivors as well as cancer patients. Overall it is estimated that there are now 2 million people living with cancer and this is set to rise to 4 million by 2030.[1]

For people affected by cancer, the effective management of their care pathway is essential to maintain quality of life. People whose care is unplanned and un-coordinated are more likely to be high users of health and social care services, including emergency care. CNSs work closely with patients and with their clinical colleagues to adapt to patients' emerging needs thus reducing the need for unplanned care.

This short guide is designed to support clinical teams, commissioners, employers and managers to understand and evaluate the contribution of CNSs in cancer as they plan their local workforce and service improvement strategies. With examples drawn from front-line services across a range of cancers, this guide sets out how effective CNS deployment drives innovation, reduces inefficiency and improves the quality of cancer care across the UK.

We still have further to go if we are to improve outcomes for all cancers, with the aim of bringing us in line with the best in Europe. Ensuring provision of CNSs where they are needed, coupled with effective use of their skills and expertise will enable us to move faster towards this goal.

Professor Sir Mike Richards
National Cancer Director

Mike Richards

Ciarán Devane
Chief Executive
Macmillan Cancer Support

Ciarán Devane

Dame Christine Beasley DBE
Chief Nursing Officer (England)
Department of Health

CBeasley

The role of the Clinical Nurse Specialist in cancer care

The roles undertaken by Clinical Nurse Specialists (CNSs) are many and varied; however, there are core clinical practice functions and a level of practice that could be reasonably expected of all CNSs in cancer care.

CNSs in cancer care can be described as registered nurses, who have graduate level nursing preparation and who would usually be expected to be prepared at Master's level. They are clinical experts in evidence-based nursing practice within a specialty area. The specialty may be focused on a population (e.g. young people), type of care (e.g. palliative care), type of problem (e.g. lymphoedema), type of treatment (e.g. chemotherapy) or tumour type (e.g. lung cancer).

CNSs treat and manage the health concerns of patients and work to promote health and wellbeing in the patients they care for. CNSs in cancer care practice autonomously and integrate knowledge of cancer and medical treatments into assessment, diagnosis, and treatment of patients' problems and concerns.[2] Whilst many specialist nurses may function at an advanced level, this level of practice is not common to all, thus the title Clinical Nurse Specialist does not in itself indicate that the nurse is an 'advanced practitioner'.

The high-level activities of CNSs can be separated into four main functions.[3] In the context of cancer care these consist of:

1. Using and applying technical knowledge of cancer and treatment to oversee and coordinate services, personalise 'the cancer pathway' for individual patients and to meet the complex information and support needs of patients and their families
2. Acting as the key accessible professional for the multidisciplinary team, undertaking proactive case management and using clinical acumen to reduce the risk to patients from disease or treatments
3. Using empathy, knowledge and experience to assess and alleviate the psychosocial suffering of cancer including referring to other agencies or disciplines as appropriate
4. Using technical knowledge and insight from patient experience to lead service redesign in order to implement improvements and make services responsive to patient need

Furthermore, some cancer CNSs have developed their roles to include technical elements, for example: physical examinations and diagnostic tests; and insertion of central venous lines for the delivery of chemotherapy or for nutritional purposes.

Many cancer CNSs work as part of a tumour specific team, whereas others may work across more than one service or setting. Although many are based within acute trusts, post-holders are also located in primary care and community settings or private and voluntary sector organisations. They may be responsible for whole client groups, or for episodes of care and nursing services more widely. They are also typically core members of a multidisciplinary team.[4]

Key contributions that CNSs make to cancer care

Clinical Nurse Specialist

- Acting as a key worker across the whole care pathway
- Advanced clinical / diagnostic skills
- In depth knowledge of a tumour area
- Ability to assess patients' holistic needs
- Advanced communication and advocacy skills
- Empathy for patients and their families
- Excellent decision making abilities
- Leadership within the MDT and wider cancer team
- Innovation, project management and change management

The cost of managing cancer

The cost to the NHS in England of patient care for cancer in 2007/8 was £5 billion.[5] Department of Health figures for 2007-08 showed that:

- Over half (i.e. over £2 billion) of the total expenditure on cancer in England went on inpatient care[6]
- Inpatient care for cancer patients accounted for 12% of all inpatient beds in England[6]
- The number of emergency admissions for cancer increased by 47% in the past 8 years[6]
- 4.7 million bed days were cancer related[6]

Statistics from 2006-07 for England show:

- 417,646 emergency inpatient admissions for cancer representing 2,963,987 bed days[6]
- 339,038 elective inpatient admissions for cancer representing 1,750,223 bed days[6]

Reducing the financial burden of cancer – the potential of the CNS

The specialist nature of the cancer CNS and their role as key worker to individual patients means that they can quickly identify emerging issues that might require medical attention, enabling care to be planned and emergency admissions averted. CNSs also support enhanced recovery after surgery – equipping patients to manage their recovery at home and reducing the need for lengthy hospital stays. These two important contributions help the NHS to improve patient experience and safety.

There are also sound economic arguments for supporting patients to manage their care at home and helping them through the complex systems of health care provision.

The National Audit Office's End of Life Care report estimated £104m savings by reducing emergency admissions by 10 per cent, and reducing the length of stay by 3 days.[7]

An economic modelling analysis by Macmillan Cancer Support in 2009[8], focusing on the role of the CNS, suggested that service improvements along the cancer pathway could release about 10% of cancer expenditure in the Manchester area. This related only to breast and lung patients admitted through the two week wait system in one health economy. If extrapolated to a national level then the economic benefits could be significant.

CNSs: leading quality and productivity in cancer care

Patients rightly expect high quality, effective healthcare and CNSs have an important role to play in meeting their needs and expectations.

The proposed NHS Outcomes Framework[9] is structured around five high level outcome domains. These are intended to cover everything the NHS is there to do. These five outcome domains are:

- Preventing people from dying prematurely
- Enhancing the quality of life for people with long-term conditions
- Helping people to recover from episodes of ill health or following injury
- Ensuring people have a positive experience of care
- Treating and caring for people in a safe environment and protecting them from avoidable harm

As practitioners and partners at the heart of multidisciplinary teams, CNSs have influence and credibility across the care pathway. They are increasingly taking a leadership role in refining systems and smoothing care pathways, making a demonstrable contribution to effectiveness, patient experience and safety.

Experience from the front line – CNSs transforming cancer care

Impact of key CNS-led activites

Improving quality and experience of care

- Managing complex, individual and changing information and support needs of patients and carers
- Supporting patients in choices around treatment and care
- Enhancing recovery and delivering care flexibly and closer to home
- Facilitating set up of support groups

Reinforcing safety

- Delivering safe, nurse-led services
- Using vigilance of symptoms and drug toxicity to trigger rescue work
- Identifying and taking action to reduce risks
- Facilitating rapid re-entry into acute services, if appropriate

Increasing productivity and efficiency

- Intervening to manage treatment side effects and/or symptom control, preventing unplanned admissions
- Providing nurse-led services that free up consultant resource
- Empowering patients to self-manage their condition

Demonstrating leadership

- Educating the wider healthcare team and acting as a mentor
- Identifying and implementing service improvement and efficiencies
- Determining measurable outcomes, auditing practice, and sharing good practice and innovation

CNSs across the country are already transforming patients' experiences of cancer care. The following case studies provide a flavour of the kinds of initiatives that CNSs are leading – highlighting their pivotal role in maximising resource and benefitting patients.

Case Studies

Innovation, project management, change management

Lesley Barnett, Macmillan Lead Cancer Nurse, Doncaster
Gina Wibberley, Macmillan Lung CNS, Lincoln

CNSs in Doncaster and Lincolnshire have implemented rapid alert systems to ensure that they are immediately informed when one of their patients enters hospital with an unplanned admission. Using mobile technology and integrated IT systems, a text message and email is sent to the CNS who can immediately attend the patient or discuss the case with the treating clinicians.

Using their specialist knowledge in lung cancer, and their understanding of individual patients' needs, CNSs in Lincolnshire use this as an opportunity to re-assess the patient's cancer pathway outside of scheduled patient planning, or identify where a quick specialist intervention can turn around an inappropriate admission. The nurses in Doncaster have identified length-of-stay reductions of one to two days per patient, they work to ensure that the patient is admitted to the correct ward and in some cases prevent admission altogether. Added to these productivity benefits is the increased quality of care experienced by patients who report feeling completely supported, knowing that they are receiving coordinated care.

Empathy for patients and their families

Frances McKay, Macmillan Mesothelioma and Lung CNS, Medway

Frances, and her colleagues Caroline Williams and Pat Cameron, run the only lung cancer and mesothelioma support group in their Cancer Network. Up to 28 people each month attend the group.

The CNSs work in collaboration with a local hospice to facilitate the monthly group meetings with a hospice volunteer managing the meeting practicalities. A successful buddy system has been established for patients and carers who face the challenging and complex issues of a terminal disease.

The group also enables the CNSs to identify emerging health issues, including helping patients to self-manage symptoms such as shortness of breath, reducing anxiety and maintaining quality of life. Importantly, the CNSs are able to mediate between patients and hospital services and quickly address any issues of concern raised by patients and their families.

Advanced clinical and diagnostic skills

Sharon McGeary and Amanda Gerrard, Paediatric Oncology Outreach Network CNSs, Newcastle Upon Tyne

Nurses from the children s oncology outreach service in Newcastle work with children and young people throughout their cancer journeys. Using specialist knowledge of symptom management, palliative and complex care, the nurses work a 24/7 on call system, allowing for timely, effective interventions which maximise care delivery. The nurse team are trained as non medical prescribers, and more than half are practising prescribers.

Working in a large geographical region, the nurses have developed effective collaborative working practices with local primary care service providers. This is particularly important in enabling children and young people with progressive disease to be cared for, and die, in their preferred place of choice, often their home.

The nurses are leading the way in the implementation of new technologies in their hospital trust. Smart Pump technology, considered to be the next generation of ambulatory infusion devices, allows the release of medication over seven days maximising symptom management and minimising hospital attendance. Corresponding drug libraries, managed by the nurses, help to improve safety by reducing drug errors, improving workflow and providing a new source of data for continuous quality improvement.

Acting as key worker across the whole care pathway

Tina Lightfoot, Lead Specialist Nurse for GI services (surgery), Chester

Tina and the colorectal specialist nurses provide quality services to enhance recovery for patients with colorectal cancer at the Countess of Chester Hospital. Through a pre operative counselling initiative, patients and carers have an increased understanding of recovery and discharge expectations, helping them to make plans for managing care at home. In addition, patients who are expected to have a stoma are visited at home by the stoma nurse for a dummy’ teaching session, reducing the time it takes to become self-sufficient in stoma management.

Patients on the enhanced recovery programme are discharged as early as two days after surgery, and there is evidence that this is significantly reducing care costs. The colorectal specialist nurses contact the patient daily after discharge for up to 10 days to assess their progress. This vigilance ensures that complications are picked up early enabling timely intervention, and patients report feeling supported through their recovery.

Excellent decision making abilities

Debbie Fitzgerald, Gynaecology CNS, Torbay

Debbie has developed an innovative early-alert service for women with ovarian cancer who suffer from a painful and distressing build up of fluid in the abdominal area.

Patients are alerted to the possibility of fluid build-up, and encouraged to phone her if they begin to experience symptoms. When contacted, Debbie makes a clinical assessment, organising an abdominal scan if required and booking blood tests pre-admission. The drainage can then be done as a day patient, preventing emergency admission to A&E and lengthy inpatient stays as well as improving patients’ quality of life.

The CNS’s coordinating role ensures that phlebotomists, radiographers, and the medical team are all available at the right time. Debbie has developed this into a protocol - now widely used.

Advanced communication and advocacy skills

Judith Clarke, Surgical Breast Care CNS, Coventry

Judith has developed an innovative system to monitor and best manage anxiety among patients recalled to the breast screening clinic for further assessment following attendance to the NHS breast screening programme. Judith devised a simple tool that encourages patients to reflect on their anxiety and prompt them to seek additional support from the breast care nurse (BCN). It also promotes greater collaboration with radiographers and a more coordinated patient-centred experience.

Designed to look like a thermometer, the assessment tool asks women to score themselves from 0 10 (low to high anxiety) enabling BCNs to triage the more vulnerable women (scoring 5 and above) and ensure they are offered a BCN consultation before being re screened. Radiographers also use the self-assessment to ensure more patient-focused care, taking into account women s concerns. Feedback from patients shows that women find this activity useful and many have commented on how it helped to reduce their anxiety.

Case Studies (continued)

Demonstrating Leadership

Catherine Oakley, Nurse Consultant, London

Catherine and the team of chemotherapy nurse specialists at Guy's and St Thomas' Hospital have been working together to redesign the way chemotherapy is delivered. Nurses in the chemotherapy unit now work in four specialised teams according to tumour types to improve consistency for patients and maximise the nurses' clinical expertise.

Catherine piloted an intervention in urology in which a specialist nurse and pharmacist delivered an improved pre-treatment consultation. The key to its success is structuring the consultation to ensure that patients' educational and supportive care needs are met to optimise safety and empower patients to actively participate in their treatment plan. Additionally, CNSs proactively call patients to monitor their progress during the course of their treatment. Closely monitoring patients in this way ensures that any side-effects can be quickly managed and that patients are supported through this sometimes difficult part of their cancer journey.

In-depth knowledge of tumour area

Tessa Fitzpatrick, Macmillan Lung CNS, North Tees

Analysis of patient experience at University Hospital of North Tees suggests that lung cancer patients and carers can encounter problems following admission to the Emergency Assessment Unit (EAU). These include unnecessary investigations, poor symptom management, lack of recognition of end of life, delays in discharge and inadequate communication. This has a negative impact on patients' confidence in the service and also on the length of stay which has a cost implication.

The CNSs at North Tees use their specialist knowledge of lung cancer to support patients who are admitted as emergency cases, reducing inpatient stays and helping patients and carers to understand and manage symptoms. University Hospital of North Tees examined a total of 94 inpatient episodes resulting in 964 bed days. The average length of stay for those patients not referred to the lung CNS was 10.8 days however there was a reduction in length of stay to 9.7 days for those patients who had lung CNS input during their admission.

Ability to assess patients' holistic needs

Anita Pabla, Sarcoma CNS, Leicester

Anita works with patients throughout their cancer journey but has particularly focussed on supporting survivorship and smoothing the transition from secondary to primary care.

Six to eight weeks post-treatment, she provides patients with detailed and individual end of treatment' summaries within the context of a holistic consultation. This captures their initial diagnosis and treatment history, medication and follow up schedule incorporating the wider services they have accessed, such as limb fitting and support groups. The summary also acts as an important communication tool for their GP, enabling greater integration between different parts of the patient pathway.

The summary and assessment has proved valuable to patients increasing their confidence and ability to self-manage as well as to primary care improving appropriate referral if and when needed.

Delivering the future for cancer patients

The NHS White Paper, Equity and Excellence: Liberating the NHS, puts patients and clinicians at the heart of decision-making in the NHS. The phrase “no decision about me without me” is used in the White Paper to emphasise patients’ involvement in their own care.[10] CNSs are often the main point of contact for cancer patients and their families, and work closely with colleagues throughout the patient’s cancer journey. As a result, they are well placed to support patients at each stage and to promote integration within care teams.

Equity and Excellence proposes a shift away from measuring clinical inputs and processes in favour of achieving improved clinical outcomes and higher quality patient experience. Here too, CNSs already demonstrate their skills in assessing and putting in place interventions to achieve these.

The Cancer Reform Strategy (2007) stated that: “Commissioners and providers should ensure that the critical roles of clinical nurse specialists in information delivery, communication and coordination of care are supported”.[11] This remains essential to achieving safe and high quality cancer care and we expect to see this reflected in the refreshed Cancer Reform Strategy.

Nursing is changing, reflecting and rewarding the skills and expertise of its workforce. Career pathways have been updated and transferable skills identified to enable nurses to shape their careers within and across different care pathways.[12] Embracing new models of care, the CNS role extends beyond the hospital setting into local community and specialist settings and increasingly includes informed individual care planning that enables patients to self-manage their condition where possible.

There is wide variation in the types of tasks that CNSs are carrying out. While some of these make good use of their skills, there is evidence that CNSs are also being diverted into general ward duties and tied up in administrative tasks. This does not represent good value to the NHS. Commissioners, employers and managers therefore need to consider whether CNSs are being deployed to best effect.

Matching workforce planning to patient need

Clinical teams will be considering whether provision of CNSs in their local area is sufficient to meet need. Understanding the patterns of access is fundamental to being able to match the CNS workforce to patients’ needs. Despite the expansion in overall CNS numbers since the 1980s, workforce shortages are still an issue.[13]

The best available data indicates that not every cancer patient has access to a CNS, despite the recommendations made in the Improving Outcomes Guidance. The National Cancer Action Team’s Workforce Review Team 2010 census demonstrates significant variation in provision of cancer CNSs in England, which cannot be accounted for by geographical differences in cancer incidence or in patient flows.[14] Since the last census in 2008,[15] there appears to have been an increase in CNS posts in rarer cancers, but the 2010 census revealed no significant growth in other tumour groups despite increasing cancer prevalence. Inequities remain across England and also between different tumour types. Patient advocacy groups have argued that in some cancers - notably lung and urological cancers - CNS provision falls significantly short of patient need and that CNSs face variable case-loads.

Issues for Employers and Managers to consider

CNSs provide quality care and contribute to improved outcomes for cancer patients. They lead innovation, and can drive efficiency in their teams. They also contribute to the delivery of health strategies and policy guidance including:

- Cancer Reform Strategy
- Improving Outcomes
- Quality, Innovation, Productivity and Prevention Challenge
- High Impact Actions for nursing and midwifery
- Equity and Excellence: Liberating the NHS
- Chemotherapy Services in England
- Vital Signs
- End of Life Care Strategy

Employers and managers may wish to ask the following questions when considering their cancer services and assessing their CNS provision, to identify to what extent cancer services are configured to maximise the safety, quality and productivity of care:

Your community

- What is the all-age, all-cause cancer incidence rate in your PCT?
- What are the demographics of your PCT in terms of: age; socioeconomic and deprivation factors; prevalence of risk factors; ethnicity?
- Are there communities with particular unmet needs?
- What priority issues for cancer have been identified through the Joint Strategic Needs Assessment?
- How have you reflected these in the selection of local priorities and incentives for health care providers e.g CQUINs? QOF?
- How do you plan to measure and improve outcomes in these areas?

Provision and capacity

- How many whole-time equivalent CNSs posts are there in your PCT?
- What is the distribution of these across different cancers?
- How does this compare to patterns in neighbouring areas and to the national picture?
- Does each specialist team dealing with a particular cancer type have at least one CNS member?
- How good is CNS attendance at MDT meetings for each team?
- How many new patients does each CNS see each year?
- Have you considered using the expertise of the Macmillan Cancer Support Service Development Team to redesign CNS roles and services should you have concerns that CNSs may not be working to the best potential of their roles?

Where can CNSs make most impact?

- How many unplanned admissions are there for cancer each year in your PCT? And how does this vary by cancer type?
- Do audited records demonstrate that at least 80% of patients receive information about their diagnosis, treatment and care plan?
- Can it be demonstrated that care is effectively coordinated across boundaries?
- Are CNSs working in roles that reflect and demand their knowledge and skills or are they undertaking general ward duties?

Further sources of information

- Cancer Commissioning Guidance
  http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_110115
- Cancer Commissioning Toolkit
  https://www.cancertoolkit.co.uk
- Cancer Reform Strategy and Annual Reports
  http://www.dh.gov.uk/en/Healthcare/Cancer/ReformStrategy
- National Cancer Intelligence Network
  http://www.ncin.org.uk
- Association of Public Health Observatories
  http://www.apho.org.uk/
- Public Health Observatory Handbook of Health Inequalities Measurement
  http://www.sepho.org.uk/viewResource.aspx?id=9707
- Guidance on Joint Strategic Needs Assessment
  http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_081097
- The Operating Framework for the NHS in England, 2010/11 (December 2009)
  http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_110107
- Specialist nurses. Changing lives, saving money. Royal College of Nursing, London. 2010
  http://www.rcn.org.uk/__data/assets/pdf_file/0008/302489/003581.pdf
- Programme Budgeting data for 2007-08
  http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/en/Managingyourorganisation/Financeandplanning/Programmebudgeting/DH_075743
- National Audit Office, End of Life Care, November 2008 available here:
  http://www.nao.org.uk/publications/0708/end_of_life_care.aspx
- Department of Health, Equity and excellence: Liberating the NHS, July 2010
  http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_117794.pdf
- To download this publication go to:
  http://ncat.nhs.uk/our-work/ensuring-better-treatment/quality-in-nursing

Acknowledgments

The Department of Health, National Cancer Action Team and Macmillan Cancer Support would like to thank all those who have contributed to the development of this publication, in particular the Clinical Nurse Specialists who provided examples of good practice, and the members of the National Quality in Cancer Nursing Steering Group for their advice and guidance.

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2 American Nurses Association. Nursing: Scope & standards of practice, 2004

3 Leary A (2011) in Leary A (Ed) Lung cancer a multidisciplinary approach, Wiley-Blackwell Oxford In press

4 National Cancer Peer Review Programme Manual for Cancer Services 2008: Breast Measures

5 Department of Health, Programme Budgeting data for 2007-08

6 NHS Improvement Transforming Care for Cancer Inpatients - Spreading the Winning Principles and Good Practice: July 2009

7 National Audit Office, End of Life Care, November 2008

8 Macmillan Cancer Support, Demonstrating the economic value of co-ordinated cancer services. An examination of resource utilisation in Manchester , March 2010

9 Department of Health , Transparency in outcomes a framework for the NHS, July 2010

10 Department of Health, Equity and excellence: Liberating the NHS, July 2010

11 Department of Health, Cancer Reform Strategy, December 2007

12 Department of Health, Towards a framework for post-registration nursing careers - consultation response report, July 2008

13 National Cancer Action Team, National Cancer Peer Review Programme 2004 – 2007. An overview of the findings from the second national round of peer reviews of cancer services in England, June 2008

14 National Cancer Action Team Workforce Review Team, Census of Cancer Specialist Nurses in English Cancer Networks, 2010

15 Trevatt, P., Leary, A., A Census of the advanced and specialist cancer nursing workforce in England, Northern Ireland and Wales, European Journal of Oncology Nursing (2009) 14:1 (68-73)

Endorsements

The content of this publication is endorsed by the following organisations:

BRAIN TUMOUR UK

BREAKTHROUGH BREAST CANCER

breast cancer care

Kidney Cancer UK
SUPPORTING PATIENTS & CARERS

Blood and Lymphatic cancers
Leukaemia CARE
supporting a quality of life

Ovarian cancer action

PANCREATIC CANCER UK
Striving for Survival

THE PROSTATE CANCER CHARITY

RCF RARER cancers FOUNDATION
incorporating Rarer Cancers Forum

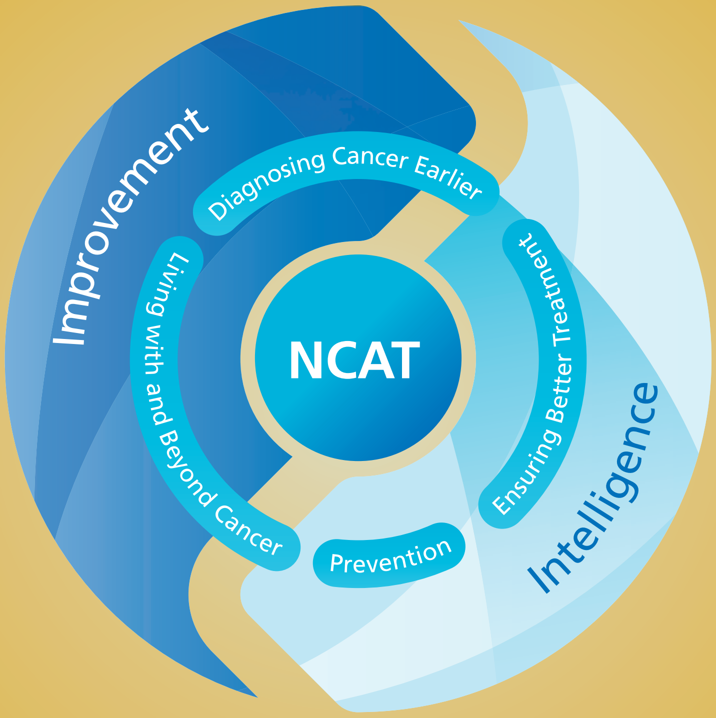
Royal College of Nursing

TARGET OVARIAN CANCER
For every woman. For life.

UKONS
Oncology Nursing Society

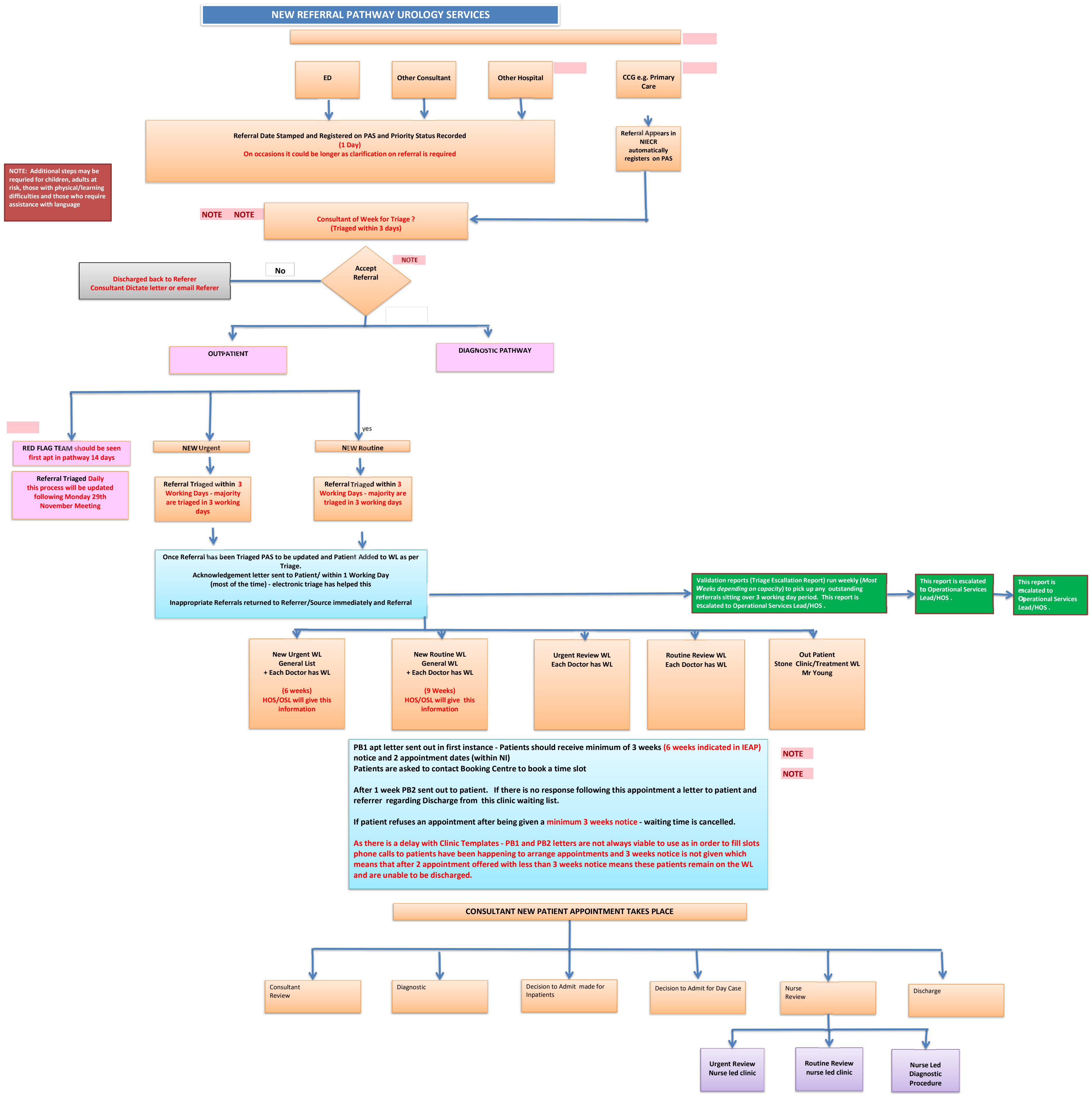
DH Department of Health

Gateway Number: 14851



WE ARE MACMILLAN. CANCER SUPPORT

NHS



NEW REFERRAL PATHWAY UROLOGY SERVICES

ED

Other Consultant

Other Hospital

CCG e.g. Primary Care

Referral Date Stamped and Registered on PAS and Priority Status Recorded
(1 Day)
On occasions it could be longer as clarification on referral is required

Referral Appears in NIECR automatically registers on PAS

NOTE: Additional steps may be requried for children, adults at risk, those with physical/learning difficulties and those who require assistance with language

NOTE NOTE

Consultant of Week for Triage ?
(Triaged within 3 days)

NOTE

Accept Referral

No

Discharged back to Referer
Consultant Dictate letter or email Referer

OUTPATIENT

DIAGNOSTIC PATHWAY

RED FLAG TEAM should be seen first apt in pathway 14 days

Referral Triaged Daily
this process will be updated following Monday 29th November Meeting

NEW Urgent

Referral Triaged within 3 Working Days - majority are triaged in 3 working days

yes

NEW Routine

Referral Triaged within 3 Working Days - majority are triaged in 3 working days

Once Referral has been Triaged PAS to be updated and Patient Added to WL as per Triage.
Acknowledgement letter sent to Patient/ within 1 Working Day
(most of the time) - electronic triage has helped this

Inappropriate Referrals returned to Referrer/Source immediately and Referral

Validation reports (Triage Escallation Report) run weekly (*Most Weeks depending on capacity*) to pick up any outstanding referrals sitting over 3 working day period. This report is escalated to Operational Services Lead/HOS .

This report is escalated to Operational Services Lead/HOS .

This report is escalated to Operational Services Lead/HOS .

New Urgent WL
General List
+ Each Doctor has WL

(6 weeks)
HOS/OSL will give this information

New Routine WL
General WL
+ Each Doctor has WL

(9 Weeks)
HOS/OSL will give this information

Urgent Review WL
Each Doctor has WL

Routine Review WL
Each Doctor has WL

Out Patient
Stone Clinic/Treatment WL
Mr Young

PB1 apt letter sent out in first instance - Patients should receive minimum of 3 weeks (6 weeks indicated in IEAP) notice and 2 appointment dates (within NI)
Patients are asked to contact Booking Centre to book a time slot

After 1 week PB2 sent out to patient. If there is no response following this appointment a letter to patient and referrer regarding Discharge from this clinic waiting list.

If patient refuses an appointment after being given a minimum 3 weeks notice - waiting time is cancelled.

As there is a delay with Clinic Templates - PB1 and PB2 letters are not always viable to use as in order to fill slots phone calls to patients have been happening to arrange appointments and 3 weeks notice is not given which means that after 2 appointment offered with less than 3 weeks notice means these patients remain on the WL and are unable to be discharged.

NOTE

NOTE

CONSULTANT NEW PATIENT APPOINTMENT TAKES PLACE

Consultant Review

Diagnostic

Decision to Admit made for Inpatients

Decision to Admit for Day Case

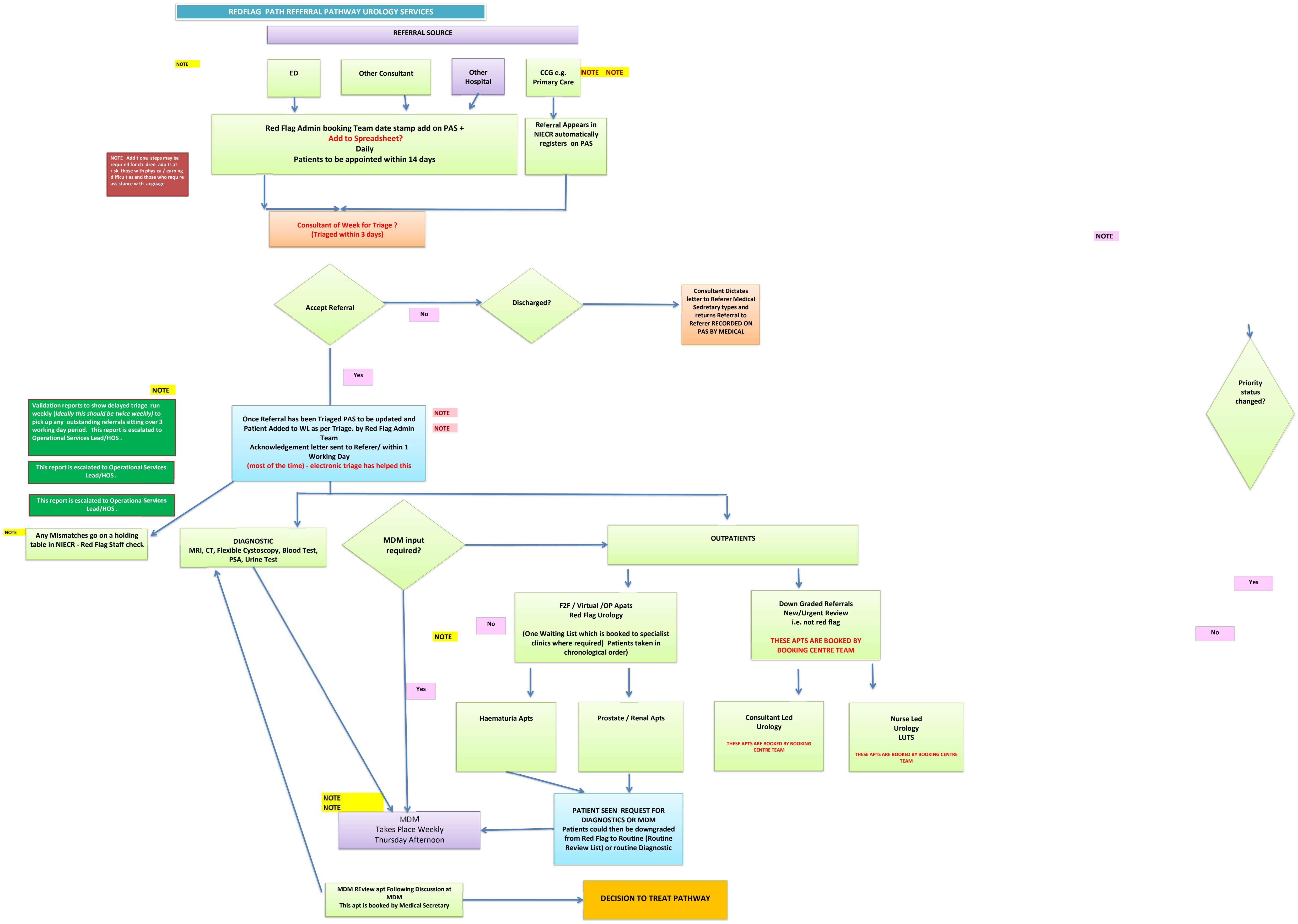
Nurse Review

Discharge

Urgent Review Nurse led clinic

Routine Review nurse led clinic

Nurse Led Diagnostic Procedure



REDFLAG PATH REFERRAL PATHWAY UROLOGY SERVICES

REFERRAL SOURCE

NOTE

ED

Other Consultant

Other Hospital

CCG e.g. Primary Care

NOTE NOTE

Red Flag Admin booking Team date stamp add on PAS +
Add to Spreadsheet?
Daily
Patients to be appointed within 14 days

Referral Appears in NIECR automatically registers on PAS

NOTE Additional steps may be required for children, adults at risk, those with physical / learning difficulties and those who require assistance with language

Consultant of Week for Triage ?
(Triaged within 3 days)

NOTE

Accept Referral

No

Discharged?

Consultant Dictates letter to Referer Medical Sedretary types and returns Referral to Referer RECORDED ON PAS BY MEDICAL

Yes

Priority status changed?

NOTE

Validation reports to show delayed triage run weekly (*Ideally this should be twice weekly*) to pick up any outstanding referrals sitting over 3 working day period. This report is escalated to Operational Services Lead/HOS .

This report is escalated to Operational Services Lead/HOS .

This report is escalated to Operational Services Lead/HOS .

Once Referral has been Triaged PAS to be updated and Patient Added to WL as per Triage. by Red Flag Admin Team
Acknowledgement letter sent to Referer/ within 1 Working Day
(most of the time) - electronic triage has helped this

NOTE

NOTE

NOTE

Any Mismatches go on a holding table in NIECR - Red Flag Staff check.

DIAGNOSTIC
MRI, CT, Flexible Cystoscopy, Blood Test, PSA, Urine Test

MDM input required?

OUTPATIENTS

Yes

No

NOTE

No

F2F / Virtual /OP Apats
Red Flag Urology

(One Waiting List which is booked to specialist clinics where required) Patients taken in chronological order)

Down Graded Referrals
New/Urgent Review
i.e. not red flag

THESE APTS ARE BOOKED BY BOOKING CENTRE TEAM

Yes

Haematuria Apts

Prostate / Renal Apts

Consultant Led Urology

THESE APTS ARE BOOKED BY BOOKING CENTRE TEAM

Nurse Led Urology LUTS

THESE APTS ARE BOOKED BY BOOKING CENTRE TEAM

NOTE
NOTE

MDM
Takes Place Weekly
Thursday Afternoon

PATIENT SEEN REQUEST FOR DIAGNOSTICS OR MDM
Patients could then be downgraded from Red Flag to Routine (Routine Review List) or routine Diagnostic

MDM REview apt Following Discussion at MDM
This apt is booked by Medical Secretary

DECISION TO TREAT PATHWAY

CHALLENGES REMAIN

DECISION TO TREAT PATHWAY

Decision to Treat Pathway has received all appointments and referral will come from MDM Meetings
Following these meetings a Management Plan is decided for Patient (Target of 31

NOTE

SURGERY
Medical Secretary will add patient to WL for Surgery this could e local or Belfast (Scheduling Team will look after Belfast Surgery REquests)

Oncology
Referral made by Medical Secretary on system and letter dictated by consultant signed and sent to Oncology Team for

CHEMOTHERAPY
Consultant will do referral - dictate letter medical secretary type and send referral

RADIOTHERAPY
Consultant will do referral - dictate letter medical secretary type and send referral

SPECIAL PALLIATIVE CARE

HORMONE THERAPY
SOME PRESCRIBED ON DAY BY CONSULTANT
SOME PRESCRIBED BY BELFAST AND WILL REQUIRE REFERRAL

SABR

IMMUNOTHERAPY
Consultant will do referral - dictate letter medical secretary type and send referral

BRACHYTHEARPY
Consultant will do referral - dictate letter medical secretary type and send referral

ACTIVE MONITORING
Consultant will ARRANGE PATIENT TO BE ADMITTED TO WARD

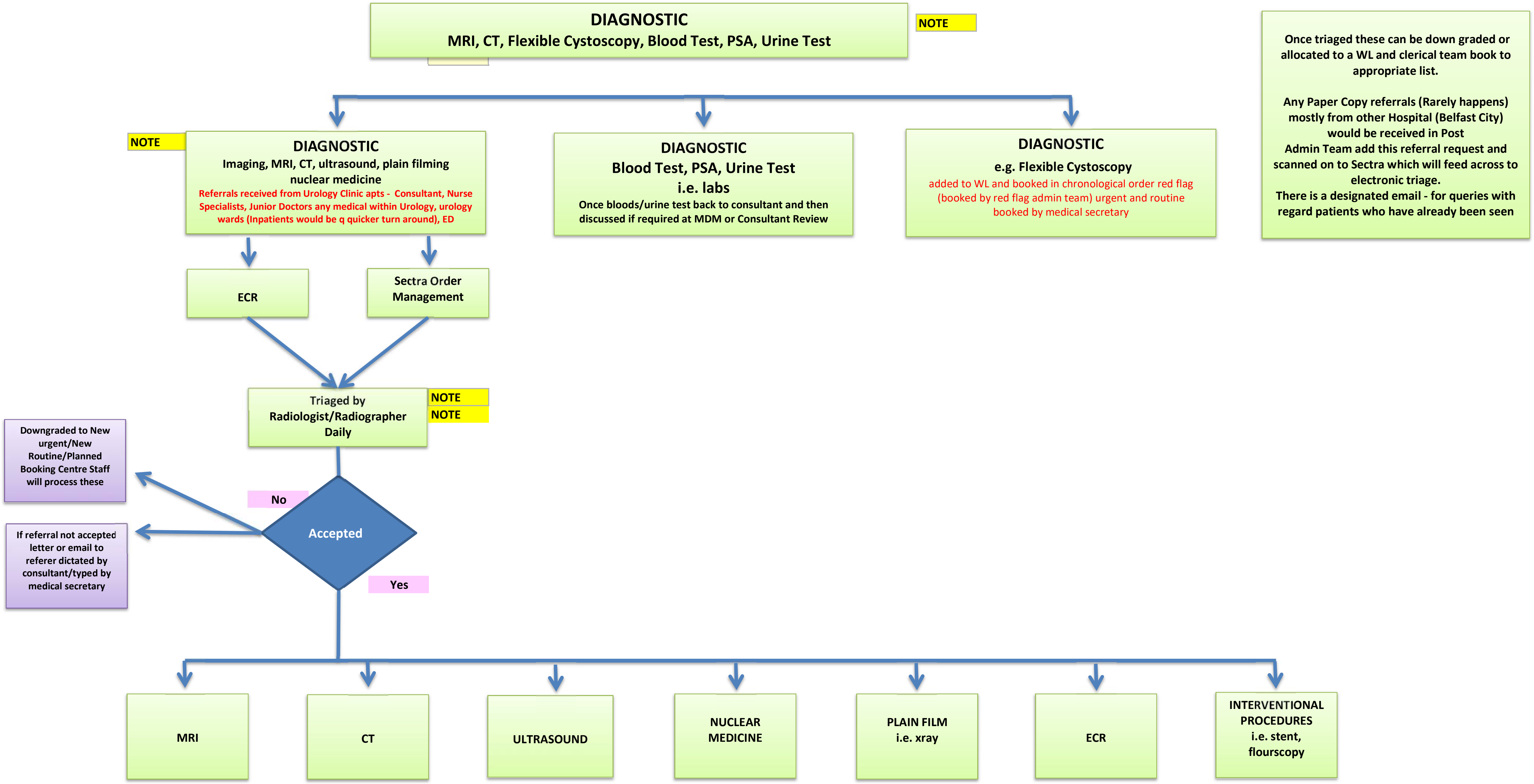
WATCHFUL WAITING
ADDED TO REVIEW WL FOR FOLLOW UP AT SPECIFIED TIME

CONSULTANT DECISION NOT TO TREAT

PATIENT DECISION NOT TO TREAT

Note Following these first definitive treatment - Tracker No longer tracks (Not Funded) after this apt

Wendy Clayton
sharon glenny
orla poland
emma lawless
gillian reaney
Hannah Jackson
caroline barron
jane scott
denise newell



DIAGNOSTIC
MRI, CT, Flexible Cystoscopy, Blood Test, PSA, Urine Test

NOTE

Once triaged these can be down graded or allocated to a WL and clerical team book to appropriate list.

Any Paper Copy referrals (Rarely happens) mostly from other Hospital (Belfast City) would be received in Post
Admin Team add this referral request and scanned on to Sectra which will feed across to electronic triage.
There is a designated email - for queries with regard patients who have already been seen

NOTE

DIAGNOSTIC
Imaging, MRI, CT, ultrasound, plain filming nuclear medicine
Referrals received from Urology Clinic apts - Consultant, Nurse Specialists, Junior Doctors any medical within Urology, urology wards (Inpatients would be q quicker turn around), ED

DIAGNOSTIC
Blood Test, PSA, Urine Test
i.e. labs
Once bloods/urine test back to consultant and then discussed if required at MDM or Consultant Review

DIAGNOSTIC
e.g. Flexible Cystoscopy
added to WL and booked in chronological order red flag (booked by red flag admin team) urgent and routine booked by medical secretary

ECR

Sectra Order Management

Triaged by
Radiologist/Radiographer
Daily

NOTE
NOTE

Accepted

No

Downgraded to New urgent/New Routine/Planned Booking Centre Staff will process these

If referral not accepted letter or email to referer dictated by consultant/typed by medical secretary

Yes

MRI

CT

ULTRASOUND

NUCLEAR MEDICINE

PLAIN FILM
i.e. xray

ECR

INTERVENTIONAL PROCEDURES
i.e. stent, flourscopy

CHALLENGES NOTED

PACS MONITOR AND IDENTIFY PATIENTS SUITABLE FOR TRANSFERRING TO IS (Independent Sector) for investigation requested, ultra sound, CT or MRI. They appoint on the longest waiter . INPATIENTS ARE CATERED FOR INHOUSE AS THEY WOULD NOT BE SUITABLE CANDIDATES FOR MOVING FOR INVESTIGATION. General outpatient and Redflag and urgent and routine.

THIS IS ALL COMPLETED ON WL - IDENTIFIED ON WL AND ARE MOVED ELECTRONICALLY TRANSFER ELECTRONICALLY TO PUT A NOTE ON THE SYSTEM INDENTIFYING IT IS INDEPENDENT SYSTEM THAT THEY HAVE SENT TO INDEPENDENT SECTOR FOR APT AND ASSOCIATED SPREADSHEET
ONCE REPORT SEEN IS ELECTRONIC AND THIS IS AVAILABLE IMMEDIATELY ON ECR AND GOOD RAPORT TO FIND OUT APTS - CROSS REFERENCING BOTH SYSTEMS FROM IS AND THE SHSCT IS, CANCER TRACKER HAS ACCESS TO RIS TO TRACK PATIENT.

Appendix 1- This is the potential process map template that will be used for the data mapping exercise being completed. The QI team have shared this pending further discussions and we will be provided with the final template once agreed. This one is for reference and details a previous exercise completed.

Process Map
Example.xlsx

Appendix 2- These are the 7 elements included in clinical governance. Individually and collectively they allow an organisation to establish how well they are performing, identify areas for quality improvement, to safeguard and maintain standards and provide assurance that a service is functioning and delivering high quality safe care.

Appendix 3- This is the regional tool used for assessing the structure/ performance of and MDT

Characteristics of an
Effective MDT Self As

Appendix 4- Minimum Data Set Form for MDM. This is the standardised data that must be submitted by all

MDM Proforma.docx

Appendix 5- This is the Cancer Action Teams guidance for Effective MDT

NCAT_MDT_Charact
eristics_FINAL.PDF

Appendix 6- This is the results from the baseline assessment of all tumour site MDTS

NCAT Self
Assessment of MDTS

Appendix 7- This is the action plan devised following the baseline assessment for each MDT chair to review and implement

MDT Service Improvement action p MDT Service Improvement action p

Appendix 8- Draft MDT Principals Document

Draft MDT Principles Document.xlsx

Appendix 9- This is the most recent feedback (2018)

CPES Report - feedback from urolog

Appendix 10- This is the regional policy outlining the information that must be given to patients on diagnosis

NICaN policy on patient information.p

Appendix 11- Template for Patient Survey

Appendix 12- Cancer Strategy 2021-2031

Cancer Strategy 2021-2031.html

Appendix 1- Training Figures. Lorna Nevin (PHA) currently setting up regional group to look at Advanced Communication Training as it is being delivered virtually in the UK and we want to move to that model here. Plans/ updates to follow

? Advanced Communication Skills Guidance

Appendix 1- Breaking Bad News Clinic Guidance. Note 2003 and PHA acknowledge this.

4b-breaking_bad_news-ireland-1.pdf

Appendix 14- Guidance for CNS weekly job plan and all elements of roles/ responsibilities

NIPEC Job Planning
Guidance for CNS role

Appendix 15- Assessment tool for CNS

Core Competence
Assessment Tool for (

Appendix 16- Whistle Blowing Policy/ Raising Concerns and Accountability & Assurance

DOH Your Right to
Raise a Concern- Whi

Whistleblowing
Policy.pdf

Nursing and
Midwifery Accountabi

Working Well
Together Policy.pdf

Appendix 17- Revalidation NMC & GMC guidelines

Revalidation lapses and actions

Appendix 18- Supervision Policy

Nursing Supervision
Policy.pdf

Appendix 19-Peer review data 2018

Oncology Cancer
Peer Review 2018.pd

Appendix 21- MDM attendance recommendations

Appendix 22- Cancer Tracking Guidelines for Urology

Urology-Care-Pathw
ay.pdf

Appendix 23- Holistic Needs Assessment Macmillan Guidance

https://www.google.co.uk/url?esrc=s&q=&rct=j&sa=U&url=https://www.macmillan.org.uk/healthcare-professionals/innovation-in-cancer-care/holistic-needs-assessment&ved=2ahUKEwjqrrDkpNT0AhVHZcAKHbO6Dn0QFnoECAcQAg&usg=AOvVaw2yoieKrbEhJOGsJaBqlErC

Appendix 24- Key Performance Indicators for Cancer Nurse Specialists from Macmillan

https://www.macmillan.org.uk/documents/aboutus/commissioners/excellenceincancercarethecontributionoftheclinicalnursespecialist.pdf

Appendix 25- NMC Code of Conduct

Appendix 26- Job Description of MDT Administrator

Appendix 27 – Process Map (Draft)

20211207_Urology Pathway Proces Map_

Care Opinion
What's your story?

Urology Services

Our staff would really value your feedback on the services that they are providing. Your story might be about you, or someone close to you. You can say what happened, what was good, and what could have been better. Care Opinion allows you to leave your feedback in a number of ways:

Online with text - www.careopinion.org.uk

Online with Images - www.careopinion.org.uk

Free post leaflet – write or draw

Freephone: 0800 122 3135

For further information on Care Opinion please contact:
Christine Armstrong or Mairead Casey, Patient and Client Experience Facilitators
Christine: 02837 560151 Mairead: 077 89505502

Southern Health and Social Care Trust
Quality Care - for you, with you

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Southern Health and Social Care Trust
Quality Care - for you, with you

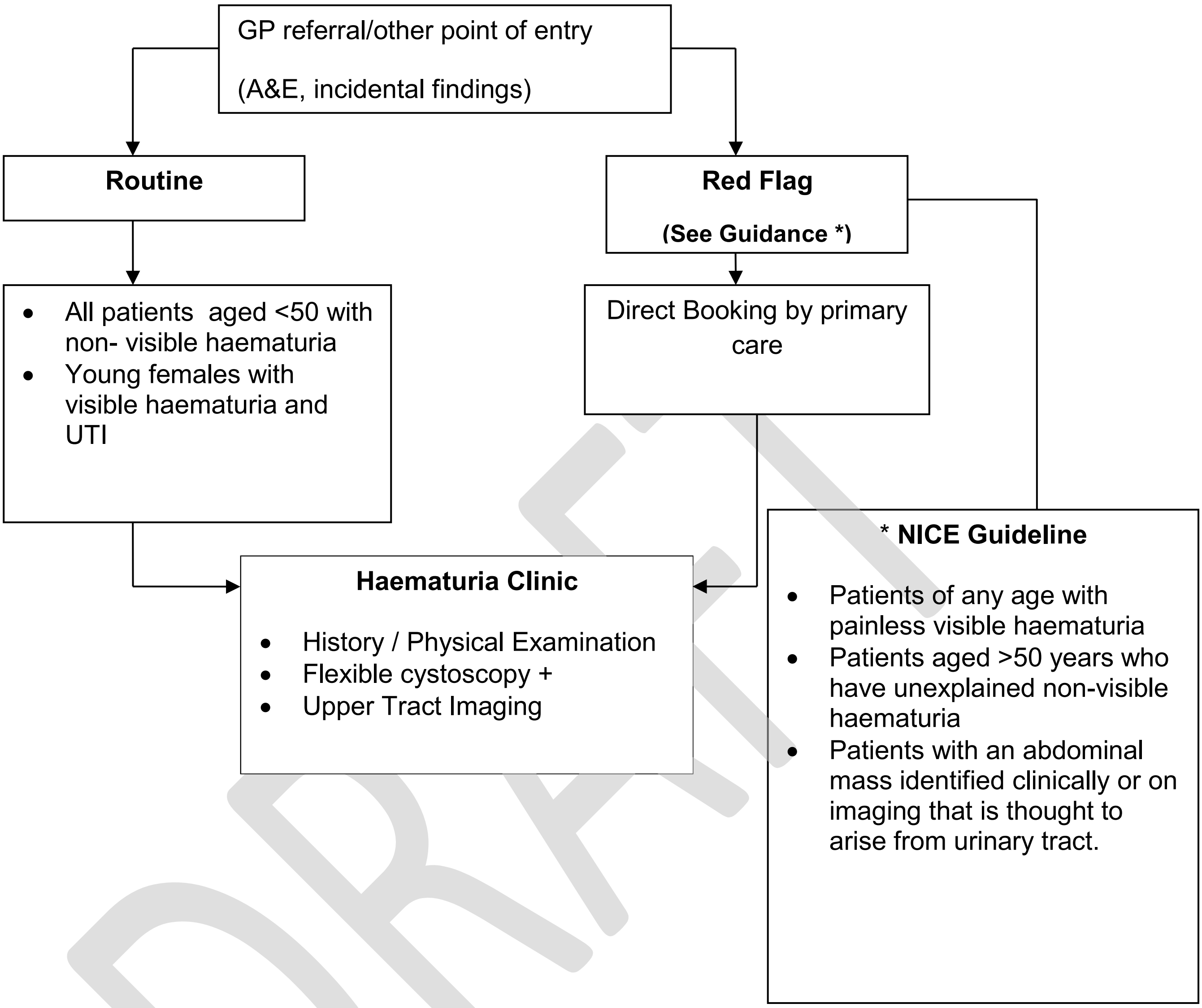
NICaN
Northern Ireland Cancer Network

Urology Care Pathways

Cancer Care Pathways outline the steps and stages in the patient journey from referral through to diagnostics, staging, treatment, follow up, rehabilitation and if applicable onto palliative care.

Timed effective care pathways are central to delivering quality and timely care to patients throughout their cancer journey and to the delivery of an equitable service. These pathways have been developed following with reference to available best practice guidance. They represent an 'ideal' pathway that can be adapted for local use. The timelines on the pathway are intended to facilitate the proactive management of patients within the access standards and it is to be noted that for some urological tumours, the patient will move much quicker through the pathway (e.g. testicular cancer).

Haematuria Referral Guideline



GP referral/other point of entry

(A&E, incidental findings)

Routine

- All patients aged <50 with non- visible haematuria
- Young females with visible haematuria and UTI

Red Flag

(See Guidance *)

Direct Booking by primary care

Haematuria Clinic

- History / Physical Examination
- Flexible cystoscopy +
- Upper Tract Imaging

*** NICE Guideline**

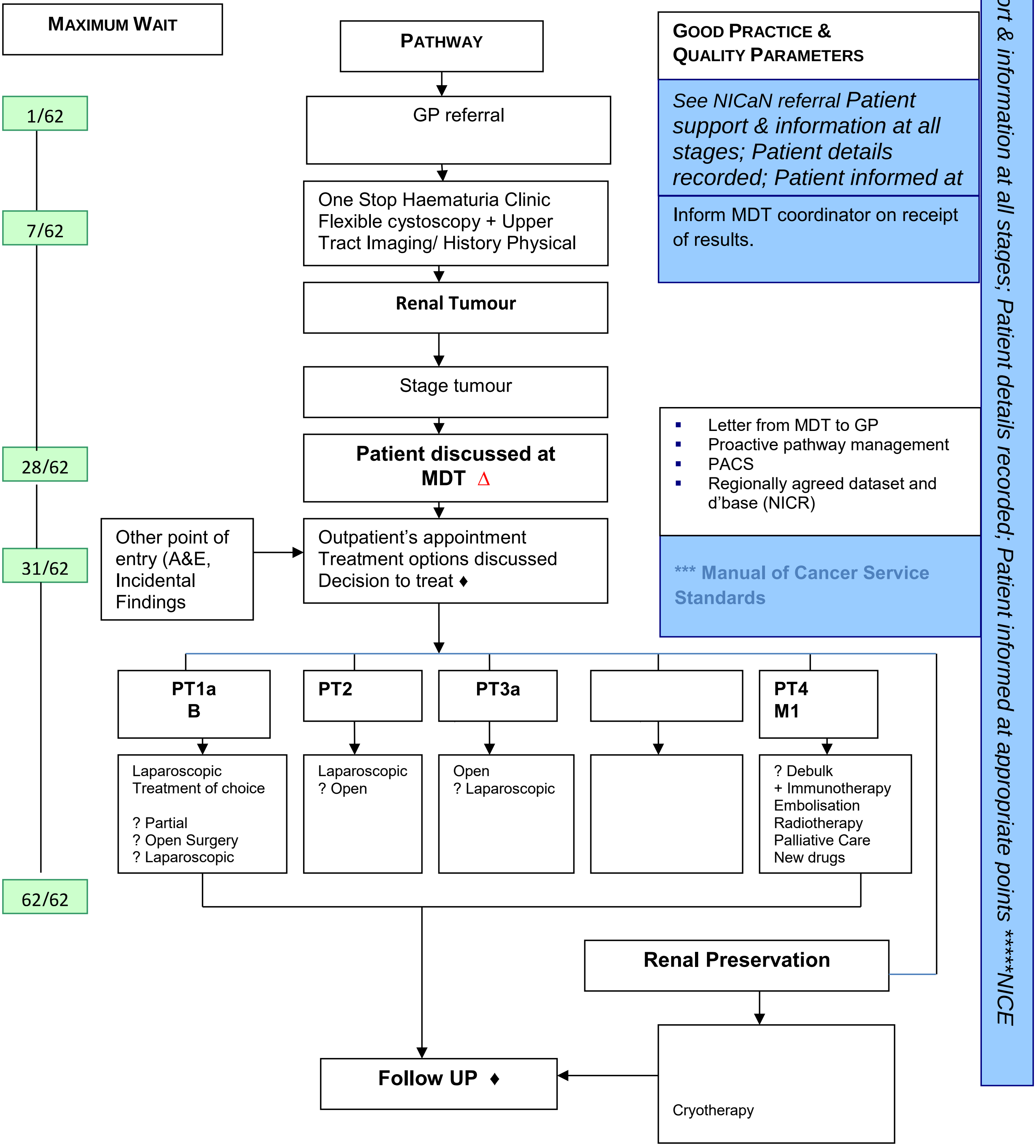
- Patients of any age with painless visible haematuria
- Patients aged >50 years who have unexplained non-visible haematuria
- Patients with an abdominal mass identified clinically or on imaging that is thought to arise from urinary tract.

NOTE: Please Consider Nephrology referral as well as referral to haematuria clinic if the patient has any of the following:

- Diabetes
- Proteinuria
- Hypertension

Appendix 3 of NICaN Urology Cancer Clinical Guidelines

Renal Tumour



MAXIMUM WAIT

1/62

7/62

28/62

31/62

62/62

PATHWAY

GP referral

One Stop Haematuria Clinic
Flexible cystoscopy + Upper Tract Imaging/ History Physical

Renal Tumour

Stage tumour

Patient discussed at MDT ∆

Other point of entry (A&E, Incidental Findings

Outpatient's appointment
Treatment options discussed
Decision to treat ♦

PT1a B
Laparoscopic
Treatment of choice

? Partial
? Open Surgery
? Laparoscopic

PT2
Laparoscopic
? Open

PT3a
Open
? Laparoscopic

PT4 M1
? Debulk
+ Immunotherapy
Embolisation
Radiotherapy
Palliative Care
New drugs

Renal Preservation

Cryotherapy

Follow UP ♦

GOOD PRACTICE & QUALITY PARAMETERS

See NICaN referral Patient support & information at all stages; Patient details recorded; Patient informed at

Inform MDT coordinator on receipt of results.

- Letter from MDT to GP
- Proactive pathway management
- PACS
- Regionally agreed dataset and d'base (NICR)

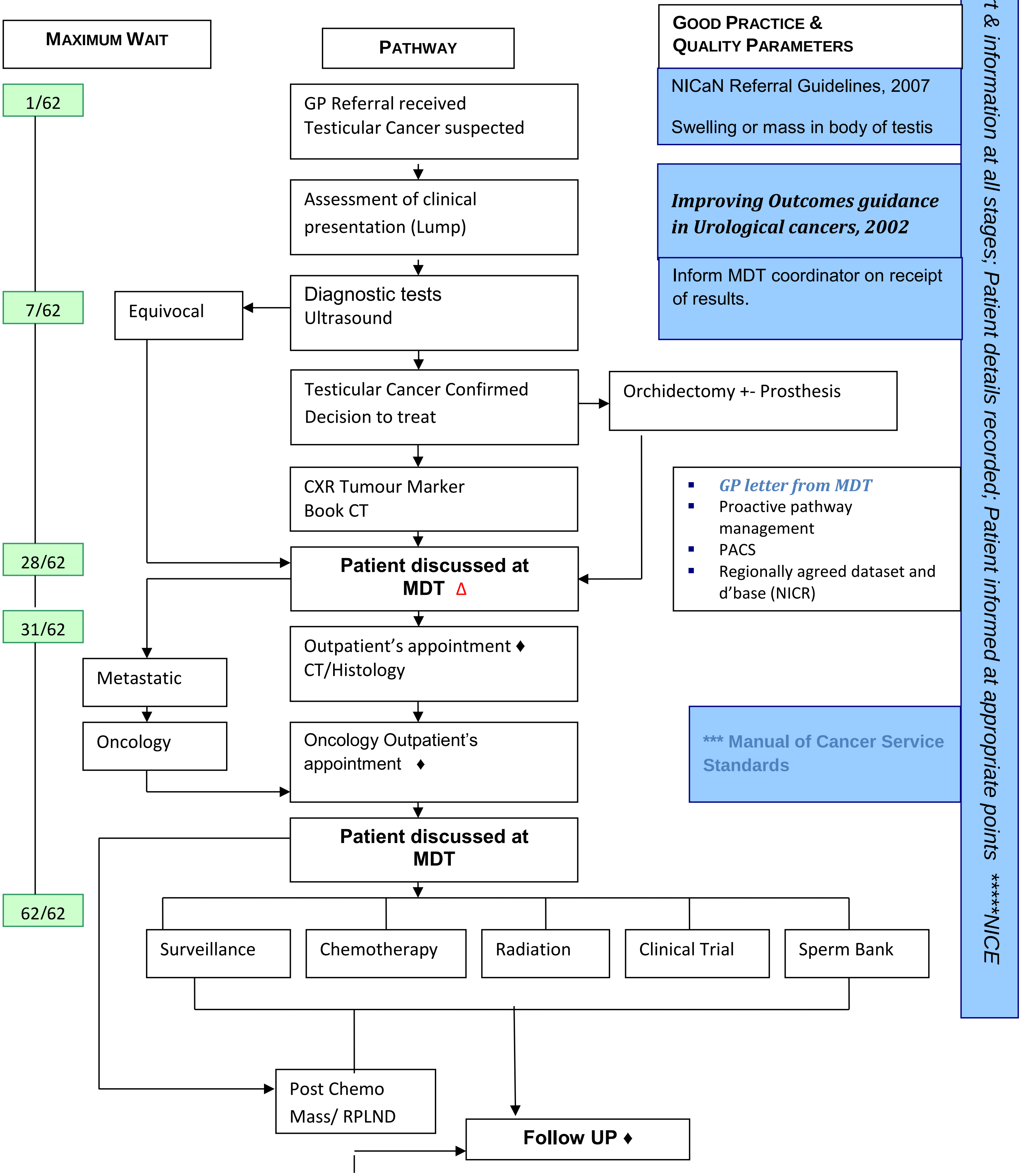
***** Manual of Cancer Service Standards**

*Patient support & information at all stages; Patient details recorded; Patient informed at appropriate points ****NICE*

♦ Indicates point of holistic assessment ∆ Inter-Trust transfer by Day 28

Appendix 3 of NICaN Urology Cancer Clinical Guidelines

Testicular Cancer Pathway



MAXIMUM WAIT

1/62

7/62

28/62

31/62

62/62

PATHWAY

GP Referral received
Testicular Cancer suspected

Assessment of clinical presentation (Lump)

Diagnostic tests
Ultrasound

Equivocal

Testicular Cancer Confirmed
Decision to treat

Orchidectomy +- Prosthesis

CXR Tumour Marker
Book CT

Patient discussed at MDT ∆

Metastatic

Oncology

Outpatient's appointment ♦
CT/Histology

Oncology Outpatient's appointment ♦

Patient discussed at MDT

Surveillance

Chemotherapy

Radiation

Clinical Trial

Sperm Bank

Post Chemo
Mass/ RPLND

Follow UP ♦

GOOD PRACTICE & QUALITY PARAMETERS

NICaN Referral Guidelines, 2007

Swelling or mass in body of testis

Improving Outcomes guidance in Urological cancers, 2002

Inform MDT coordinator on receipt of results.

- *GP letter from MDT*
- Proactive pathway management
- PACS
- Regionally agreed dataset and d'base (NICR)

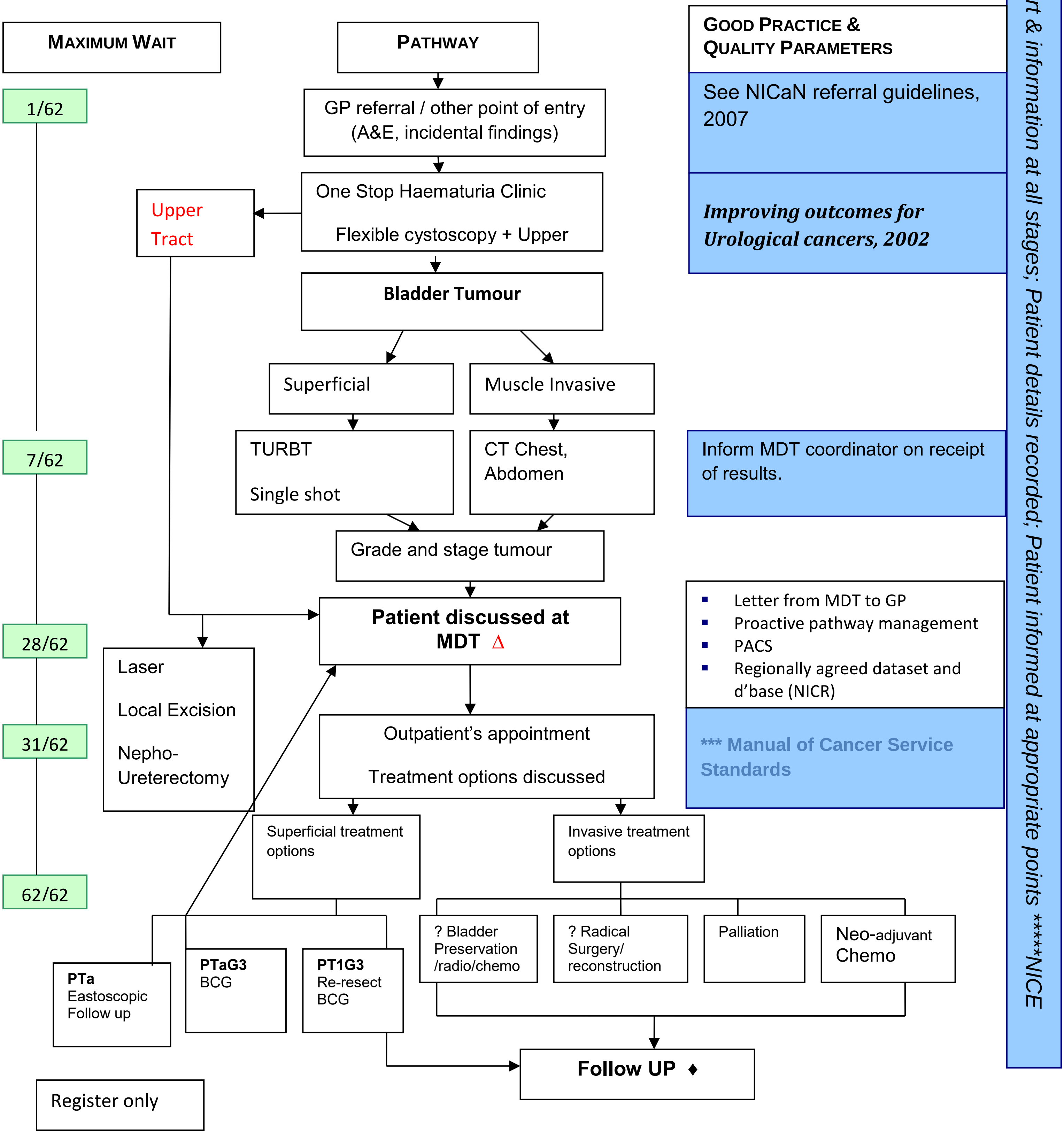
***** Manual of Cancer Service Standards**

*Patient support & information at all stages; Patient details recorded; Patient informed at appropriate points ****NICE*

♦ Indicates point of holistic assessment ∆ Inter-Trust transfer by Day 28

Appendix 3 of NICaN Urology Cancer Clinical Guidelines

♦ Indicates point of holistic assessment ∆ Inter-Trust transfer by Day 28



MAXIMUM WAIT

1/62

7/62

28/62

31/62

62/62

PATHWAY

GP referral / other point of entry (A&E, incidental findings)

One Stop Haematuria Clinic

Flexible cystoscopy + Upper

Upper Tract

Laser

Local Excision

Nepho-Ureterectomy

Bladder Tumour

Superficial

Muscle Invasive

TURBT

Single shot

CT Chest, Abdomen

Grade and stage tumour

Patient discussed at MDT ∆

Outpatient's appointment

Treatment options discussed

Superficial treatment options

PTa Eastoscopic Follow up

PTaG3 BCG

PT1G3 Re-resect BCG

Register only

Invasive treatment options

? Bladder Preservation /radio/chemo

? Radical Surgery/ reconstruction

Palliation

Neo-adjuvant Chemo

Follow UP ♦

GOOD PRACTICE & QUALITY PARAMETERS

See NICaN referral guidelines, 2007

Improving outcomes for Urological cancers, 2002

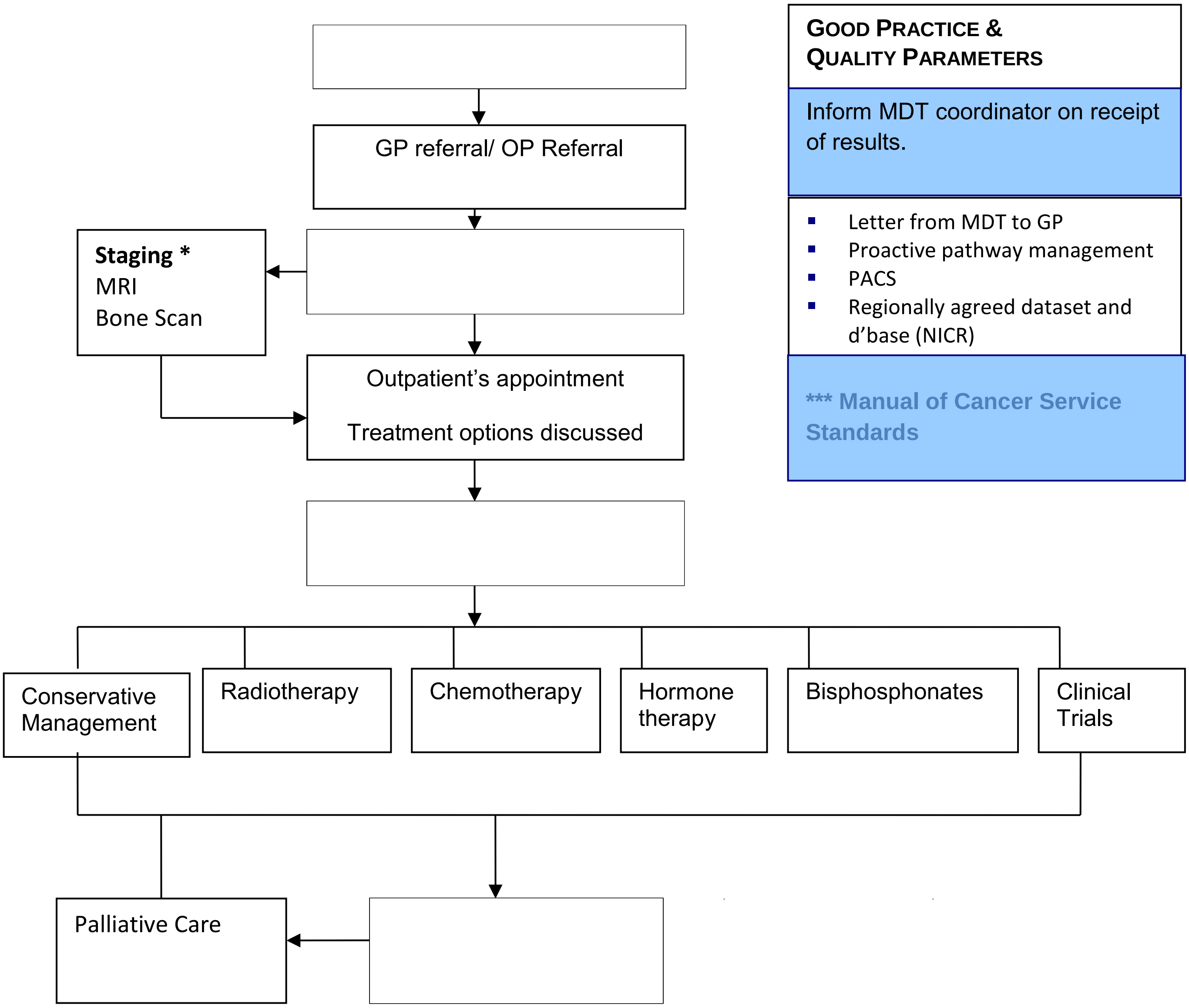
Inform MDT coordinator on receipt of results.

- Letter from MDT to GP
- Proactive pathway management
- PACS
- Regionally agreed dataset and d'base (NICR)

***** Manual of Cancer Service Standards**

*Patient support & information at all stages; Patient details recorded; Patient informed at appropriate points ****NICE*

Castration Resistant Prostate Cancer



GOOD PRACTICE & QUALITY PARAMETERS

Inform MDT coordinator on receipt of results.

- Letter from MDT to GP
- Proactive pathway management
- PACS
- Regionally agreed dataset and d'base (NICR)

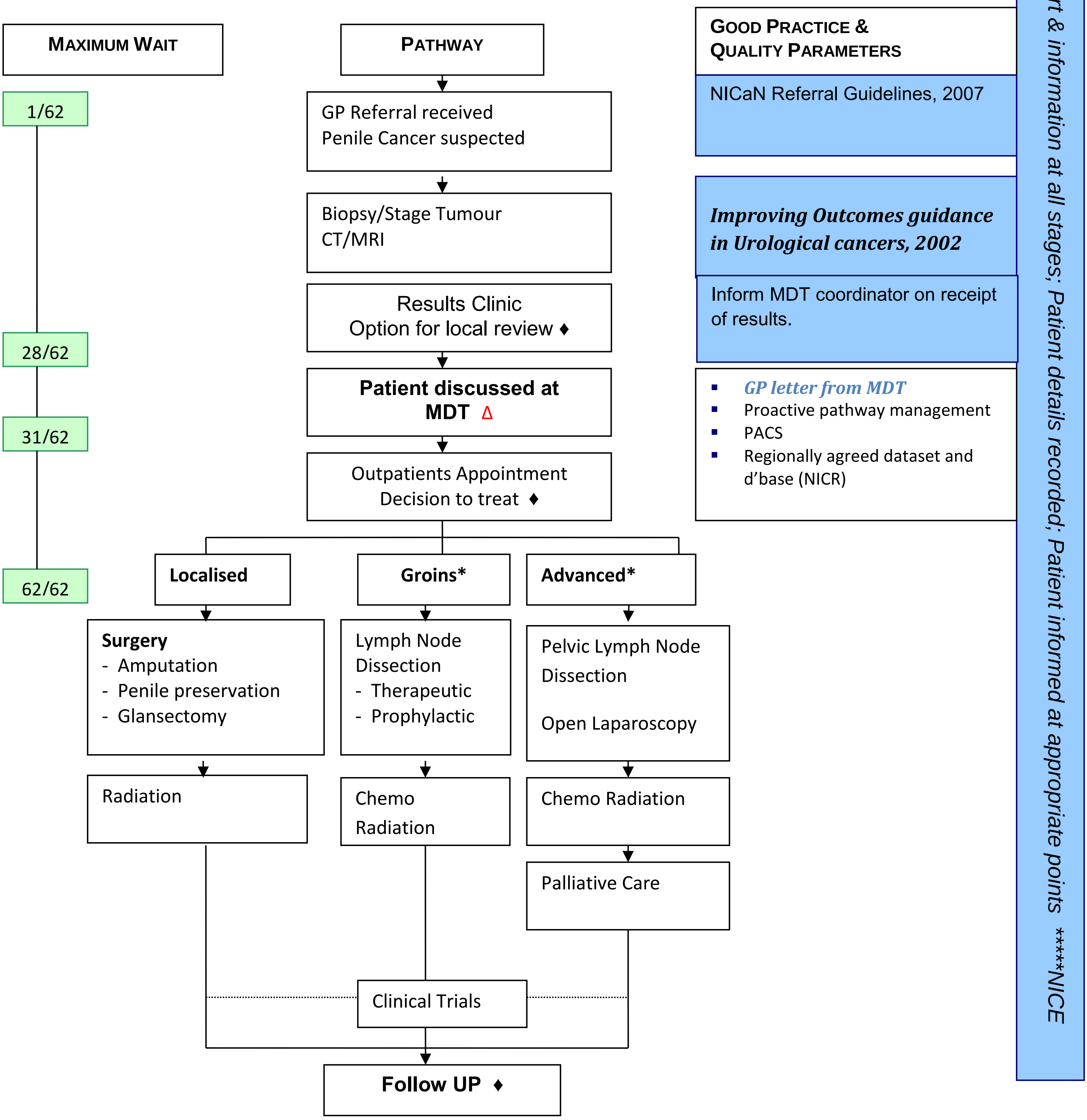
***** Manual of Cancer Service Standards**

*Patient support & information at all stages; Patient details recorded; Patient informed at appropriate points ****NICE*

* MRI/Bone Scan as clinically indicated

Appendix 3 of NICaN Urology Cancer Clinical Guidelines

Penile Cancer Pathway (Currently Under Review as part of development of local penile service 2019)



MAXIMUM WAIT

1/62

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31/62

62/62

PATHWAY

GP Referral received
Penile Cancer suspected

Biopsy/Stage Tumour
CT/MRI

Results Clinic
Option for local review ♦

Patient discussed at MDT Δ

Outpatients Appointment
Decision to treat ♦

Localised

Surgery
- Amputation
- Penile preservation
- Glansectomy

Radiation

Groins*

Lymph Node Dissection
- Therapeutic
- Prophylactic

Chemo
Radiation

Advanced*

Pelvic Lymph Node Dissection

Open Laparoscopy

Chemo Radiation

Palliative Care

Clinical Trials

Follow UP ♦

GOOD PRACTICE & QUALITY PARAMETERS

NICaN Referral Guidelines, 2007

Improving Outcomes guidance in Urological cancers, 2002

Inform MDT coordinator on receipt of results.

- *GP letter from MDT*
- Proactive pathway management
- PACS
- Regionally agreed dataset and d'base (NICR)

*Patient support & information at all stages; Patient details recorded; Patient informed at appropriate points ****NICE*

♦ Indicates point of holistic assessment Δ Inter-Trust transfer by Day 28

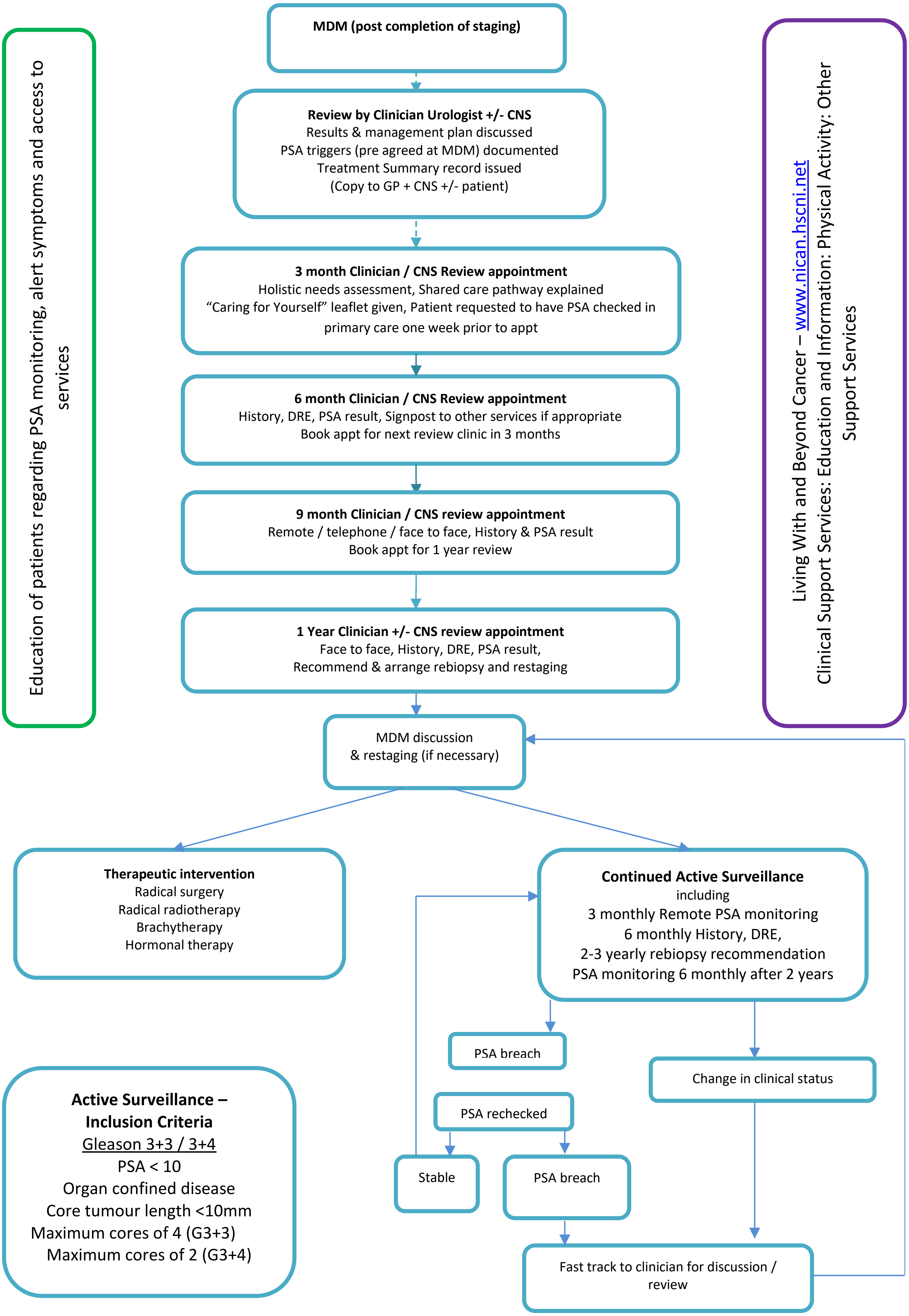
Appendix 3 of NICaN Urology Cancer Clinical Guidelines

Policy Code / Reference No:

Trust Logo

Appendix 3 of NICaN Urology Cancer Clinical Guidelines

Pathway 2 Prostate Cancer: Active Surveillance



Education of patients regarding PSA monitoring, alert symptoms and access to services

MDM (post completion of staging)

Review by Clinician Urologist +/- CNS
Results & management plan discussed
PSA triggers (pre agreed at MDM) documented
Treatment Summary record issued
(Copy to GP + CNS +/- patient)

3 month Clinician / CNS Review appointment
Holistic needs assessment, Shared care pathway explained
"Caring for Yourself" leaflet given, Patient requested to have PSA checked in primary care one week prior to appt

6 month Clinician / CNS Review appointment
History, DRE, PSA result, Signpost to other services if appropriate
Book appt for next review clinic in 3 months

9 month Clinician / CNS review appointment
Remote / telephone / face to face, History & PSA result
Book appt for 1 year review

1 Year Clinician +/- CNS review appointment
Face to face, History, DRE, PSA result,
Recommend & arrange rebiopsy and restaging

MDM discussion
& restaging (if necessary)

Therapeutic intervention
Radical surgery
Radical radiotherapy
Brachytherapy
Hormonal therapy

Continued Active Surveillance
including
3 monthly Remote PSA monitoring
6 monthly History, DRE,
2-3 yearly rebiopsy recommendation
PSA monitoring 6 monthly after 2 years

PSA breach

PSA rechecked

Stable

PSA breach

Change in clinical status

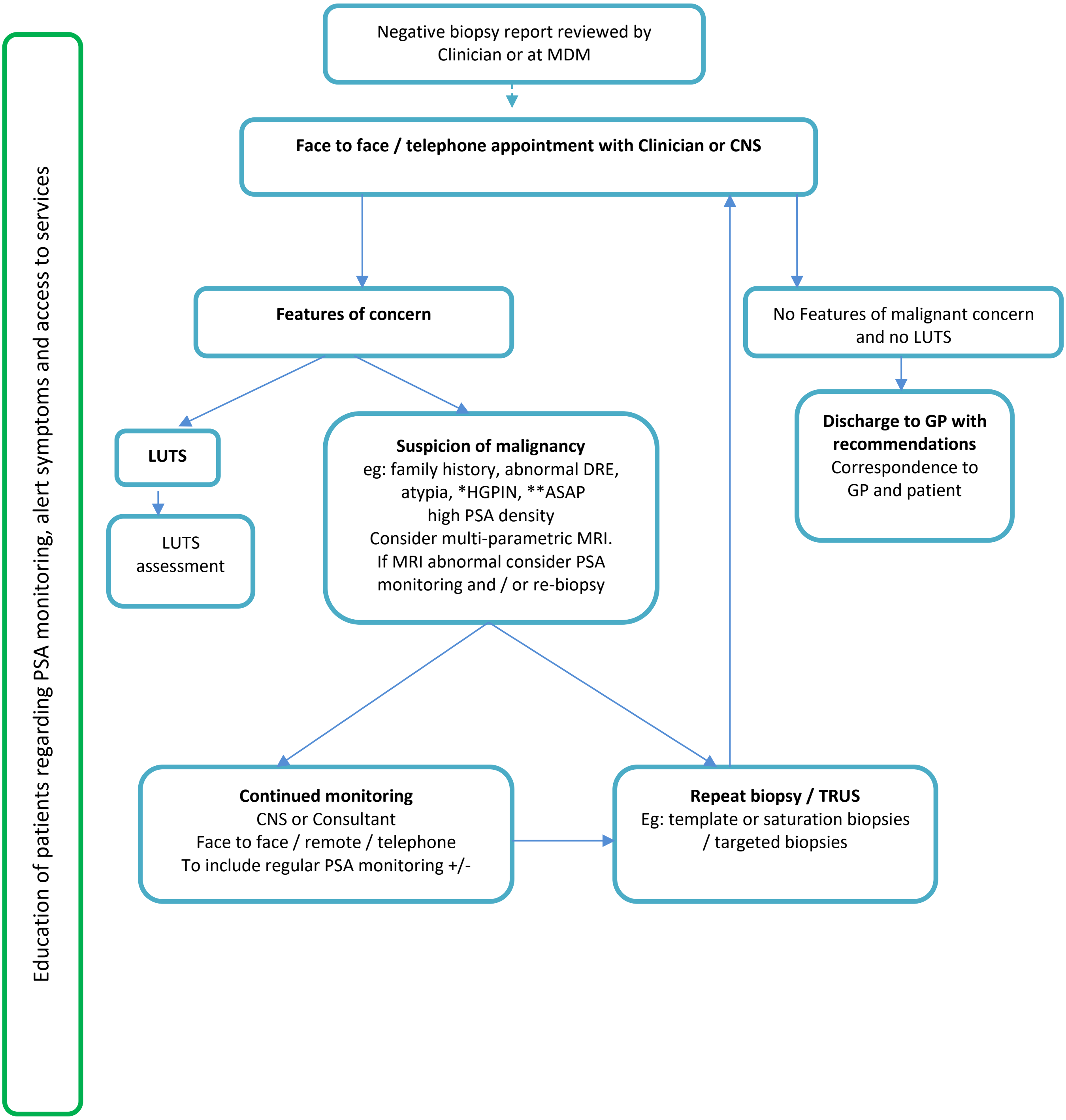
Fast track to clinician for discussion / review

Active Surveillance – Inclusion Criteria
Gleason 3+3 / 3+4
PSA < 10
Organ confined disease
Core tumour length <10mm
Maximum cores of 4 (G3+3)
Maximum cores of 2 (G3+4)

Living With and Beyond Cancer – www.nican.hscni.net
Clinical Support Services: Education and Information: Physical Activity: Other Support Services

Appendix 3 of NICaN Urology Cancer Clinical Guidelines

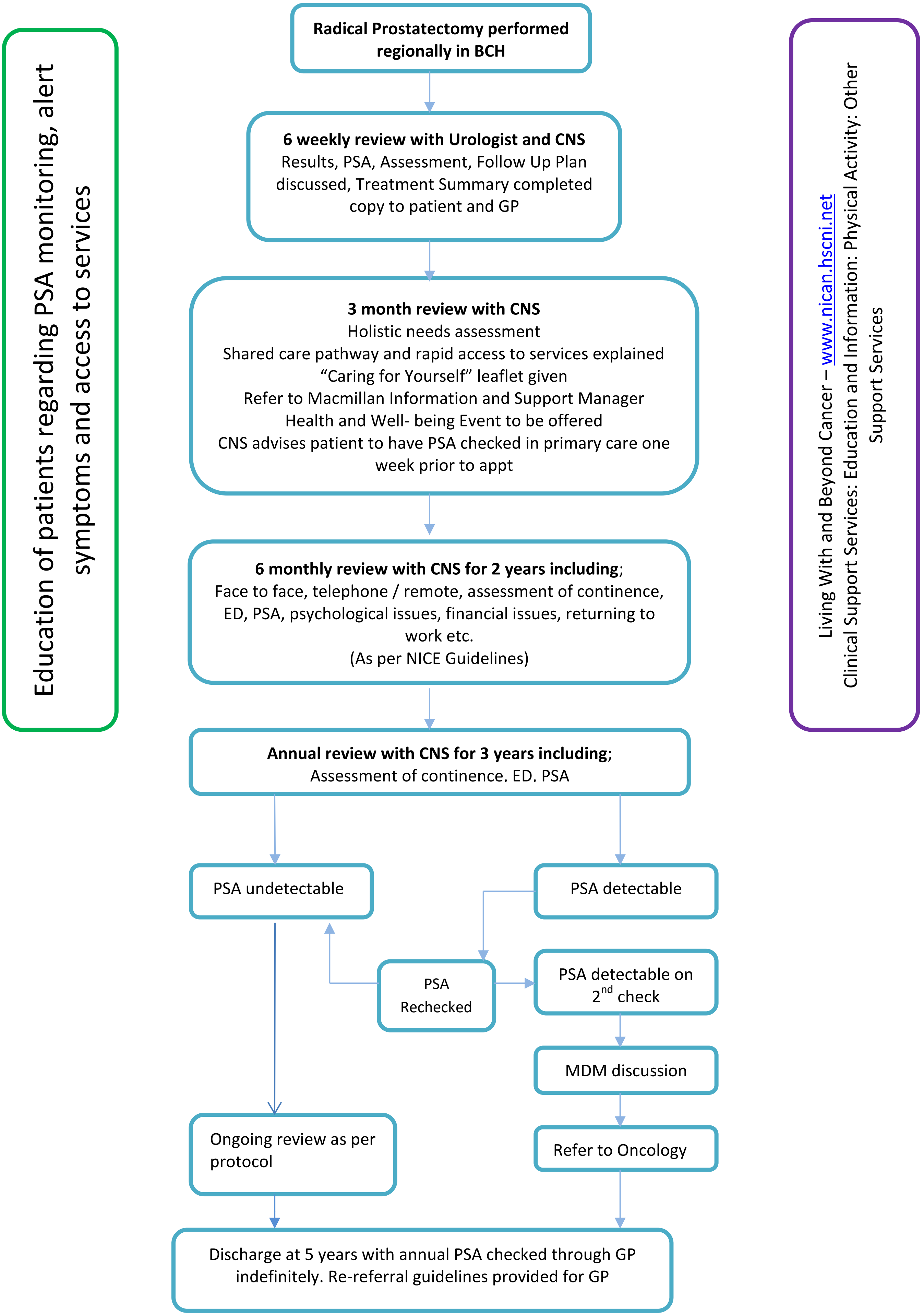
Pathway 3 Raised PSA & Negative Biopsy



*HGPIN – High grade prostatic intra-epithelial neoplasia
**ASAP – Atypical small acinar proliferation

Appendix 3 of NICaN Urology Cancer Clinical Guidelines

Pathway 4 Prostate Cancer: Radical Surgery – Negative margins



Education of patients regarding PSA monitoring, alert symptoms and access to services

Radical Prostatectomy performed regionally in BCH

6 weekly review with Urologist and CNS
Results, PSA, Assessment, Follow Up Plan discussed, Treatment Summary completed copy to patient and GP

3 month review with CNS
Holistic needs assessment
Shared care pathway and rapid access to services explained
“Caring for Yourself” leaflet given
Refer to Macmillan Information and Support Manager
Health and Well- being Event to be offered
CNS advises patient to have PSA checked in primary care one week prior to appt

6 monthly review with CNS for 2 years including;
Face to face, telephone / remote, assessment of continence, ED, PSA, psychological issues, financial issues, returning to work etc.
(As per NICE Guidelines)

Annual review with CNS for 3 years including;
Assessment of continence, ED, PSA

PSA undetectable

PSA detectable

PSA Rechecked

PSA detectable on 2nd check

MDM discussion

Refer to Oncology

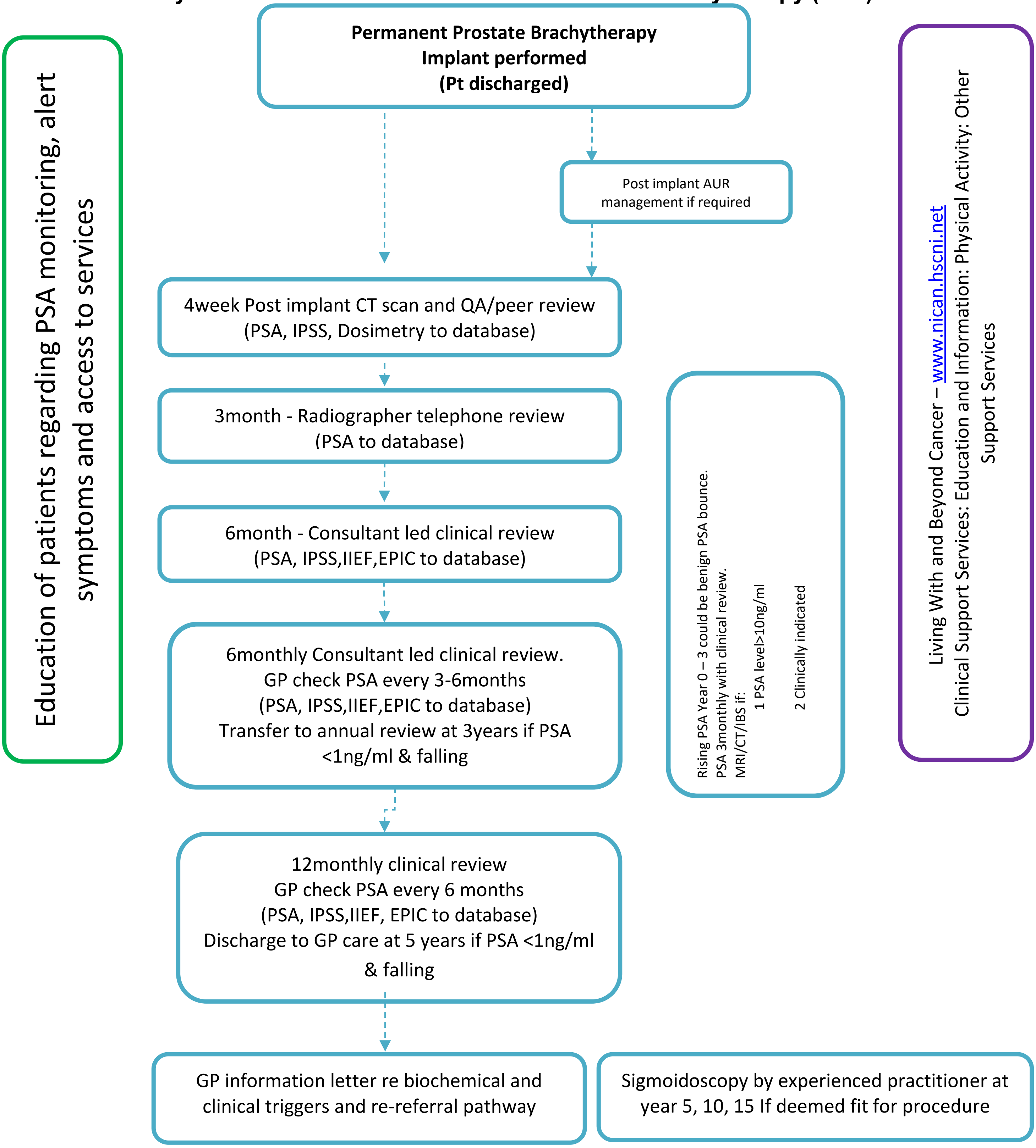
Ongoing review as per protocol

Discharge at 5 years with annual PSA checked through GP indefinitely. Re-referral guidelines provided for GP

Living With and Beyond Cancer – www.nican.hscni.net
Clinical Support Services: Education and Information: Physical Activity: Other Support Services

Appendix 3 of NICaN Urology Cancer Clinical Guidelines

Pathway 5 Prostate Cancer: Permanent Prostate Brachytherapy (LDR)



Permanent Prostate Brachytherapy
Implant performed
(Pt discharged)

Post implant AUR management if required

4week Post implant CT scan and QA/peer review
(PSA, IPSS, Dosimetry to database)

3month - Radiographer telephone review
(PSA to database)

6month - Consultant led clinical review
(PSA, IPSS,IIEF,EPIC to database)

6monthly Consultant led clinical review.
GP check PSA every 3-6months
(PSA, IPSS,IIEF,EPIC to database)
Transfer to annual review at 3years if PSA <1ng/ml & falling

12monthly clinical review
GP check PSA every 6 months
(PSA, IPSS,IIEF, EPIC to database)
Discharge to GP care at 5 years if PSA <1ng/ml & falling

GP information letter re biochemical and clinical triggers and re-referral pathway

Sigmoidoscopy by experienced practitioner at year 5, 10, 15 If deemed fit for procedure

Education of patients regarding PSA monitoring, alert symptoms and access to services

Rising PSA Year 0 – 3 could be benign PSA bounce.
PSA 3monthly with clinical review.
MRI/CT/IBS if:
1 PSA level>10ng/ml
2 Clinically indicated

Living With and Beyond Cancer – www.nican.hscni.net
Clinical Support Services: Education and Information: Physical Activity: Other Support Services

Selection criteria for Permanent Prostate Brachytherapy

Clinical inclusion criteria:
Organ confined prostate cancer T1 or T2
Estimated life expectancy >10yrs
Gleason 6 and PSA <15ng/ml
Gleason 7 and PSA <15ng/ml

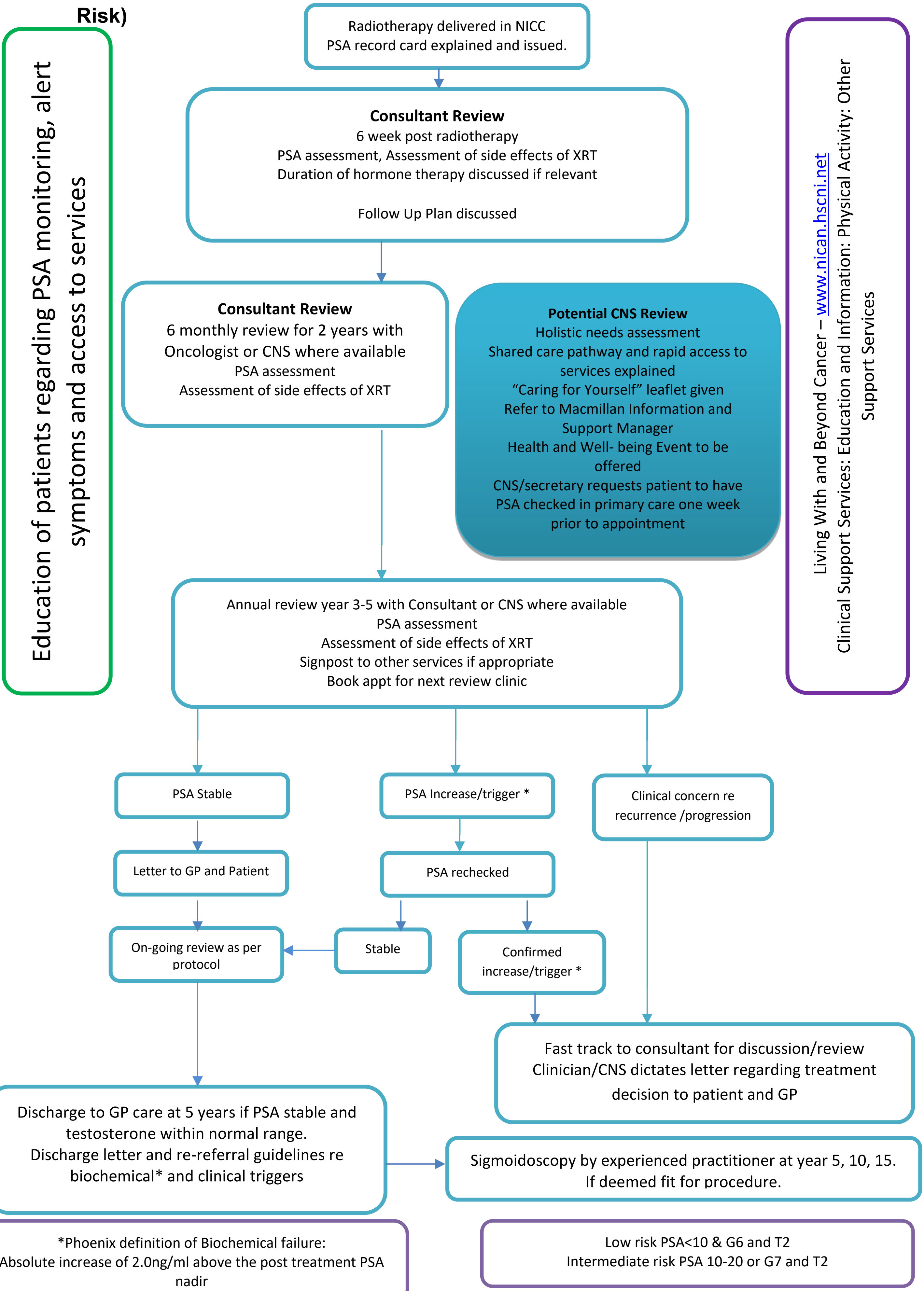
Clinical exclusion criteria for brachytherapy:
Prostate volume >50ml (> 65ml prior to hormonal cytoreduction)
IPSS >9. (Would consider for implant is <15 & Qmax >12ml/sec)
Life expectancy <5years
Large or poorly healed TURP defect
Unacceptable operative risk
Relative contraindications for brachytherapy:
Large median lobe

Selection criteria for combined Permanent Prostate Brachytherapy + EBRT

Selected men with:
High volume Gleason 7 or
Low volume Gleason >7 or
Early T3a disease
May be suitable for dose escalation with combination therapy and should be referred for discussion to central

Appendix 3 of NICaN Urology Cancer Clinical Guidelines

Pathway 6: Prostate Cancer: Radiotherapy+/-Hormones (Low Intermediate Risk)



Education of patients regarding PSA monitoring, alert symptoms and access to services

Radiotherapy delivered in NICC
PSA record card explained and issued.

Consultant Review
6 week post radiotherapy
PSA assessment, Assessment of side effects of XRT
Duration of hormone therapy discussed if relevant

Follow Up Plan discussed

Consultant Review
6 monthly review for 2 years with Oncologist or CNS where available
PSA assessment
Assessment of side effects of XRT

Potential CNS Review
Holistic needs assessment
Shared care pathway and rapid access to services explained
"Caring for Yourself" leaflet given
Refer to Macmillan Information and Support Manager
Health and Well- being Event to be offered
CNS/secretary requests patient to have PSA checked in primary care one week prior to appointment

Living With and Beyond Cancer – www.nican.hscni.net
Clinical Support Services: Education and Information: Physical Activity: Other Support Services

Annual review year 3-5 with Consultant or CNS where available
PSA assessment
Assessment of side effects of XRT
Signpost to other services if appropriate
Book appt for next review clinic

PSA Stable

Letter to GP and Patient

On-going review as per protocol

PSA Increase/trigger *

PSA rechecked

Stable

Confirmed increase/trigger *

Clinical concern re recurrence /progression

Fast track to consultant for discussion/review
Clinician/CNS dictates letter regarding treatment decision to patient and GP

Discharge to GP care at 5 years if PSA stable and testosterone within normal range.
Discharge letter and re-referral guidelines re biochemical* and clinical triggers

Sigmoidoscopy by experienced practitioner at year 5, 10, 15.
If deemed fit for procedure.

*Phoenix definition of Biochemical failure:
Absolute increase of 2.0ng/ml above the post treatment PSA nadir

Low risk PSA<10 & G6 and T2
Intermediate risk PSA 10-20 or G7 and T2

Brainstorm For Urology Cancer QI Project (Feb 22)

Questionnaire

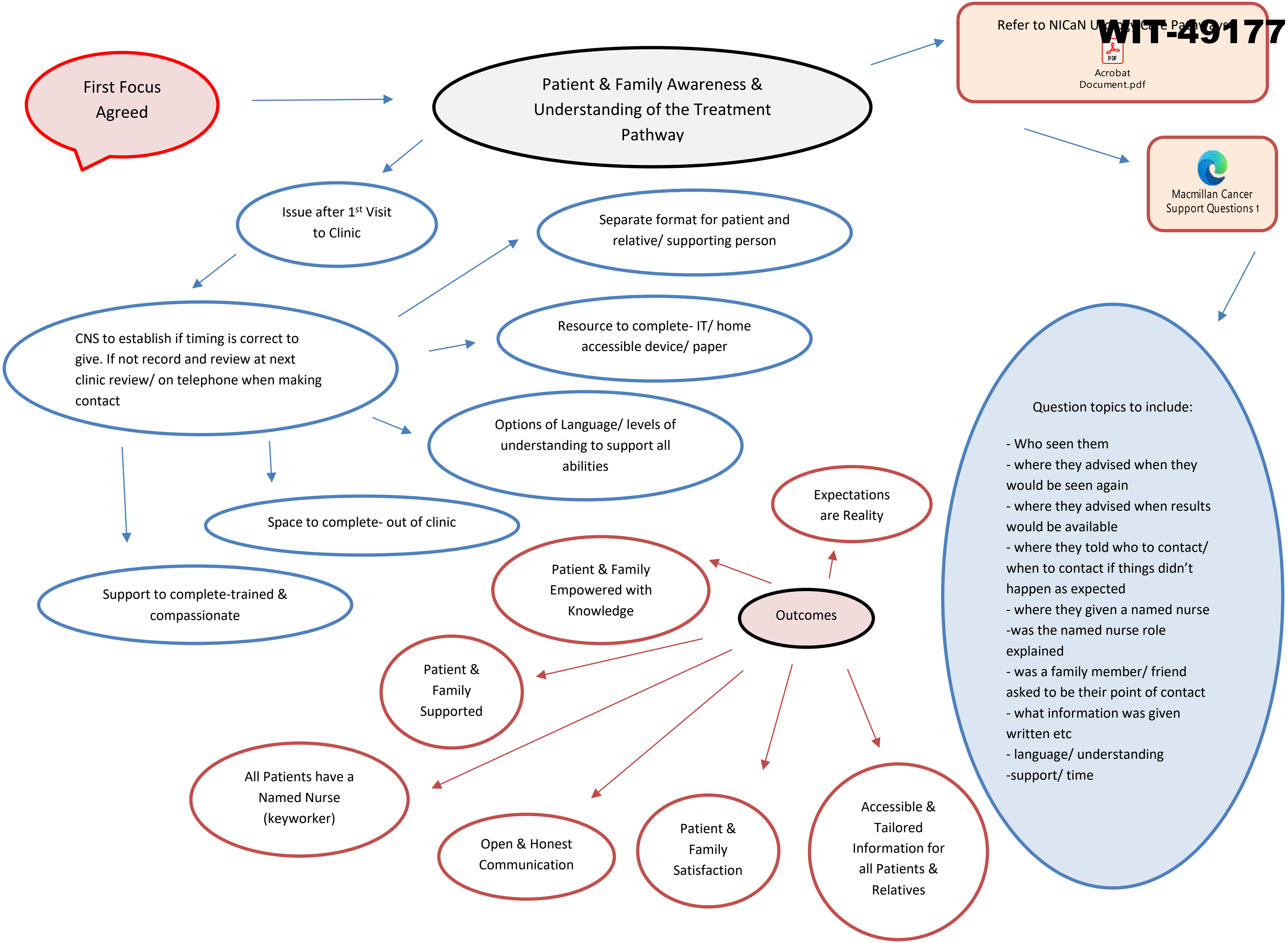
- Format- Paper Copy & online form. Automated bounce back email to thank for completion
- Separate questionnaire for patient and family/ support system
- Who completes this?
- Timing of Giving to Patients/ Family – Link with CNS for timing/ patient continuity
- Phased approach- sectioned for different stages
- Accessibility of technology- tablets for unit/ not all patients have access at home
- Multiple language options
- Assistance for patients/ relatives- eg reading/writing difficulties. Support from people who are trained
- Space to do away from clinic/ safe comfortable space

Knowledge

- What do patients/ families know about their treatment pathway
- Do patients/ families know the timescales associated with each stage
- Do patients know who to contact if they don't get what is expected
- Do patients feel empowered to ask about their journey of things not happening as expected
- Prompts for questions for patients to ask
- Is the information provided accessible/ available for all languages and abilities/ understanding

Process

- Patient passport for patients to prevent repetition of information
- MDT Hard copy of notes for those who cannot access online HNA for example
- Summary sheets detailing last scan/last appointment
- Journal options to allow thoughts and feelings to be recorded for patient and relatives
- Flow Diagrams for specific cancer pathways and when to expect for eg HNA
- Contact details at each stage & prompts for eg "if you have not received your appointment by….please ring…."
- Infographic for keeping handy- stages of process/ what to do and when
- How CNS collaborate/communicate when patient has more than one cancer site- streamline of reviews to prevent repetition
- Openness/ Honesty & Duty of Candour from staff to patients.



First Focus Agreed

Patient & Family Awareness & Understanding of the Treatment Pathway

Refer to NICaN Urology Care Pathways

Acrobat Document.pdf

Macmillan Cancer Support Questions t

Issue after 1st Visit to Clinic

CNS to establish if timing is correct to give. If not record and review at next clinic review/ on telephone when making contact

Separate format for patient and relative/ supporting person

Resource to complete- IT/ home accessible device/ paper

Options of Language/ levels of understanding to support all abilities

Space to complete- out of clinic

Support to complete-trained & compassionate

Question topics to include:

- Who seen them
- where they advised when they would be seen again
- where they advised when results would be available
- where they told who to contact/ when to contact if things didn't happen as expected
- where they given a named nurse
-was the named nurse role explained
- was a family member/ friend asked to be their point of contact
- what information was given written etc
- language/ understanding
-support/ time

Outcomes

Expectations are Reality

Patient & Family Empowered with Knowledge

Patient & Family Supported

All Patients have a Named Nurse (keyworker)

Open & Honest Communication

Patient & Family Satisfaction

Accessible & Tailored Information for all Patients & Relatives

Appendix 10- This is the regional policy outlining the information that must be given to patients on diagnosis

NICaN policy on
patient information.p

NICaN
Northern Ireland Cancer Network

Title	Guidance for HSC staff on the provision of information to people affected by cancer	
Developed by	HSC Trust Cancer Information Leads – see Appendix 3	NICaN Service Improvement Lead for Patient Information – see Appendix 4
Version Control	Final version 1.0 issued May 2017	
Implementation	All Trusts	
Contact Person (s)	HSC Trust Cancer Information Leads	NICaN Office Tel: [redacted]
Review Date	June 2019	
Group Responsible	HSC Trust Cancer Information Leads	

Table of Contents

NICaN

Section 1: General Information

1. Purpose

This Guidance has been developed to support the implementation of generic information packs across cancer health and social care (HSC) services.

2. Scope

This Guidance relates to all HSC staff. It is not limited to specialist cancer services and staff.

People receive health and social care services, directly related to their cancer investigations, diagnosis or otherwise, in various settings and from a wide range of HSC staff. Staff could be asked directly for cancer-related information or could identify a need for cancer-related information in their patient/client.

In this Guidance, 'information' means both clinical and non-clinical information. It is used to describe 'permanent' information for example, leaflets, booklets, web-based material, and audio-visual material.

This Guidance should be read and implemented in conjunction with the Trust policy on informed consent.

3. Aims/objectives

- To improve patient safety and patient/carer experience

?

- To help HSC Trusts achieve and evidence their delivery of patient information-related elements of patient safety alerts e.g. National Patient Safety Agency (NPSA)
- To help HSC Trusts achieve and evidence their delivery of the patient information standard in the Service Framework for Cancer Prevention, Treatment and Care
- To help HSC Trusts achieve and evidence their delivery of the patient information-related measures in Peer Review
- To help Service managers understand their responsibility in supporting the implementation of generic cancer information packs
- To help staff understand their responsibilities to provide information to people affected by cancer
- To help staff use generic information packs as a tool to do so.

4. Roles and responsibilities:

4a. HSC Trust leads for cancer patient information
Each HSC Trust has nominated a lead for cancer patient information.

The main role of the Cancer Information Lead is to provide advice to Trust managers on the implementation of network-agreed generic information packs in the Trust.

The role crosses several boundaries, notably between specialist and non-specialist cancer services, and between primary, secondary and tertiary care. The Cancer Information Lead is a resource and guide who communicates with those who have service responsibility to people affected by cancer.

Each Trust's Cancer Information Lead nomination is outlined in Appendix 2.

4b. NICaN role for Patient Information
The NICaN role for patient information is the coordination of the work of groups developing generic information packs and support to the work of Trust Cancer Information Leads.

4c. Staff providing specialist and non-specialist cancer care
The main roles of staff relevant to this Guidance are to provide appropriate information to patients in line with cancer information pathways and to record such provision as evidence for audit.

5. Context
Patients and carers cannot express preferences about care and make choices on involvement in decision making unless they have access to appropriate and timely information. Furthermore informed consent for investigations or treatment for example cannot be obtained if patients do not have the appropriate information.

The DHSSPS report on its Regional Audit of Consent in 2007 states that,

"Seeking consent is a process of providing information, discussion and decision making. Consent for a (procedure or) treatment must be based on the patient having the information they need to make a valid decision. They can be given the information to read, and have time to discuss it with their family, carers or healthcare professionals before giving consent to the treatment.

As patients and staff move between different Health & Social Care (HSC) organisations throughout Northern Ireland it is important that the information used across the HSC is standardised".

Staff must adhere to their Trust's policy on seeking informed consent and should consult NICaN to see if regional information for investigations or treatment has been agreed.

Many patients report that they receive inadequate information from health and social care professionals. The Northern Ireland Cancer Patient Experience Survey, 2015 showed that only 64%

of patients reported having received information on the type of cancer they had at diagnosis comparted to 72% in England. It also showed that only 65% of patients reported having received information on the type of operation they were having compared to 76% in England (i).

Information materials of high quality should be available in places where patients can access them readily, with patients being offered them at key stages in the patient pathway (ii).

While good face to face communication skills are vital, patients also need access to other sources of information. Studies have shown that some patients only remember one tenth of what they were told during a consultation. Face to face communication needs to be backed up with high quality, accurate information that the patient can return to in their own time (iii).

Surveys have consistently shown nine out of ten people diagnosed with cancer want to receive information about their disease, its diagnosis, treatment options, side effects, and clinical outcome. It can enable them to feel informed and subsequently empowered to make their own choices, rather than having these imposed on them.

Studies have revealed that patients who are well-informed, experience less anxiety, and are more likely to cope with their illness than those who are ill-informed or uninformed (iv, v, vi).

There is evidence that leaflets specific to a condition are read by patients (vii) and evidence that patients receiving written information are more satisfied with the information they are given (viii).

Cancer has become a chronic disease that people live with for a number of years. Many of these people have an on-going need for care, rehabilitation, information and support. This might include information about the long-term side-effects of treatment and other 'survivorship issues' that can help an individual regain a sense of normality in their lives e.g. sexuality, fertility, financial issues, employment, and sources of support such as counselling and support groups.

The Service Framework for Cancer Prevention, Treatment and Care (DHSSPS, 2010)(ix) includes standards that aim to improve the patient experience. It builds on several other regional policy documents that address patient information, including Cancer Services: Investing in the future (Campbell Report, 1996)(x) and The Cancer Control Programme (DHSSPS 2006) (xi).

This Framework is currently under review however Health and Social Care (HSC) Trusts are still required to actively monitor performance against framework standards. This includes a specific standard on the provision of information.

> All people affected by cancer should be offered good information to support them throughout their cancer journey. This information should be tailored to their needs both in content and the way in which it is given (DHSSPS, 2010).

In recent years, there has been development work undertaken by Cancer Services within Northern Ireland to regionally agree high quality information for people affected by cancer. This guidance aims to help HSC staff understand how they can improve patient experience through making use of such work.

Section 2: Generic Information Packs

6. What is a generic information pack?
A generic information pack is an agreed core set of information given at or close to diagnosis of cancer. The current pack contains:

1. The Cancer Guide (Macmillan)
2. Information for you booklet (NICAN)
3. Benefits advice service leaflet (Macmillan CAB)
4. Living with and beyond cancer, survivorship website flyer (NICAN)
5. Macmillan support and information centre/service information (Local Trust)

The information resources have been identified as offering clear, accurate and well written information likely to be relevant to everyone diagnosed with cancer. This core generic pack can be added to throughout the cancer journey, to reflect the information needs of individuals e.g. Cancer Specific or treatment information, advice on talking to children etc.

Staff with any queries about tumour-specific information should direct them to Trust specialist staff for those cancer types in the first instance. The Cancer Information Manager/ Health and Wellbeing Coordinator within each trust may also be able to help (see Appendix 3 for list of managers).

7. Where can staff find information packs?
Generic information packs are available from Cancer Information Managers / Health and Wellbeing Coordinators or Clinical Nurse Specialists within each trust.

(See Appendix 3 for list of cancer information managers/health and wellbeing coordinators)

Section 3: Providing information

8. The interaction between information provider and recipient
There are a number of steps involved in a basic interaction between an information provider and the patient/carer. This includes selecting or sourcing information in alternative formats as needed.

These steps are outlined in Appendix 1.

See section 9 below for reference to complex interactions.

9. Skills development in information provision
Communication is a core competency within the Knowledge and Skills Framework (KSF). Each staff member's training needs on information provision, particularly complex interactions, should be assessed and addressed at their KSF appraisal.

10. Recording information provision
It is important that the Trust is able to evidence that information has been offered.

All staff providing information should record that the generic information pack has been offered and should file this in the patient's/client's case note. This could be achieved by using the keyworker sticker for example. Cancer Information Leads or Information Mangers within each trust should be contacted to determine the documentation method agreed locally.

Section 4: Monitoring and review

11. Monitoring:
The Trust will regularly and robustly monitor their implementation of this Guidance.

12. Review:
This Guidance will be reviewed in June 2019

References

i. Northern Ireland Cancer Patient Experience Survey, 2015

ii. Improving Supportive and Palliative Care for Adults with Cancer, National Institute for Clinical Excellence, 2004

iii. NHS Cancer Plan, 2000

iv. The Quality of Life. Fallowfield L. London Human Horizons Series Souvenir Press 1990

v. Information needs of cancer patients in the west of Scotland Meredith C, Symonds P, Webster L, Lamont D, Pyper E, Gillis CR, Fallowfield L. BMJ 1996 313 724-726

vi. How much truth and to whom? Respecting the autonomy of cancer patients when talking with their families-ethical theory and patients' view. Benson J, Britten N. BMJ 1996 313 729-731

vii. Edwards, M. (1990) "Satisfying Patients' Needs for Surgical Information". British Journal of Surgery vol. 77. pp 463-5

viii. Mayberry, J. (1988) "Information Booklets for Patients with Inflammatory Bowel Disease" International Disability Studies. Vol. 10 pp 179-80

ix. The Service Framework for Cancer Prevention, Treatment and Care, DHSSPS, 2010

x. Campbell Report, 1996

xi. The Cancer Control Programme, DHSSPS 2006

Appendices

Appendix 1 - The information interaction

(Based on Macmillan Cancer Support, Managing Cancer Information Materials 3rd edition)

Appendix 2 - Cancer Information Leads as at January 2017

Appendix 3 - HSC Information post holders as at January 2017

Appendix 1: The information interaction

(Based on Macmillan Cancer Support, Managing Cancer Information Materials 3rd edition)

Beginning	1.Be approachable 2.Use open body language and eye contact 3.Listen to the person's concerns 4.Try not to interrupt, but be ready to speak when they are finished
Explore the content of the enquiry	1.Use open questions to tease out information needs 2.Consider topics included on the information pathway 3.The person's real issue of concern may not always be their opening question 4.Establish any information they have previously received on the topic 5.Reflect back what they have said
Clarify and summarise	1.Clarify the question to ensure you have interpreted their needs correctly 2.Describe and agree together what they need 3.If there are a range of issues, consider prioritising some– do this with the person and check that they are happy to do so
Guide enquirer through range of options appropriate to them and their query These options may be you providing information yourself, or you signposting them somewhere else	1. Consider resources listed in the information pathway. -Published leaflets -Non-print resources, e.g. CD -Guided internet search -Listening support -Counselling -Signposting to specialist services 2. Consider the person's information capacity. Do they need information in another language, an 'alternative format' or at a higher/lower literacy level? Remember you may have a statutory duty here (you can ask your Equality Manager for more information about this) 3.Go through the benefits and limitations of the options 4.Do not overwhelm the person 5.Agree and provide the information materials 6. If you don't know the answer to their question, signpost the person to an appropriate source. Do not risk giving wrong information 7.Offer the person written details of any websites or organisations and any resources you do not have to hand
Identify how to end and clarify enquirer's choices	1. Consider putting a timeframe on the end of the enquiry, e.g. "During the next five minutes or so, we'll go through what we've just discussed, and then I'll leave you to look through the information". 2.Check you have answered their question(s) 3.Confirm options and close the enquiry, e.g. "I think I have given you all of the information you have asked for, but let me know if there is anything else you need" 4.Ensure the person knows how they can get more information 5.Record the information you offered and whether the person took it up

Appendix 2: Cancer Information Leads

Trust	Name	Designation
BHSCT	Margaret McManus	Information Manager, Macmillan Support and Information Centre
NHSCT	Pat McClelland	Clinical Services Manager
SEHSCT	Mary Jo Thompson	Clinical Manager for Cancer Services
SHSCT	Fiona Reddick	Head of Service
WHSCT	Elizabeth England	Lead Cancer Nurse

Appendix 3: HSC Information post holders

Trust	Name	Designation
BHSCT	Margaret McManus(BCH),	Information Manager
	Angela Small (RVH)	Information Manager
	Lindsey Anderson (BCH)	Information and Support Radiographer
SEHSCT	Karen Kelly	Health and Wellbeing Coordinator
NHSCT	Norma Adams	Information and Support Manager
WHSCT	Martha Magee	Information Manager
SHSCT	Sharon Clarke	Health and Wellbeing Coordinator

Appendix 4: NICaN Service Improvement Lead for Patient Information (Oct 14- ? 15)

Organisation	Name	Designation
NICaN	Edel Aughey	Service Improvement Lead for Information (Jan 15- Oct 15)

Appendix 11- Breaking Bad News Clinic Guidance. Note 2003 and PHA acknowledge this.

4b-breaking_bad_news-ireland-1.pdf

NATIONAL COUNCIL
FOR HOSPICE
AND SPECIALIST
PALLIATIVE CARE
SERVICES

Breaking Bad News ...Regional Guidelines

Developed from
Partnerships in Caring (2000) DHSSPS
February 2003

Department of Health, Social Services & Public Safety
An Roinn Sláinte, Seirbhísí Sóisialta agus Sábháilteachta Poiblí

Published by: Department of Health, Social Services and Public Safety,
Castle Buildings, Belfast BT4 3SJ

Telephone (028) 9052 0627

Textphone: (028) 9052 7668.

www.dhsspsni.gov.uk

February 2003

Ref: 261/02

contents

Section **Pages**

Section 1 Breaking Bad News - Regional Guidelines

Department of Health, Social Services and Public Safety. Northern Ireland Group of the National Council for Hospice and Specialist Palliative Care.

These guidelines have been developed to assist clinical staff break bad news to patients, relatives and carers. While many of the themes are of a general nature, the emphasis of these guidelines are on breaking bad news to adults. The development of this document has drawn on the work of the Scottish Intercollegiate Guidelines Network (SIGN) and "A Guideline Developers' Handbook".

Scope and Purpose

"Breaking Bad News", outlines a pathway for medical and other professional staff to deliver bad news to patients, clients, their families and carers.

Stakeholder Involvement

This document has been developed as one part of the recommendations identified in the Regional Review of Palliative Care Services, 'Partnerships in Caring'.[1] The development of the "Breaking Bad News" guidelines was led by the Northern Ireland Group of the National Council for Hospice and Specialist Palliative Care, guidelines subgroup, whose membership is detailed in Appendix A.

Consultation on the detail of the guidelines involved the stakeholders outlined in Appendix D.

Rigour of Development

These guidelines for Breaking Bad News have been developed using the best research evidence available and have been externally reviewed by Professor Peter Maguire, Christie Hospital, Manchester.

The guidelines will be reviewed and updated in two years by the Northern Ireland Group of the National Council for Hospice and Specialist Palliative Care.

Applicability

These guidelines are applicable to all Health and Social Care Staff who are involved in breaking bad news to adult patients and clients.

Implementation

Local ownership of the implementation process is crucial to success in changing practice. For this reason the guidelines group is responsible for the development of the guidelines but not for implementation.

Implementation of the Regional Guidelines for Breaking Bad News is the responsibility of each HPSS Trust, HPSS and Voluntary Providers, in partnership with education providers and individual professionals.

A chart summarising the steps to take in breaking bad news is attached at Appendix B.

Section 2

Breaking Bad News
Guidelines for the Health and Personal Social Services

Background

No one likes breaking bad news. Although doctors and other professionals have always broken bad news the increase in chronic illness and the issues related to quality of life, heighten the importance of understanding how the delivery of bad news affects patients, their family /carers and doctors/other professionals.[2]

What is bad news?

Bad news can mean different things to different people. There have been numerous definitions of bad news including, "any information, which adversely and seriously affects an individuals view of his or her future"[3] or, in situations where there is either a feeling of no hope, a threat to a person's mental or physical well-being, risk of upsetting an established lifestyle, or where a message is given which conveys to an individual fewer choices in his or her life'.[4]

Examples include:
- A patient who is told they are HIV positive.
- The man who is told his partner has Alzheimer's disease.
- The patient who is told the lump has been diagnosed as cancer.
- The couple who are told they cannot have children.

The common denominator is that bad news is a message, which has the potential to shatter hopes and dreams leading to very different lifestyles and futures.

Bad news situations can include, disease recurrence, spread of disease, or failure of treatment to affect disease progression, the presence of irreversible side effects, results of genetic tests, or raising the issue of palliative care and resuscitation. Studies have consistently shown that the way a doctor or other health or social care professional delivers bad news places an indelible mark on the doctor/professional-patient relationship.

Whose information is it?

The issue of who to tell bad news to has been debated for many years. This has been given greater emphasis more recently with the Data Protection Act[5] and the European Convention on Human Rights, Article 8, the respect for private and family life.

There is some evidence that doctors are failing to inform patients when they diagnose cancer, particularly in older patients.[6,7,8] This is despite evidence that some patients with malignancy want to know if their illness is cancer, and others want to know as much as possible about their illness, often more than a doctor assume they want to know.[9,10,11,12]

At the same time it has been common practice in some areas to give relatives large amounts of confidential information without the expressed permission of the patient, and often before the patient themselves are aware of their condition. This practice ought to stop. While the ramifications of the Human Rights Act are not entirely clear, practitioners must make sure they respect the private and family lives of patients. While each case is different, clinicians must be careful to fully consider the needs of the patient and their family when they are disclosing information.

What are the skills required?

Breaking bad news is a complex communication task that requires expert verbal and non-verbal skills. This complexity can create serious miscommunications, such as the patient misunderstanding the prognosis of the illness or purpose of care.[13,14] When bad news is delivered poorly the experience may stay in a patient's or family's mind long after the initial shock of the news has been dealt with.[15] Where English is not a first language staff should avail of interpreting services. When patients have other special needs such as sensory impairment, learning or physical disabilities staff should ensure that the appropriate support mechanisms are available.

What do patients want?

The debate about the levels of truth given to patients about their diagnosis has developed significantly over the last few years. While doctors and professionals now increasingly share information it has been the practice to withhold information because it was believed to be in the best interests of the patient.[16]

The evidence indicates that patients increasingly want additional information regarding their diagnosis, their chances of cure, the side effects of therapy and a realistic estimate of how long they have to live.[17,18,19] Patients want their doctor to be honest, compassionate, caring, hopeful and informative. They want to be told in person, in a private setting, at their pace, with time for discussion and if they wish, with a supportive person present.[20]

What is the impact on you as a health care professional?

Breaking bad news can be extremely stressful for the doctor or professional involved. The evidence suggests that the bearer of bad news experiences strong emotions such as anxiety, a burden of responsibility for the news and fear of a negative response. This stress can result in a reluctance to deliver bad news.[21] When staff are uncomfortable breaking bad news they can avoid discussing distressing information, such as poor prognosis or convey unwarranted optimism to the patient that may predispose to depression.[22]

The process of breaking bad news can also have an adverse effect on those delivering the news. This is particularly evident when the doctor or professional is inexperienced, the patient is young, or there are limited options for treatment.[23]

Clinicians are often uncomfortable discussing prognosis and possible treatment options if the information is unfavourable. The evidence suggests that this is due to a number of reasons including:

- Uncertainty about the patient's expectations
- Fear of destroying the patient's hope.
- Fear of their own inadequacy in the face of uncontrollable disease.
- Not feeling prepared to manage the patients anticipated emotional reactions.
- Embarrassment at having previously painted too optimistic a picture for the patient.[24,25,26,27]

Patients and their relatives rely on professional staff breaking bad news as well and as effectively as they can. It is not always possible to get this very complex and emotional exchange of information right.

It is important to recognise the potential stresses that breaking bad news can cause. It is important, for all staff, including senior staff, to reflect on the experience as appropriate with their clinical supervisors, mentors or education facilitators as soon as possible after the event.

Communicating bad news to patients well is not an optional skill; it is an essential part of professional practice.

Section 3 A Strategy for Breaking Bad News.

The following strategy is developed from the work of SPIKES.[28]

Preparation - Setting up the Interview

Prepare yourself -

It is natural for the bearer of bad news to be anxious about the interview with the patient or carer.

- Familiarise yourself with the patient's background, medical history and test results. You will also need to have some knowledge of the choices in the future management of the patient's condition.
- It is helpful to mentally rehearse the interview, the likely questions you will be asked, the patient's emotional and potential responses.
- While it is important to remember that the bad news may be very sad for the patient, the information that you will be giving will be important in allowing him/her to plan for the future.
- It is strongly recommended that a colleague such as the patient's named nurse or specialist nurse accompanies you. This individual may remain with the patient if appropriate and help provide continuing support to the patient.
- The patient may want a member of their family with them, however this must be established prior to the interview. The clinician must be guided by the wishes of the patient. It can be helpful to suggest to the patient, when investigations are being carried out, that they may wish a family member or friend to accompany them for support, when results are discussed with them.

Prepare your setting -

- Arrange some privacy. Ideally an interview room or where a patient is confined to bed, pull the curtains around the bed. The latter is not an ideal situation, but can occasionally be difficult to avoid. (A practical hint is to have some tissues at hand in case the patient becomes upset.)

- Do not stand over the patient. Sit down, as this is less intimidating and shows that you are not going to be rushed. It is important to have no barriers between you and the patient. If you have recently examined the patient allow them to dress before the discussion.
- It is important to gain a rapport with your patient. The mechanisms by which you do this will depend very much on the patient, their condition, cultural background and age.
- It is important that you balance the time available with the needs of the patient and that you conduct the interview accordingly. You may need to switch off your pager or get a colleague to answer calls on your behalf. If the interview is rushed the doctor/other professional may be perceived as uninterested.

Prepare your Patient -

- Patient perceptions. It is important before you begin breaking bad news that you assess the patients' understanding of their condition. At this stage you can correct any misunderstandings and it will enable you to assess if the patient is engaging in either denial, wishful thinking or unrealistic expectations of treatment.[29]
- Obtaining the Patients' Permission. While many patients increasingly want to have details about their disease and diagnosis, some patients do not and this should be respected and appropriately managed. One mechanism to help you is to assess the level of information the patient wants. If this is not explicit, broach the subject when tests are being ordered, by asking questions such as, "How would you like me to give you the results of these tests?" or " Are you the type of person who likes detailed information, or would you like a general overview?" or " Have you had any thoughts as to what may be wrong".

The Interview

Providing the Information -

There is no easy way to give a patient bad news. Warning a patient that bad news is coming may help lessen the shock and may help the patient to go on to process the information they receive.[30,31] Examples include terms such as, "Unfortunately I've got some bad news to tell you" or "I am sorry to tell you".

In providing the facts to the patient it is important to remember:

a) Start at the level of comprehension and vocabulary of the patient.

b) Use non-technical words such as 'spread' instead of 'metastases'. Remember patients may not understand the words 'malignancy' or 'tumour' to mean 'cancer'.

c) Provide information simply and honestly, avoiding excessive bluntness, as it is likely to leave the patient isolated and angry, with a tendency to blame the messenger.

d) Give the information in small chunks and stop periodically to check the patients understanding. One helpful approach is to provide information in steps, introducing more specific language at each step. For example this allows the patient with cancer to introduce the word 'cancer' themselves.

e) When the prognosis is poor, avoid using terms such as "there is nothing more we can do for you", as goals in care will change to good pain control and symptom relief, all of which are possible.

f) Encourage questions and allow time.

g) Remember it is likely that the patient may not be able to recall all of the conversation you have had. You may need to return and repeat the process at a later stage.

h) Offer to speak to family members or carers should the patient wish.

Where possible and appropriate, information given verbally should be supported with written information.[32,33] It is of equal importance to share this information and the patients response with the multidisciplinary care team and the patient's General Practitioner who may feel it is necessary to repeat the information when the patient is at home. Some patients may find it helpful if you offer to tape the interview for them.

Providing Support

Providing support to the patient begins with responding to the patient's emotions, which can range from silence to disbelief, crying, denial or anger. An empathetic response consists of five steps:

a) Observe for emotions such as tearfulness, silence or shock.

b) Acknowledge and identify with the emotion experienced by the patient. When a patient is silent use open questions, asking them how they are feeling or thinking. This will help them articulate what their emotions are. Allow time for silence and tears.

c) Do not say "I know how you feel". Even if you have had personal experience of the disease or condition, you cannot know how an individual feels. Empathy can be shown by using terms such as "I think I understand how you must be feeling".

d) Check the reason for the response. This will usually be related to the news you have just given them or the impact the news will have on their family or children.

e) Encourage and allow the patient time to express their emotions and let the patient know you understand and acknowledge their emotions. This reduces the patient's isolation, expresses solidarity and validates their feelings or thoughts as normal and to be expected.[34,35]

Unless the emotions of the patient are adequately addressed it is difficult for the doctor/other professional and patient to move on to discuss other relevant issues.

Providing a Plan -

Patients who have a clear plan for the future are less likely to feel anxious and uncertain. An important part of this is providing treatment and care options to the patient. For example in chronic illnesses such as diabetes, a clear management plan or when malignant disease is confirmed, the options for treatment and if appropriate ongoing support and palliative care. It may be helpful if the patient has the option to speak to the professional delivering the bad news at a later stage.

After the Interview

Documentation -

It is important that accurate records are maintained of the conversation and the information and details exchanged. These will assist in the future care of the patient and enhance communication within the multidisciplinary team including the patient's General Practitioner.

This record should be documented in the patient's notes. The specific words used to describe the disease should be recorded, for example, tumour, growth or malignant disease.

A template to record the information given (Appendix C), is provided for local adaptation and use. It is suggested that this should be sent immediately by secure fax if available to the patients' General Practitioner.

Despite following these guidelines patients may not be able to absorb the detail of the news being delivered. A well informed multi-disciplinary team is the key if the news is to be reinforced ensuring the patient and where appropriate, the family have the fullest understanding possible.

Taking the time to prepare for an interview to break bad news to patients will help ensure the process is more effective. That said it has to be acknowledged that receiving a diagnosis of bad news may be overwhelming for the patient and their family or carers regardless of the care the doctor or professional takes in communicating it.

Appendix A

Sub Group Membership

Name	Organisation
Dr Sheila Kelly, Consultant Palliative Medicine	Marie Curie Cancer Care, Belfast.
Dr Bernie Corcoran, Consultant Palliative Medicine	Belfast City Hospital Trust
Dr Kiran Kaur, Consultant Palliative Medicine	Northern Ireland Hospice/Royal Group Hospitals Trust
Dr Yvonne Duff, Consultant Palliative Medicine	United Hospitals Trust
Pauline Douglas Allied Health Professions Representative	Belfast City Hospital Trust
Dr Jenny Jingles, Consultant Public Health Medicine	Eastern Health and Social Services Board
Heather Monteverde Service Development Manager	Macmillan Cancer Relief
Jane Graham, Chief Officer	Eastern Health and Social Services Council
Dr Brid Farrell, Consultant Public Health Medicine	Southern Health and Social Services Board
Mary Hinds, Director of Nursing & Quality	Mater Hospital Trust

Appendix B
Breaking Bad News - A Guide for Clinical Staff

Prepare Yourself	• Familiarise yourself with the patient's background, medical history, test results and future management / treatment choices. • Mentally rehearse the interview including likely questions and potential responses. • Arrange for a colleague such as the patient's named nurse or specialist nurse to accompany you. Relatives can be in attendance, however you must be guided by the wishes of the patient.
Prepare Your Setting	• Arrange some privacy. • Do not stand over the patient, sit down as this relaxes the patient and shows that you are not going to be rushed. If you have recently examined the patient allow them to dress before the interview. • Switch your pager off or get a colleague to answer calls on your behalf.
Prepare Your Patient	• Assess the patients understanding of their condition. *"Can you help me by telling me what you understand about your illness?"* • While many patients want to have details about their disease and diagnosis, some patients do not want this detail and their wishes should be respected and appropriately managed. Never impose information.
Providing Information	• Start at the level of comprehension and vocabulary of the patient. • Use non-technical words such as 'spread' instead of 'metastases'. • Avoid excessive bluntness, as it is likely to leave the patient isolated and later angry. • Set the tone. *"I am afraid I have some bad news"* • Give the information in small chunks and stop periodically to check the patients understanding. *"Is this making sense?"* or *"Would you like me to explain more?"* When the prognosis is poor, avoid using terms such as "there is nothing more we can do for you," as goals in care will change to pain control and symptom relief.
Providing Support	• Acknowledge and identify with the emotion experienced by the patient. When a patient is silent use open questions, asking them how they are feeling or thinking. This will help them articulate what their emotions are. *"How are you feeling now?"* • Do not say "I know how you feel". Even if you have had personal experience of the disease or condition, you cannot know how an individual feels. Empathy can be shown by using terms such as, *"I think I understand how you must be feeling."* • Allow the patient time to express their emotions and let the patient know you understand and acknowledge their emotions. • Unless patients' emotions are adequately addressed it is difficult for the doctor and patient to move on to discuss other important issues but remember the patient's crisis is not your crisis - Listen.
Providing a Plan	• Provide a clear plan for the future, with treatment options or management plan discussed. • Offer to meet and talk to the family if not present.
After the Interview	• Make a clear record of the interview, the terms used, the options discussed and the future plan. Ensure the detail of the interview is shared with the multi-disciplinary team, including the General Practitioner.

Appendix C

Breaking Bad News Record Template

Patients Name/Address:	**Hospital Number:**
Date and time of interview:	
Location: Ward	**Outpatients**
Names of those present:	
Name:	**Position/Relationship:**
Clinical Diagnosis:	
Clinical Options for future management and immediate plan discussed:	
Detail of the words used when breaking the bad news:	
Copy to General Practitioner:	**Referral to Palliative Care Team: Yes/No**
	Referral to District Nurse: Yes / No
Filed in Patients Notes:	**Referral to Others (Please Specify)**
Signature of the Clinician:	**Date:**

Appendix D

Key Stakeholders Involved in Consultation

- DHSS&PS Board Members
- DHSS&PS Directors
- Chief Executives/Directors of Nursing/Directors of Public Health, Health & Social Services Boards
- Chief Executives/Directors of Nursing/Medical Directors, Health & Social Services Trusts
- Nurse Leaders Network
- Chief Executives, Health & Social Services Councils
- Hospice and Palliative Care Organisations
- Regional Advisory Committee on Cancer
- Campbell Commissioning Group
- Marie Curie Cancer Care
- NI Hospice
- Foyle Hospice
- Newry Hospice
- Macmillan Cancer Relief
- Action Cancer
- Age Concern
- Help the Aged
- NI Practice and Education Council for Nursing & Midwifery
- Postgraduate Medical & Dental Education Council
- Central Services Agency
- NI Social Care Council
- Community Practitioners & Health Visitors Association
- Central Nursing Advisory Committee
- Royal College of Nursing
- Royal College of Midwifery
- GP Forum Members
- Education Providers
- Queens University of Belfast
- University of Ulster
- The Beeches Management Centre, Nursing & Midwifery Education
- North & West In-Service Education Consortium
- In-Service Education, United Hospitals Trust

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  - CANCER CNS PROFORMA
  - SHSCT MDM Proformas
  - Cancer Trackers/MDT Co-Ordinators
  - CNS ProformasCurrently selected
  - Head and Neck

Site Contents

CNS Proforma

CANCER CNS PROFORMA
Form will be emailed to admin.cancersupportworkers@southerntrust.hscni.net
PATIENT DETAILS
Name:
DOB: Date Picker
H+C: Cannot be blank
Tumour Site: Choose an Item
Date of Referral: Date Picker
Date of 1st Contact: Date Picker
Date of MDM: Date Picker

Type of Contact: Choose an Item.
Reason for Contact: Choose an Item.
CNS (Please choose your name): Choose an Item.
Consultant:
Hospital Site: Choose an Item.

Treatment Intent: Curative ☐ Palliative ☐
Patient Type: New ☐ Recurrence ☐ Benign ☐
CNS Email
Diagnosis:
Staging:

Treatment Received
Chemotherapy ☐ Radio ☐ Surgery ☐ Supportive Care ☐ A/S ☐ W/W ☐ Other:

Reason for referral to service
Breaking bad news: ☐
Pain Management: ☐
Other Symptom Management: ☐
Holistic Needs Assessment: ☐
Rapid Access: ☐

Pathway (if applicable)
Shared Care: ☐
Consultant Led: ☐
Contact info given: Choose an Item.
Core info pack given: Choose an Item.

HNA
HNA Status: Choose an Item.
HNA to be booked: Yes ☐ No ☐
If yes, when:
Date Picker
H+WB Event: Choose an Item.

Referrals to other services
Move more: ☐
Hospice: ☐
Charis: ☐

Community Macmillan Team: ☐
Smoking cessation: ☐
Counsellor/Psychologist: ☐
CAB referral: ☐

Other, Please Specify:
CAPPS updated: Yes ☐ No ☐
Date of Death (if applicable):
Date Picker

Send to Admin Cancer Support Workers

Appendix 23- Holistic Needs Assessment Macmillan Guidance

https://www.google.co.uk/url?esrc=s&q=&rct=j&sa=U&url=https://www.macmillan.org.uk/healthcare-professionals/innovation-in-cancer-care/holistic-needs-assessment&ved=2ahUKEwjqrrDkpNT0AhVHZcAKHbO6Dn0QFnoECAcQAg&usg=AOvVaw2yoieKrbEhJOGsJaBqlErC

Concerns Checklist - identifying your concerns

Patient's name or label

Key worker:

Date:

Contact number:

This self assessment is optional. It has been designed to help us support you by identifying any concerns you may have and information you may require.

What do I need to do?

Select any areas that may have caused you concern recently and you would like to discuss with your key worker.

When selecting please score each concern between 1-10, with 1 being low level of concern and 10 the highest.

Key worker to complete

☐ Copy given to patient

☐ Copy to be sent to GP

Physical concerns

☐ Breathing difficulties
☐ Passing urine
☐ Constipation
☐ Diarrhoea
☐ Eating, appetite or taste
☐ Indigestion
☐ Swallowing
☐ Cough
☐ Sore or dry mouth or ulcers
☐ Nausea or vomiting
☐ Tired, exhausted or fatigued
☐ Swelling
☐ High temperature or fever
☐ Moving around (walking)
☐ Tingling in hands or feet
☐ Pain or discomfort
☐ Hot flushes or sweating
☐ Dry, itchy or sore skin
☐ Changes in weight
☐ Wound care
☐ Memory or concentration
☐ Sight or hearing
☐ Speech or voice problems
☐ My appearance
☐ Sleep problems
☐ Sex, intimacy or fertility
☐ Other medical conditions

Practical concerns

☐ Taking care of others
☐ Work or education
☐ Money or finance
☐ Travel
☐ Housing
☐ Transport or parking
☐ Talking or being understood
☐ Laundry or housework
☐ Grocery shopping
☐ Washing and dressing
☐ Preparing meals or drinks
☐ Pets
☐ Difficulty making plans
☐ Smoking cessation
☐ Problems with alcohol or drugs
☐ My medication

Emotional concerns

☐ Uncertainty
☐ Loss of interest in activities
☐ Unable to express feelings
☐ Thinking about the future
☐ Regret about the past
☐ Anger or frustration
☐ Loneliness or isolation
☐ Sadness or depression
☐ Hopelessness
☐ Guilt
☐ Worry, fear or anxiety
☐ Independence

Family or relationship concerns

☐ Partner
☐ Children
☐ Other relatives or friends
☐ Person who looks after me
☐ Person who I look after

Spiritual concerns

☐ Faith or spirituality
☐ Meaning or purpose of life
☐ Feeling at odds with my culture, beliefs or values

Information or support

☐ Exercise and activity
☐ Diet and nutrition
☐ Complementary therapies
☐ Planning for my future priorities
☐ Making a will or legal advice
☐ Health and wellbeing
☐ Patient or carer's support group
☐ Managing my symptoms
☐ Sun protection

☐ **I have questions about my diagnosis, treatments or effects**

MACMILLAN CANCER SUPPORT
RIGHT THERE WITH YOU

Appendix 12- Cancer Strategy 2021-2031

Cancer Strategy 2021-2031.html

A Cancer Strategy for Northern Ireland 2021-2031

Department of Health
An Roinn Sláinte
Männystrie O Poustie
www.health-ni.gov.uk

Minister's Foreword

My vision is to ensure that everyone in Northern Ireland, wherever they live, has equitable and timely access to the most effective, evidence-based referral, diagnosis, treatment, support and person centred cancer care.

The number of cancer cases diagnosed in Northern Ireland has increased by 54% over the past 25 years and is projected to double by 2040. Cancer services were challenged before the pandemic and there continues to be significant capacity and workforce challenges across a range of areas. There is a need to move forward urgently to implement the recommendations outlined in this strategy to rebuild and transform our services in the short, medium and longer term. I have recently published a cancer recovery plan 'Building Back; Rebuilding better' which will focus on dealing with the current backlogs and immediate pressures, however there is a much bigger task to transform cancer services for the decade ahead. The Cancer Strategy affords us the opportunity to look forward 10 years to identify and implement what will really make a difference for people living with cancer.

Reducing health inequalities is integral to the implementation of this strategy. Social deprivation and health inequalities are a major contributory factor in the development of the majority of cancers. This means that there are potentially avoidable variations in outcomes, patient experience and survival across NI. Tackling inequalities goes far beyond the remit of the Department of Health and will require a concerted, co-ordinated focus across government departments. Improving cancer services for the people of Northern Ireland must be a major priority for the whole Executive in the years ahead.

At the heart of the many successes of cancer services is the hard work and dedication of our staff, in every grade and role, who are delivering care at higher levels than ever before. In addition to maintaining oncology services throughout the pandemic many staff from a wide range of professions have been involved in the development of this strategy

The successful delivery of this strategy will require collaboration. This will involve maintaining and building on the many successful developments which happened over the past year in response to the pandemic, and learning from what could have been done better. Collaboration between HSC organisations, across sectors and with patients, families and carers will be a key enabler to effecting meaningful change.

People living with cancer and staff providing treatment and care have been at the heart of the development of this strategy. As we move towards implementation we will ensure that this collaborative working continues.

This 10 year strategy is ambitious and is currently unfunded as the costs cannot be met from within the Department's financial allocation. Significant recurrent funding is therefore required, if we are to deliver these recommendations to improve diagnosis, treatment and care for all those who need it now and in the years ahead.

Personal information redacted by USI

[redacted]

Co Chairs Foreword

Over time cancer impacts on the lives of all of us. While there have been many advances in the diagnosis, treatment and care of people over recent years we know that, with many more people surviving cancer combined with a rapidly ageing population, our current system is unsustainable. Transformational change is needed if we are to provide evidence-based, high quality care for all those who need it in the future.

We are pleased to present this strategy which has been developed by co-production and has brought together people with lived experience of cancer, cancer charities, healthcare professionals from across all Health and Social Care Trusts, the Public Health Agency (PHA), the Health and Social Care Board (HSCB), Primary Care, and policy makers.

The strategy has been developed using a quality improvement approach called quadruple aim which focuses on;

- Improving the health of our people
- Improving the quality and experience of care
- Supporting and empowering staff
- Ensuring sustainability of our services

We believe we can do better for people who have cancer and that we should have the ambition to have a world class service which is based on improving outcomes for everyone diagnosed with cancer. We are committed to ensuring that the voice of people who use and work in cancer services are threaded through the recommendations and that our services are efficient and effective and respond in a timely way to the needs of all who use it. There is much more we can do to support our workforce to deliver the best care. This requires change, working and thinking in different ways and seeing things from different perspectives. The strategy has drawn on the best available evidence and 67 recommendations have been developed which will move us closer to the world class service we all aspire to.

We strongly believe that all of us have responsibilities for our own health and there is much each of us can do to reduce our risk of developing cancer. There is undeniable evidence of the impact of smoking, poor diet and obesity on cancer rates. The use of sun beds and exposure to sunlight are the major contributing factors to the very significant increase in skin cancer which is the most common type of cancer in NI. Not everyone is aware of the risks associated with developing cancer or is in a position to change their lifestyle. Strenuous efforts must be made to support people to lead healthy lifestyles, participate in screening programmes and to come forward with health concerns, particularly those from less heard groups and in more deprived populations.

Finally we would like to thank the co-chairs and members of the seven subgroups who continued their work on this strategy during the pandemic and the small team at the Department of Health, in particular Heather Monteverde and Gay Ireland. Special thanks must go the many people living with cancer, who so generously shared their experiences and insights which have shaped the strategy.

Personal information redacted by USI

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Contents

Why we need a cancer strategy

Cancer is a common condition. In Northern Ireland one in two people born since 1960 will be diagnosed with some form of cancer in their lifetime. Survival has improved for many cancers over recent years and now over half of people will live ten years or longer following diagnosis and treatment. This is largely due to earlier detection, improvements in treatments and changes in exposure to risk factors. The number of people diagnosed is however expected to continue to rise, largely due to our ageing population.

More than 26 people in NI are diagnosed with cancer every day, and almost 10,000 people are diagnosed with cancer annually. The number of cancer cases diagnosed increased by 54% over the past 25 years and is projected to double by 2040 (45% for males and 58% for females). Large increases are predicted for many cancers with poor survival including pancreatic and liver cancers and lung cancer in females with only stomach and cervical cancer numbers projected to decrease.

This brings considerable challenges to health services in meeting the ever growing demand for diagnostic services, screening programmes, treatment, follow-up surveillance, supportive and palliative care. Increased demands will be felt across the entire health and social care system as many people diagnosed with cancer are also living with multiple other long term conditions.

Despite efforts being made to reduce the growth in the incidence of preventable cancers in Northern Ireland (NI), there is evidence to suggest that the pace of change in reducing the risk factors underpinning these cancers is not sufficient. Largely preventable cancers predicted to increase include melanoma and lung cancer. Ultimately, this highlights the real need to maintain focus on tackling preventable cancers, and the urgency for accelerating change.

Although cancer survival in Northern Ireland has improved over the years it still lags behind other comparable countries both in Europe and internationally. The International Cancer Benchmarking Project (ICBP) Module 1 report showed cancer survival in Northern Ireland (NI) to be behind other parts of the UK, Australia, Canada, Denmark, Republic of Ireland, New Zealand and Norway. Northern Ireland consistently ranked between 8th and 10th out of the 12 jurisdictions involved.

Recently published ICBP Module 2[1] evidence shows that the UK as a whole had the lowest 1- and 5-year survival rates between 2010-2014 for 4 of the 7 cancer types reviewed.

Cancer has accounted for over 20% of all deaths in Northern Ireland every year since 1987. In 2018, the most recent year for which detailed statistics are available, cancer was the leading cause of death in Northern Ireland – accounting for 28% of all deaths. Unsurprisingly, death rates from cancer are usually higher among those aged 85+ than any other age group among both men and women. [2]

England, Scotland and Wales and the Republic of Ireland have in recent years produced new cancer strategies for their respective jurisdictions designed to further improve the outcomes for people affected by cancer. These strategies have all identified new approaches to service planning and delivery as well as prevention.

The New Decade, New Approach Agreement gave a commitment that the NI Executive would develop a new cancer strategy by the end of December 2020, however this deadline had to be pushed back due to the COVID-19 pandemic.

The Cancer Strategy affords us the opportunity to look forward 10 years to identify and implement what will really make a difference for cancer patients in Northern Ireland. This will require a comprehensive approach to prioritisation – making rapid change early where possible and laying the groundwork for truly revolutionary evidence-based interventions where we know this could transform outcomes.

Strategy Development

The development of the strategy, has been led by the Chief Nursing Officer, Professor Charlotte McArdle. It is based on co-production methodology which has brought together people with lived experience of cancer and healthcare professionals from across all Health and Social Care Trusts (HSC), Public Health Agency (PHA), Health and Social Care Board (HSCB), Primary Care, policy makers and cancer charities to develop the 10 year strategy. The strategy aims to place Northern Ireland at the forefront of world class cancer prevention, treatment and patient experience.

A Steering Group was established, supported by seven sub-groups: prevention; diagnosis and screening; treatment; care and support; living well; palliative and end of life care, children and young people.

The aims of the strategy are threefold;

- to reduce the number of people diagnosed with preventable cancers,
- to improve survival and
- to improve the experience of people diagnosed with cancer. This is illustrated in the Driver Diagram (Figure x) in the following page.

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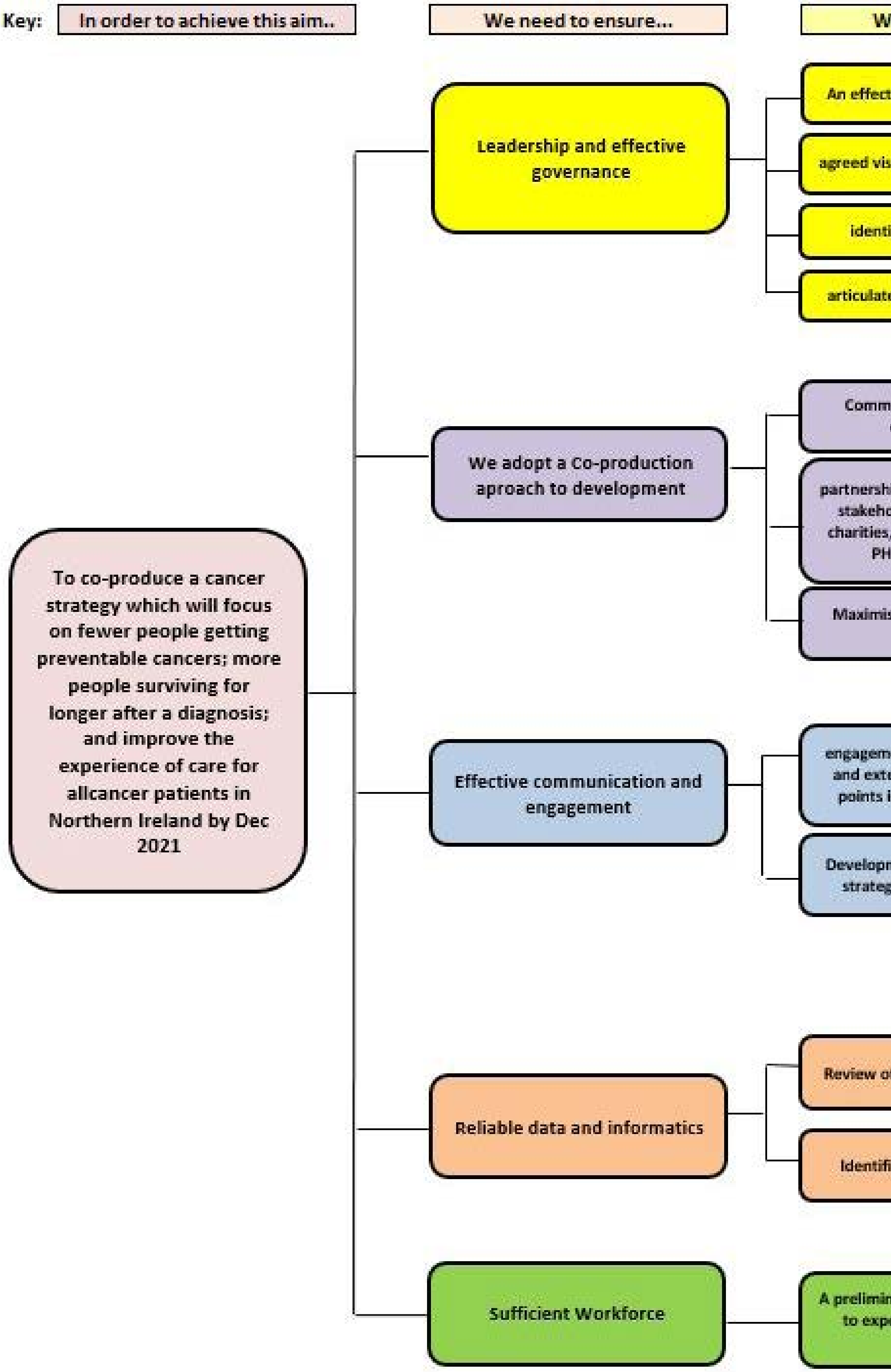
[1] Progress in cancer survival, mortality, and incidence in seven high-income countries 1995–2014 (ICBP SURVMARK-2): a population-based study - The Lancet Oncology

[2] Statistics fact sheet (macmillan.org.uk)



Key: In order to achieve this aim.. | We need to ensure... | W

To co-produce a cancer strategy which will focus on fewer people getting preventable cancers; more people surviving for longer after a diagnosis; and improve the experience of care for allcancer patients in Northern Ireland by Dec 2021

Leadership and effective governance

We adopt a Co-production aproach to development

Effective communication and engagement

Reliable data and informatics

Sufficient Workforce

hich requires...

Ideas to ensure this happens

- ive governance structure
- ion and strategic priorities
- fied population needs
- ed priority areas of focus

- Establish a steering group to include the key stakeholders, including a SRO with strong clinical leadership and a co-chair with lived experience
- Establish 7 sub groups: prevention, diagnosis, treatment, care and support, living well, palliative/end of life and child and young people and 3 forums: lived with Experience, Patient Charities and Staff
- Development of a business case and project plan to include risk register
- Complete health needs analysis, map resources with need and demand
- Present the strategy to Health Minister for approval

- itment to connect and empower People
- ip working with a range of olders: lived experience, , HSC Professionals, DOH, A, HSCB, Trusts etc
- ing the Lived Experience Voice

- Populate the membership of the steering group and subgroups to ensure a wide range of representation across all stakeholder groups - ensuring membership reflects principles in the co-production guide
- Appoint co-chairs who bring expertise by lived experience and expertise by profession/role
- Utilise the PCC to create a network of people with lived experience and to support partnership working and co-design
- Utilise a appreciative enquiry and consensus approach at key phases of the project plan: design, development, and agree recommendations

- ent with relevant internal ernal stakeholders at key n strategy development
- ment of a communication y with the wider public

- Enable engagement with staff working in policy and service through formal and informal meetings and events
- Enable engagment with trade unions and members of the public
- promotion through use of social media - for example, twitter, posters
- Target pre - consultation/consultation to ensure representation across all Northern Ireland including lesser heard groups

- f data relevant to strategy
- ed measures of success

- Identify and consider learning from other jurisdicitons
- Commission a baseline assessment on data currently available for NI with recommendations for better integration and functionality in line with DHCNI strategic direction
- Identify quality indicators to enable outcome based accountability
- Embed data analytics function in new ways of working

- ary workforce assessment edite and inform future planning

- Undertake a multiprofessional workforce gap analysis to enable implementation of the strategy at pace
- Consider how to influence future flexible and responsive workforce fit for the transformation in the future

Cancer services were challenged before the pandemic with unacceptable waiting times and significant capacity and workforce challenges across a range of areas. COVID-19 has led to a worsening waiting times position, resulting in considerable anxiety for patients. A Cancer Recovery Plan, Building Back; Rebuilding Better has been developed to address the immediate issues in adult cancer services with the aim of getting us to a place where services are stronger than before, providing a solid foundation for the world class service envisaged in the strategy. Building Back; Rebuilding Better was published by the Minister for Health on 24th June 2021 and is fully aligned with the short term recommendations in the Cancer Strategy and will focus on a 3 year timescale.

Key Aims of Building Back; Rebuilding Better

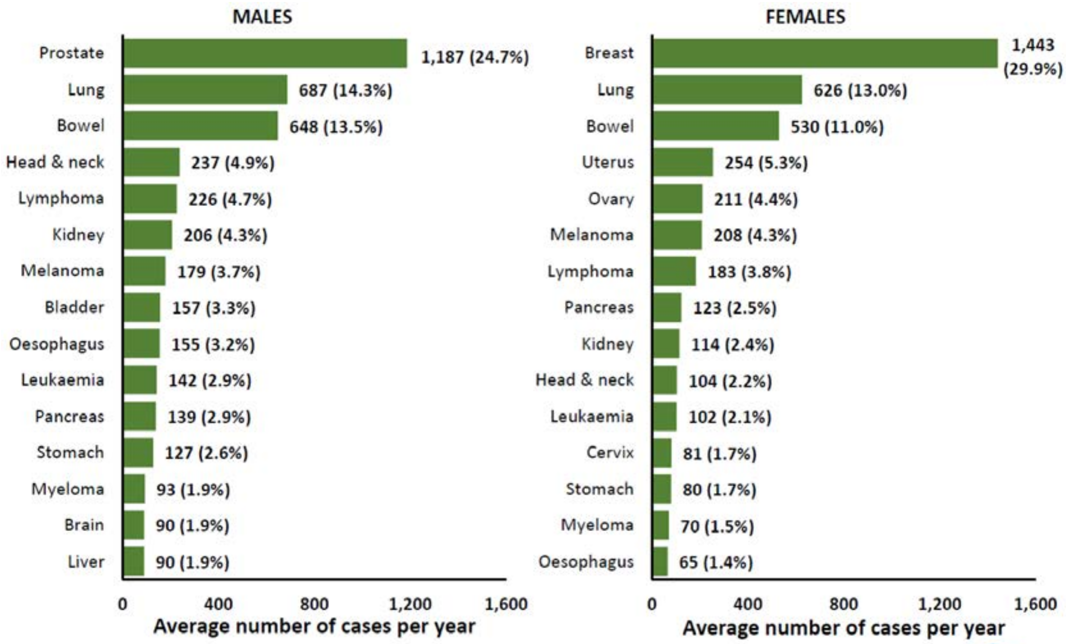
1. Adopt a regional approach for Northern Ireland, where appropriate, to ensure patients receive equitable access to diagnostics, care, treatment and support.
2. Create smoother and more efficient patient pathways from initial referral, through diagnosis and treatment encompassing the appropriate care and support during and after treatment with the aim of improving cancer waiting times and patient outcomes and patient experience.
3. Invest in cancer services and enable new, more sustainable, models of care that will be resilient to potential future surges of COVID-19 and to the projected increase in cases of cancer.
4. Learn from the impact of COVID-19 on cancer services and the wider HSC and adopt the successful innovations for the future.

Prior to the pandemic many core services were fragile and struggling to deliver in a timely manner, with escalating waiting lists. We fully recognise the immense pressures the HSC, including all those involved in cancer services, has been put under over the past year as a result of COVID-19. Creating a sustainable workforce to care for those with a cancer diagnosis is an integral part of this recovery plan and for the Cancer Strategy.

Cases

In 2018 cancer was diagnosed in 13452 people from NI, 3823 of these were Non Melanoma Skin Cancer (NMSC), a disease that is easily treated and causes few deaths but which use health service resources and also cause a lot of concern and trauma to patients. This strategy takes account of these conditions but focuses on the more serious, almost 10,000 per year, cancers which are a major cause of cancer deaths. The most common cancer in men (excluding NMSC) was prostate (1,187 cases per year, 25%), and in women was breast cancer (1,443 cases per year, 30%). Lung (1,313 cases per year) and colorectal cancers (1,178 cases per year) were common in both genders (see figure 1).

Figure 1: Average number of cancers diagnosed per year by sex and cancer type: All cancers (ex. NMSC), 2014-2018



Source: Northern Ireland Cancer Registry

The risk of developing cancer increases with age, with two thirds (67%) of cases in men, and over half (58%) in women diagnosed over age 65. This compares to 11% of cases (ex. NMSC) diagnosed in those under 50 years. Those living in socio-economically deprived areas had overall cancer levels 15% higher than the NI average, with especially higher rates for lung (70% higher per year), liver, head and neck, cervical and stomach cancers. Those living in higher socio-economic areas had levels 6% lower than the NI average overall, but higher levels of prostate cancer and melanoma.

Almost half (49%) of male and 42% of female cancer (ex. NMSC) patients had a comorbidity recorded up to one year prior to their diagnosis. Comorbidities (other medical conditions) are more common with age, can affect treatment options and affect survival, ranging at one year from 83.5% if no comorbidity, to 48.3% among those with at least four comorbidities recorded prior to diagnosis.

The number of cancer cases diagnosed has increased by 54% over the past 25 years and is projected to double by 2040 (45% for males and 58% for females). This projected rise to 6,788 male and 7,450 female cases (excluding NMSC) is due primarily to population ageing. Large increases are predicted for the cancers with poor survival, (pancreas, liver and especially in women lung cancers), with only stomach and cervical cancer numbers projected to decrease. Cancers which are largely preventable and predicted to increase include melanoma and lung cancer.

Every year in Northern Ireland, around 60 children under 16 years of age and 80 teenagers and young adults aged 16 -24 years are diagnosed with cancer. While there is variation year to year, these numbers have remained stable over the past 20 years.

The most common types of cancer diagnosed in the 0-15 age group are blood cancers and brain tumours.

Teenager and Young Adult refers to people aged 16 up to their 25th birthday. The numbers of cancers diagnosed are low and the most common cancers in this age group are lymphoma and leukaemia, testicular, ovarian, brain and colorectal cancers.

Deaths

Cancer was the largest cause of death in Northern Ireland during 2018, with 2,326 male (30%) and 2,122 female (26%) deaths per year. The most common causes of cancer death among men were lung (554, 24%), prostate (276, 12%) and bowel (232, 10%), and among women were lung (469, 22%), breast (314, 15%) and bowel (207, 10%).

Prevalence

The number of people living at the end of 2018 after a diagnosis of cancer (prevalence) is estimated at 97,807 (including 37,894 with NMSC) with 12% of these diagnosed in the previous year. The most common cancer types prevalent (ex. NMSC) in men were prostate (10,938) and bowel (4,713), with breast (16,462) and bowel (4,048) the most common among female survivors.

By 2033 the number of cancer survivors in the population is projected to increase by over 40%, with increases among men for all cancer types except bladder cancer, and among women for all cancer types except cervical cancer. In particular 10-year prevalence is expected to more than double among males for liver cancer, with significant increases for melanoma, kidney cancer and pancreatic cancer. Among females the number of survivors is expected to almost double for lung, pancreatic, liver and kidney cancer. Many patients will be cured, others will live for many years with cancer as a long term condition and for others the disease will progress.

Although many more people will be cured from their cancer not all continue to live well and for many the late effects and consequences of treatment will present lifelong problems. Cardiac problems due to some chemotherapy drugs, bowel problems post pelvic radiotherapy and osteoporosis due to hormonal therapies and prolonged use of steroids are some of the many ongoing problems survivors have to deal with.

Survival

Cancer survival is a key measure of the effectiveness of cancer services reflecting preventive initiatives such as vaccinations (HPV), screening, early detection, access to timely diagnostics and rapid and effective treatment by specialists. Stage at diagnosis is important. Currently 48% of pancreatic, 44% of lung and a fifth of cancers overall are diagnosed at a late stage when the treatment options are limited and survival is poor.

Five-year survival for patients diagnosed with cancer (ex. NMSC) in 2009-2013 was 54.3% for men and 58.5% for women. Five-year survival varies considerably by cancer site. In addition to poor survival for lung cancer (12%), survival is very low for other tobacco related cancers (e.g. pancreatic, stomach and oesophageal cancers). Changes in tobacco use could have the greatest impact on cancer incidence and survival. Cancer survival rates in NI, like the rest of the UK, fall short when compared internationally. While year on year improvements in survival have been documented, the COVID-19 pandemic is likely to reduce survival.

Improvements in treatment seen in the past five decades mean that around 80% of children 0-16 years diagnosed with cancer in the UK will survive their cancer for at least five years. This means that there is a growing population of children and young adults who have experienced cancer and treatment as children. Most will require ongoing follow up and support and some will require this for life.

Preventing Cancer

Background

The proportion of cancer incidence in NI attributable to modifiable lifestyle and environmental factors is estimated to be in the 30% to 40% range. A population approach, supported by policy and legislative measures, is required to encourage and support people to live healthier lives and reduce the prevalence of cancer risk factors such as tobacco and alcohol consumption, obesity, lack of physical activity and UV radiation exposure.

Like other European countries, the number of cancers in NI is increasing driven by an ageing population, changes in exposure to risk factors and improved survival as a result of earlier detection and better treatments. There is evidence to suggest that the pace of change in reducing the risk factors underpinning these cancers is not sufficient. Ultimately, this highlights the real need to maintain focus on tackling preventable cancers, and the urgency for accelerating change. Although death rates for cancer are falling, the total number of cancer deaths continue to rise due to an increase in the numbers of older people in the age range when the cancer typically occurs. This brings considerable challenges to health services in meeting the demand for care as well as the impact on the individuals affected. Treatment services alone cannot address the burden of cancer care. Prevention must be a key focus of this cancer strategy as it offers the most long-term, cost effective approach, however it will take time before the impact can be realised.

By implementing robust prevention strategies not only can we reduce the risk of cancer by up to 40% but also up to 75% of new cases of heart disease, stroke and type 2 diabetes, and significantly reduce the risk of dementia.

Health Inequalities

Reducing health inequalities must be a key focus of this strategy.

Inequalities in health arise because of inequalities in the conditions in which people are born, grow, live, work and age. These conditions influence the ability of individuals, families and communities to take control over their lives and choices, and whether they are enabled and supported to lead, long, healthy, active lives.

Health inequalities are associated with lower symptom awareness, later presentation and lower uptake of services including screening. Inequality across NI means there are potentially avoidable variations in outcomes, patient experience and survival. The majority of cancer types have much higher incidence in more deprived areas. There is strong evidence linking risk factors which are more common in areas of deprivation with higher incidence of cancer including smoking, obesity and poor diet. Addressing health inequalities cannot be achieved by the recommendations of this strategy alone and will require a concerted cross departmental approach.

We also need to embed health literacy. Low levels of health literacy are associated with poorer access to health services, poorer communication with health-care professionals, lower adherence to treatment and poorer self-management of health conditions. Better health literacy could therefore contribute to reducing health inequalities, strengthen health and improve health-care efficiency.

Major strides have been made in the development of relationships with many community and voluntary sector organisations as a result of the pandemic. We need to learn from the COVID-19 experience and continue engagement with lesser heard communities including BAME groups, people with learning disabilities, those for whom English is not their first language to ensure equality of access to cancer services across the pathway and to information and support services.

CANCER IS A PREVENTABLE DISEASE –

WHAT ARE THE MAIN KNOWN MODIFIABLE RISK FACTORS?

SMOKING

Tobacco is the single greatest modifiable risk factor for cancer prevention.

RADIATION & OCCUPATIONS

UV radiation is the main cause of skin cancer.

Overexposure to radon gas increases the risk of lung cancer.

Some occupations are linked with a higher risk of cancer, eg mining, construction, manufacture.

ENERGY IMBALANCE & DIET

Being active lowers the risk of colon, breast, prostate & endometrial cancers.

Excess weight raises the risk of gallbladder, liver & kidney cancers.

Heavy consumption of processed meats & high GI foods increase the risk of cancer. Low GI foods decrease it.

30-50% of all cancers are PREVENTABLE (World Health Organisation)

INFECTIONS

Papilloma viruses increase the risk of cancers of the cervix, penis, vagina, anus & oropharynx.

Hep B & Hep C increase the risk of liver cancer.

H pylori increases the risk of stomach cancer.

ALCOHOL USE

Heavy alcohol intake is a risk factor for oral cavity, pharynx, larynx, liver, bowel & breast cancers.

ENVIRONMENTAL POLLUTION

Air pollution increases the risk of lung cancer.

HSC	Public Health Agency Health Intelligence	Pocket Briefings August 2019	CANCER PREVENTION CANCERS CAUSED BY MODIFIABLE RISK FACTORS

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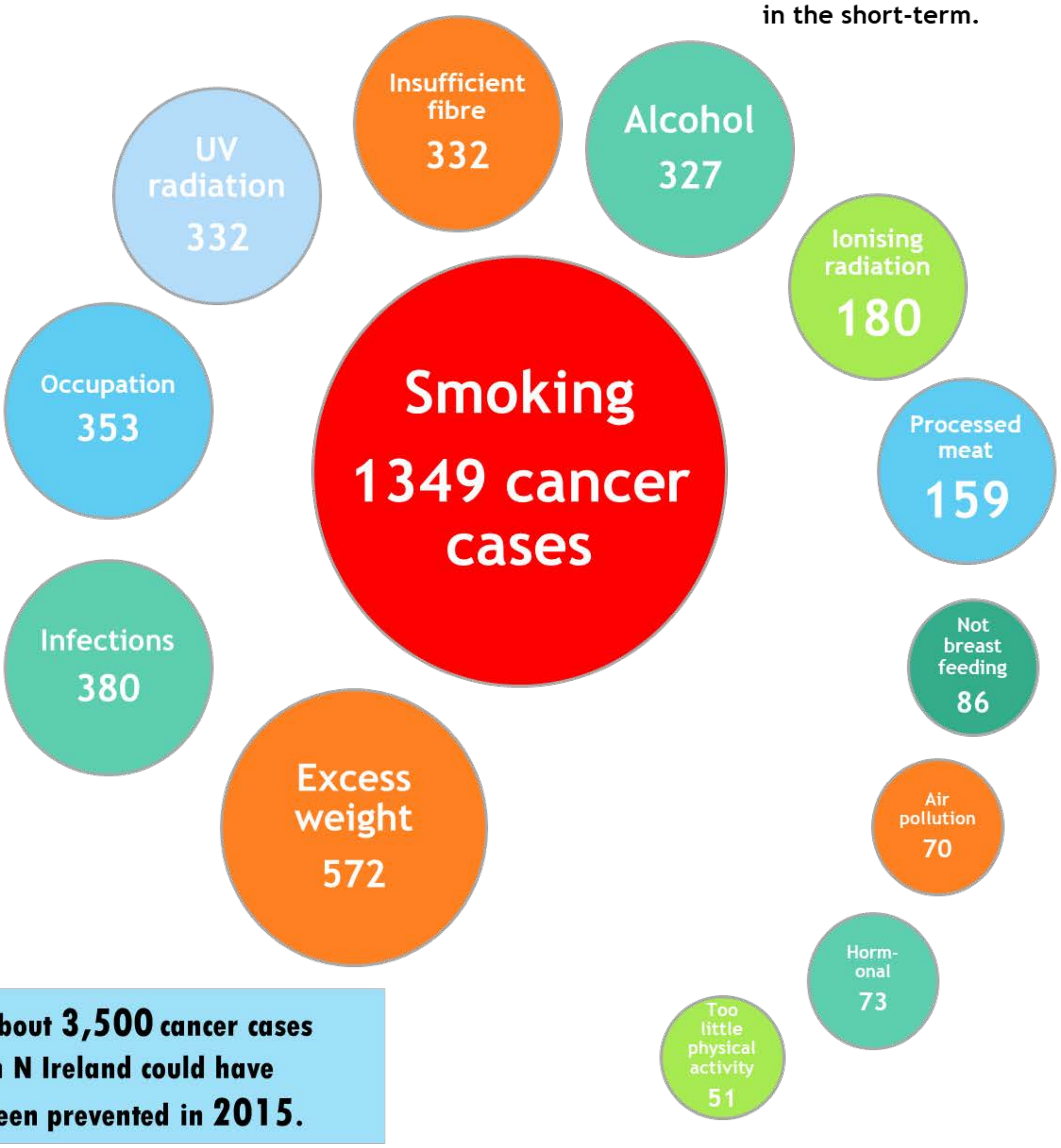
[3] Public Health Agency Health Intelligence, Pocket Briefings, August 2019, Cancer Prevention- Cancers caused by modifiable risk factors

ESTIMATION OF PREVENTABLE CANCER CASES IN NI

- Nearly 4 in 10 cancer cases in NI could be prevented.
- Not all modifiable risk factors have the same impact on cancer risk.
- It can take years for the cancers caused by modifiable risk factors to exhibit. The impact of current/new prevention measures may not be seen in the short-term.



About 3,500 cancer cases In N Ireland could have been prevented in 2015.

BJC (2018) 118:1130-1141; https://doi.org/10.1038/s41416-018-0029-6
Excluding non-melanoma skin cancer, age 16+, hormonal covers post-menopausal hormones & oral contraceptives.
Cancer cases for Individual risk factors do not sum to the total due to the method used to combine attributable fractions.

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[4] Public Health Agency Health Intelligence, Pocket Briefings, August 2019, Cancer Prevention- Cancers caused by modifiable risk factors

[5] Brown, K.F., Rumgay, H., Dunlop, C. et al. The fraction of cancer attributable to modifiable risk factors in England, Wales, Scotland, Northern Ireland, and the United Kingdom in 2015. Br J Cancer 118, 1130–1141 (2018). https://doi.org/10.1038/s41416-018-0029-

Cancer Risk factors

Smoking

The numbers of new cases of lung cancer are falling as a result of the decrease in smoking prevalence over several decades. Tobacco use, however, continues to be a significant factor in many cancers and cancer deaths across NI. There are over 1300 cancer deaths per year caused by smoking. It is the main cause of preventable death from cancer in NI. Smoking prevalence for 2020 is estimated to be nearly 30% for the most deprived communities compared to 10% for the least deprived.

The vast majority of lung cancers and over half of all head and neck cancers (oral cavity, oesophageal, laryngeal and pharyngeal) can be attributed to smoking. Smoking is also a contributory factor in many other cancers including kidney, bladder, liver, pancreas and cervix. Public awareness of the links between smoking and lung cancer are strong but there are low levels of awareness of the wide range of other preventable cancers caused by smoking.

Ambitions of achieving a 'smoke free' target of 5% average adult smoking prevalence have been set in some UK nations but, to date, not in Northern Ireland.

We will take account of the learning and progress made through the implementation of the Tobacco Control Strategy and, when required will support the need for the development of a new Tobacco Control Strategy. We will raise public awareness of the links between tobacco and cancer.

Smoking prevalence has fallen;

24% in **2010/11**

17% in **2019/20**

Obesity

Obesity is responsible for almost 600 cases of cancer each year in NI. It is a key contributory factor associated with cancer risk and mortality, including breast, uterus, liver, gall bladder, colorectal and kidney.

Obesity is the second biggest preventable cause of cancer in Northern Ireland .

65% of adults in NI are overweight or obese with around a quarter (27%) of children aged 2-5 either overweight (19%) or obese (8%). Trend analysis shows that rates of overweight or obesity have remained relatively static and there are no indications of a long-term decrease. There is a low level of understanding amongst the general public of the links between obesity and cancer.

There is no single action that will solve Northern Ireland's high obesity and overweight prevalence; a combination of actions is required to address the food environment and ensure that people are supported to live healthier lives.

The intended impact of this recommendation is for people in Northern Ireland to be supported to make healthier food choices, removing triggers to purchase unhealthy food, and ultimately reduce prevalence of overweight and obesity. This in turn will lead to fewer obesity related cancers.

We will take account of the learning and progress made through the implementation of the existing obesity strategy and when required will support the development of a new obesity strategy. We will raise public awareness of the links between obesity and cancer.

65% of adults in 2019/20 were either; **overweight (38%)** or **obese (27%)**
(up from 62% in 2018/19)

Diet and Physical Activity

The importance of lifestyle factors including physical activity, sedentary behaviour, and diet and their association with cancer has been recognised in recent years.

Breast feeding is the best start for baby and has a protective effect for the mother. Breastfeeding for 12 months reduces the risk of developing breast cancer in the future by over 4%.From Health Intelligence Data NI it is encouraging to note that the number of mothers attempting to breastfeed increased from 54.1% to 61.2% between 2012 and 2018 .There is however a deprivation gap with 46.8% of mothers living in the most deprived areas reporting as attempting to breastfeed compared to 74.9% from the least deprived areas. Efforts to increase breastfeeding must be supported across a range of programmes both in midwifery units and in the community.

High consumption of processed meats is a major contributory factor to bowel cancer but conversely a diet high in fruit and vegetables reduces the risk of many cancers including bowel, stomach and oesophagus.

Health Survey data 2017/18 shows that 17% of adults ate processed meats most days of the week. This is an increase from 2010/11. There is a gender differential with more men than women eating processed meats (23% v 12%) and a deprivation gap between the most and least deprived (24% v 12%).

In 2019/2020 56% of adults ate less than the recommended 5 portions of fruit and vegetables per day. This is down from 68% in 2010/11, with lower rates for men and for the most deprived.

Less than two-fifths (39%) of those living in the **most deprived areas** reported eating **5 or more** portions of fruit and vegetables compared with over half of those in the **least deprived areas** (56%)

Sedentary behaviour is associated a higher risk of many cancers but most notably colon, endometrial and breast cancers.

Health Survey NI data for 2016/17 shows that 45% of adults did not meet the recommended levels for physical activity. There is a gender differential with more women than men inactive (49% v 39%) and a deprivation gap between the most and least deprived (56% v 37%).

Ultraviolet Radiation

Skin cancer is the most common form of cancer in N Ireland. The figures for skin cancer in NI are stark with incidence rising year on year. Incidence has trebled since the mid-1980's. By 2040 a further 82-149% increase in malignant melanoma cases and a further 99-132% increase in non-melanoma skin cancer cases are predicted.

The main cause of skin cancer is over exposure to UV radiation from the sun or artificial tanning devices. Health survey results (2016/17) indicate that 4% of females and 1% of males currently use sunbeds, and 31% of females and 11% of males have used sunbeds in the past. This level of use is equivalent to or slightly higher than reported use in 2012/13. The number of sunbed premises in N Ireland has more than doubled in 10 years, to 19.6 sunbed businesses per 100,000 population in 2019.

The Health Survey 2016/17 reported that 33% of adults in NI never check for any changes in their skin which could indicate skin cancer and 21% reported having had sunburn in the previous year.

Sunbed use poses a specific risk for melanoma, independent of skin type and of solar exposure. Melanoma risk increases with younger age of first sunbed use and with greater lifetime use of sunbeds. Sunbed use has also been associated with increased risk of non-melanoma skin cancers and ocular melanoma (cancer of the eye), especially for those who started artificial tanning at a younger age.

Development of any new version of the skin cancer prevention strategy should give consideration to including a specific focus on occupational skin cancer. The World Health Organisation (WHO) is expected to introduce a new 1CD-11 code for skin cancer of occupational origin in 2022.

We will take account of the learning and progress made through the implementation of the skin cancer prevention strategy and when required will support the need for the development of a new strategy. We will raise public awareness of the links between skin cancer and cancer.

Alcohol

Drinking alcohol causes over 300 cases of cancer a year in the Northern Ireland. Alcohol causes a variety of types of cancer; mouth, upper throat (pharynx), larynx, oesophageal, breast, bowel, and liver. These encompass some of the most common cancer types and some of the most difficult to treat. The risk of some of these cancer types is increased even at low levels e.g. oesophageal, oral cancers and breast cancer while others are only increased at moderate to heavy consumption e.g. bowel and liver respectively. When combined with smoking the risks are increased significantly. Awareness amongst the public of the relationship between alcohol and cancer is low. There is an opportunity for this to be highlighted in the Substance Abuse Strategy as a significant risk factor.

Introducing a minimum unit price for alcohol products could be an effective way of reducing alcohol related cancers in Northern Ireland.

Three Quarters **(77%)** of adults aged 18 or over **drink alcohol**

We will take account of the learning and progress made through the implementation of the Substance Abuse strategy. We will raise public awareness of the links between substance use and cancer.

Infections

Several specific infections are implicated in the development of some cancers including H pylori, hepatitis B and C and the human papilloma virus (HPV). H pylori is associated with an increased risk of stomach cancer, however it is no longer common in the UK and for most people it is successfully treated with antibiotics and will not cause any further problems.

Chronic infections with hepatitis B and C are associated with an increased risk of developing liver cancer. Laboratory confirmed cases of both hepatitis B and C have increased significantly in the past decade. A hepatitis B immunisation programme for young children was introduced in 2017 which will subsequently reduce the risk of developing cancer in the future.

HPV is one of the most common sexually transmitted infections. Infections with HPV cause the vast majority of cervical cancers, most anal cancers and a significant proportion of oropharyngeal, vaginal, vulval and penile cancers. The HPV vaccination programme for both adolescent girls and more recently boys has been successful in reducing sexually transmitted infections which as a result will reduce the numbers of these cancers in the future. Men having sex with men, aged under 45 and who are attending Genitourinary clinics, can also avail of HPV vaccinations.

Going forward it is crucial that we maintain the high uptake rates for these vaccination programmes.

Comprehensive sex education and awareness programmes must be developed and implemented to reduce the number of sexually transmitted infections which could lead to the development of a preventable cancer.

Oral Health

Cancer of the oral cavity is on the increase, particularly among our younger population. This includes cancers of the lip, tongue and oropharynx. Checking for signs and symptoms of cancer is perhaps the most important role dentists carry out routinely. Attendance for routine examination and care is an ideal time for 'opportunistic' screening. In addition dentists also have a key role to play in supporting many people having treatment for cancer.

The established risk factors for developing mouth cancer are smoking (or using tobacco in other ways for example chewing tobacco), drinking alcohol and infection with the human papilloma virus (HPV). The risk of developing oral cancer for those who use tobacco and drink alcohol is greater than the sum of the separate risks. (i.e. the risk is multiplied not added). Oral cancers caused by HPV tend to affect younger individuals than those associated with alcohol and tobacco.

In 2018, 290 people in Northern Ireland were diagnosed with oral cancer, 188 males and 102 females. The median age at diagnosis was 63 and 62 years respectively, however, 30 (12%) of those diagnosed were aged under 50 years. Over the 25 year period from 1993 to 2018, the number of people diagnosed with oral cancer in Northern Ireland has increased by more than 80% with the relative increase being greater among women than men.

Unfortunately, the majority of oral cancers in Northern Ireland are diagnosed at stage IV which has a significant impact on survival. Five year survival rate for oral cancer in Northern Ireland is approximately 45% overall but is 66% for those diagnosed at stage I and only 25% for those diagnosed at stage IV. Like many other cancers, studies indicate there is a socio-economic gradient with oral cancer - the risk of developing oral cancer is significantly greater among those from deprived communities.

We will raise public awareness of the risk factors and early signs of mouth cancer and the importance of regular dental check-ups for those at increased risk.

Environmental Pollution

In 2013, the International Agency for Research on Cancer (IARC) confirmed that outdoor air pollution is a cause of cancer. In Northern Ireland, around 70 cases of cancer each year are caused by exposure to outdoor air pollution. The smallest particles known as PM10 and PM2.5 are linked to lung cancer.

Northern Ireland is currently the only nation within the UK that does not have a dedicated strategy to reduce air pollution. The Northern Ireland Department of Agriculture, Environment and Rural Affairs is currently consulting on a discussion paper in advance of developing such a strategy.[6]

Air pollution in Northern Ireland comes from a variety of sources. Domestic combustion (burning wood and open fires) is one of the biggest sources of PM10 (27%) and PM2.5 (44%) in the UK.[7] Road transport is responsible for 11% both of PM10 and PM2.5 emissions across the UK,[8] of which 27% to 43% is from vehicle exhaust emissions and the remaining is from tyre and brake pad wear.[9]

We will liaise with the Department of Agriculture, Environment and Rural Affairs and support the development and delivery of Northern Ireland's first Clean Air Strategy.

Radon

Radon is a radioactive gas which is naturally produced in the ground from uranium which is present in small quantities in soil and rocks. Most radiation exposure from radon arises from inhaling its short-lived solid radioactive decay products rather than radon itself. Radon is recognised by the International Agency for Research into Cancer (IARC) as a Class 1 carcinogen (IARC, 2012). In the UK, exposure to indoor radon is responsible for an estimated 1,100 lung cancer deaths each year with smokers and ex-smokers at the greatest individual risk. There is currently no strong evidence to link radon exposure to cancers other than lung cancer or to other diseases (AGIR, 2009). The Department of Agriculture, Environment and Rural Affairs and other agencies are contributing to a UK National Radon Action Plan.

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[6] Northern Ireland Department of Agriculture, Environment and Rural Affairs (2020) Clean Air Strategy for NI – Public Discussion Document (pdf)

[7] UK Department for Environment, Food and Rural Affairs (2020) National Statistics – Emissions of air pollutants in the UK, 1970 to 2018 – Particulate matter (PM10 and PM2.5) (website)

[8] UK Department for Environment, Food and Rural Affairs (2020) National Statistics – Emissions of air pollutants in the UK, 1970 to 2018 – Particulate matter (PM10 and PM2.5) (website)

[9] UK Air Quality Expert Group (2019) Non-Exhaust Emissions from Road Traffic (pdf)

Chemoprevention

Chemoprevention is the use of medication to prevent the development of cancer and is a relatively new approach to cancer prevention. Its use is primarily focused on those known to be at a significantly higher risk of developing cancer, for example those with a strong family history or diagnosis of a premalignant or predisposing condition. Guidelines produced by the National Institute for Health and Care Excellence (NICE) for familial breast cancer recommend that women at an increased risk of breast cancer should be offered medication to reduce their risk. There is also emerging evidence of the protective effect of aspirin in Lynch Syndrome. Going forward, as new evidence emerges, chemoprevention is likely to play a greater role in the prevention of more cancers.

We will develop a co-ordinated approach towards chemoprevention and implement NICE guidance within an agreed timeframe.

Targeted Surveillance

Significant research developments are happening at present which will bring changes to the organisation and delivery of services so that patients at higher risk of a condition can be "targeted" for additional surveillance so that an early diagnosis of cancer can be made for these conditions.

Many precancerous lesions, if detected, can be adequately treated preventing progression to cancer. Progression from precancerous disease to cancer varies by site and there has been limited research following patients with precancerous conditions on a population basis.

In Northern Ireland research teams at Queen's University Belfast have established the following precancerous databases:

- Barrett's Oesophagus Register – The Northern Ireland Barrett's oesophagus Register is one of the largest population-based registers of Barrett's oesophagus worldwide.
- Colorectal Polyp Register.
- Endometrial Hyperplasia Register
- Monoclonal Gammopathy of Undetermined Significance (MGUS) Register

These databases are enabling researchers to identify clinical and molecular characteristics that predict progression to cancer that can facilitate service planning and healthcare provision. Expansion of the precancerous databases would enable Northern Ireland to lead the way in population based research on precancerous conditions.

We will make sure that Trusts have surveillance systems in place for conditions where there is clear evidence regarding the pre malignant potential of a particular condition to ensure people are not lost to follow up.

Secondary Prevention

There is a long-established evidence base showing that certain behaviours are linked to the development of cancer (smoking, being overweight/obese, drinking at harmful levels, exposure to UV without protection). People who have developed cancers arising from these factors may worry about the cancers returning, and could be at an increased risk of recurrence without behavioural changes. Multiple studies have demonstrated strong evidence for the benefits of physical activity in reducing the risks of both cancer recurrence and death from cancer for a variety of tumour types. We know from feedback from patients and health professionals that people who have been diagnosed with cancer would like more information, tailored to their individual needs on how to make lifestyle changes.

HSC providers should ensure that all people treated for cancer are given advice, tailored to their individual circumstances and risk level, on how to improve their lifestyle. Advice should include healthy eating, weight control, physical activity, smoking cessation and alcohol consumption, to help prevent secondary cancers and reduce the risk of recurrence. This advice should be recorded in their medical notes. All people treated for cancer should be signposted to local services in their community where they can be supported in making their lifestyle changes.

We will ensure that all people diagnosed with cancer have appropriate and targeted information and support to live well and reduce the risk of long term consequences and developing second cancers.

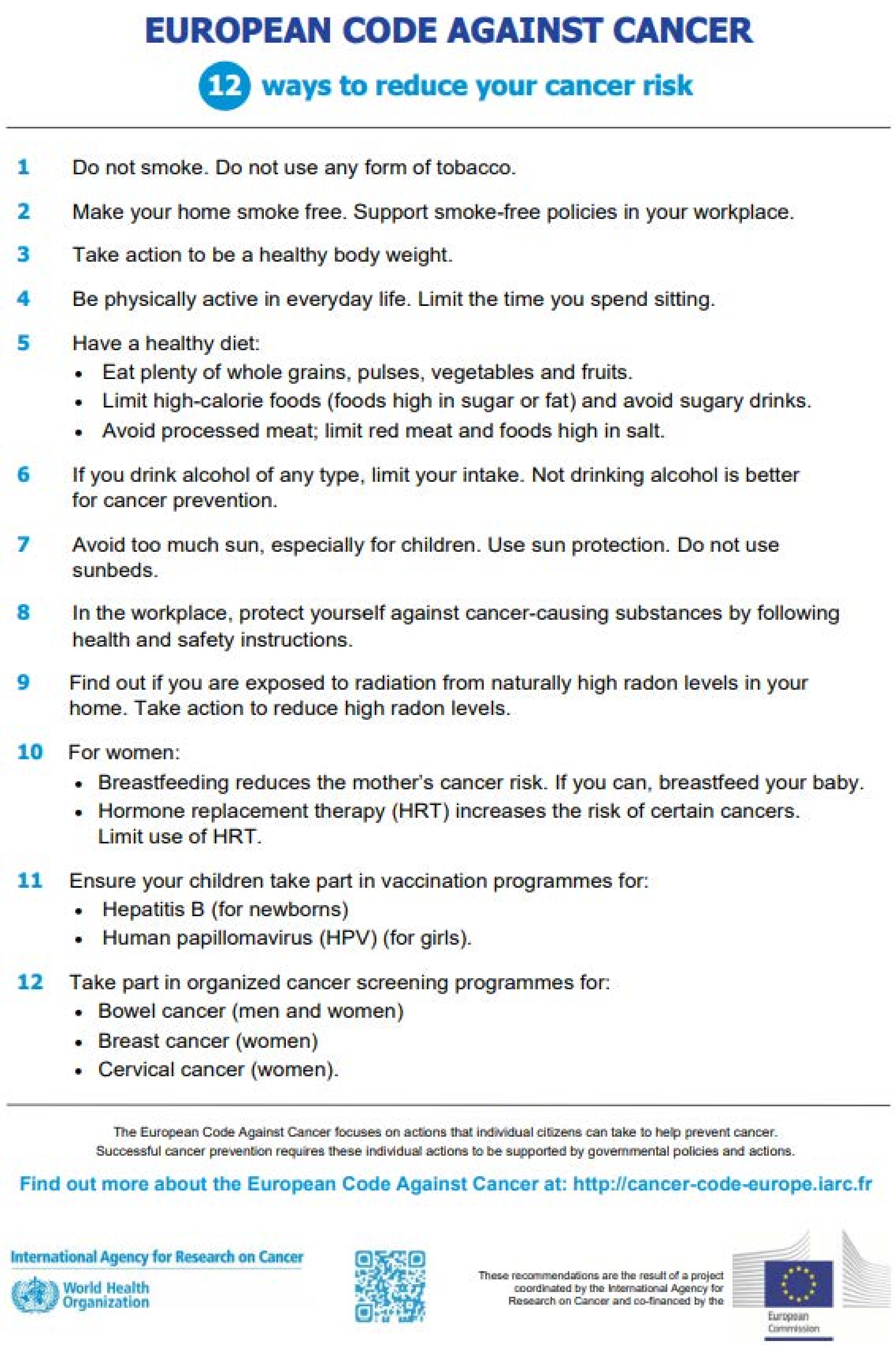
From the evidence it is clear that reducing the number of preventable cancers in NI goes far beyond the remit of the Department of Health and will require a concerted focus across government departments. Social deprivation and health inequalities are a major contributory factor in the development of the majority of cancers. More evidence on carcinogenic chemicals and substances will undoubtedly become available over the coming years. In addition to health measures, legislation will be required and funding made available if the change needed is to be realised.

Making Life Better

Making Life Better (MLB) is the overarching strategic framework for public health through which the Executive committed to creating the conditions for individuals, families and communities to take greater control over their lives, and be enabled and supported to lead healthy lives.

The All Department's Officials Group (ADOG) is a key part of the structures for co-ordinating implementation of MLB. Its key function is to bring together senior officials from all NI Government Departments and to inform and support the Executive's Ministerial Committee for Public Health in carrying out their role of providing strategic leadership and cross-government coherence effectively. ADOG could therefore be used as the mechanism to engage with other Government Department and Agencies in addressing the wider social determinant of cancer, and ensuring the Government policy aligns to prevent cancers developing in the first place.

Alternatively consideration could also be given to the establishment of a sub group of the NI Civil Service board, chaired by the permanent secretary of the Department of Health.



EUROPEAN CODE AGAINST CANCER

12 ways to reduce your cancer risk

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1 Do not smoke. Do not use any form of tobacco.

2 Make your home smoke free. Support smoke-free policies in your workplace.

3 Take action to be a healthy body weight.

4 Be physically active in everyday life. Limit the time you spend sitting.

5 Have a healthy diet:
- Eat plenty of whole grains, pulses, vegetables and fruits.
- Limit high-calorie foods (foods high in sugar or fat) and avoid sugary drinks.
- Avoid processed meat; limit red meat and foods high in salt.

6 If you drink alcohol of any type, limit your intake. Not drinking alcohol is better for cancer prevention.

7 Avoid too much sun, especially for children. Use sun protection. Do not use sunbeds.

8 In the workplace, protect yourself against cancer-causing substances by following health and safety instructions.

9 Find out if you are exposed to radiation from naturally high radon levels in your home. Take action to reduce high radon levels.

10 For women:
- Breastfeeding reduces the mother's cancer risk. If you can, breastfeed your baby.
- Hormone replacement therapy (HRT) increases the risk of certain cancers. Limit use of HRT.

11 Ensure your children take part in vaccination programmes for:
- Hepatitis B (for newborns)
- Human papillomavirus (HPV) (for girls).

12 Take part in organized cancer screening programmes for:
- Bowel cancer (men and women)
- Breast cancer (women)
- Cervical cancer (women).

The European Code Against Cancer focuses on actions that individual citizens can take to help prevent cancer.
Successful cancer prevention requires these individual actions to be supported by governmental policies and actions.

Find out more about the European Code Against Cancer at: http://cancer-code-europe.iarc.fr

International Agency for Research on Cancer
World Health Organization

These recommendations are the result of a project coordinated by the International Agency for Research on Cancer and co-financed by the European Commission

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[10] European Code Against Cancer - International Agency for Research on Cancer (IARC). European Commission: 12 ways to reduce your cancer risk.

Diagnosing Cancer

Pathways to diagnosis

People can receive a cancer diagnosis in a variety of places such as screening centres, GP surgeries, hospital settings including outpatient departments, inpatient wards and emergency departments. Increasingly during the COVID-19 pandemic people received their diagnosis in their own homes by phone.

The first ever Pathways to a Cancer Diagnosis report for NI was published in January 2020. This was a research project between the Health Foundation, Queen's University Belfast (QUB) and Business Support Organisation (BSO) which looked at how and where patients with cancer are diagnosed. One of the key findings of this work was to highlight the significant proportion of people being diagnosed in the emergency department, the majority of whom are presenting with late stage disease. This includes 28% of blood and lymph cancers, 42% of digestive tract cancers, 27% of upper gastrointestinal tract, 25% of head, neck, brain and eye cancers and 35% of lung cancer. Other key findings were the significant survival differences dependent on the route to diagnosis, with 3 year survival highest for screen detected cancers at 97% compared to 3 year survival of 21% for those presenting as an emergency.

It is important that this work is repeated regularly in order to understand how improvements in the system and increased public awareness are impacting on how and where people are presenting, being diagnosed and the stage of disease at diagnosis.

Raising Awareness

There is little doubt that early diagnosis of cancer improves survival and reduces mortality. For certain cancers the difference is stark. Bowel cancer diagnosed at stage I or II, has a one-year survival of 90%, if diagnosed at stage IV survival is less than 10%.

Early diagnosis is a complex, multifaceted topic dependent on a range of factors including public awareness of symptoms, access to primary care, access to diagnostic services, referral guidelines and pathways. People who recognise abnormal or persistent symptoms and seek medical advice are much more likely to have earlier stage disease and have better outcomes.

Raising public awareness on the signs and symptoms of cancer has been proven to be successful elsewhere in the UK. England and Scotland run regular campaigns designed to raise awareness of the signs and symptoms of different types of cancer and to encourage patients to visit their GP if they experience symptoms or notice changes in their body.

England's 'Be Clear on Cancer' campaign was particularly successful in increasing the numbers of early stage operable lung cancers.

The Public Health Agency (PHA) developed a cancer awareness programme for Northern Ireland, Be Cancer Aware, in 2015. It has a dedicated website but, largely due to funding constraints, there have been no media campaigns run since 2016.

In addition to financial issues there has been concern that such campaigns will lead to increased visits to already overstretched GPs and an increase in referrals to already overstretched diagnostic services.

Awareness campaigns must be co-designed with General Practice and diagnostic colleagues as any promotional activity will drive increased presentations to general practice and will inevitably result in increased referrals to diagnostic services. This is more important than ever as we emerge from a global pandemic with an expected surge in the numbers of patients presenting with symptoms combined with very significant backlogs.

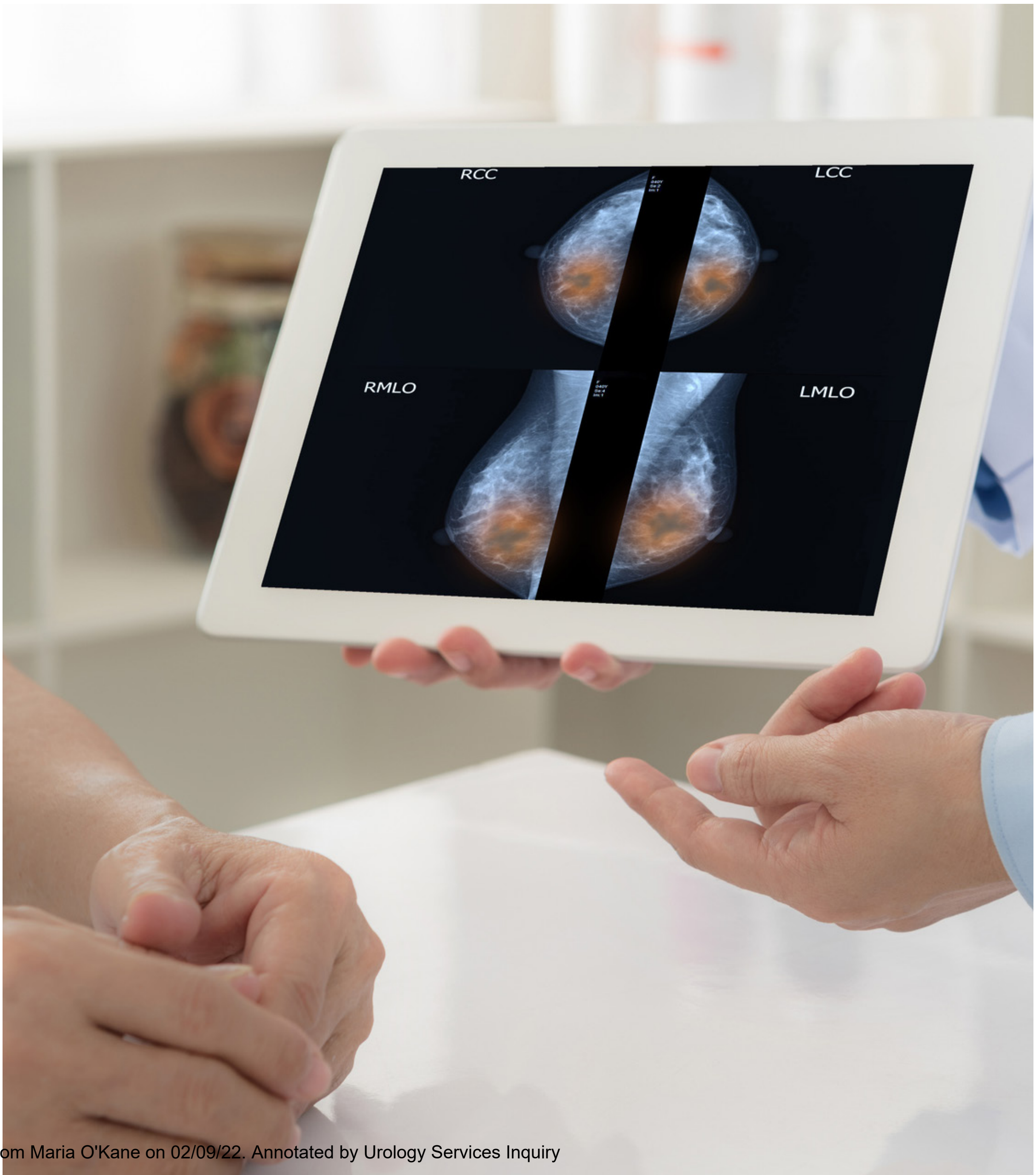
There is evidence that people from lower socio-economic groups often have lower recognition of signs and symptoms of cancer. This is likely to be the case for other seldom-heard and harder to reach groups, particularly those from ethnically diverse backgrounds and those with learning disabilities. Awareness raising campaigns must be co-produced and specifically tailored to be more easily understood. Consideration must also be given to translation of resources into other languages and to the provision of appropriate resources for those people with sensory impairment.

Many cancer charities have a focus on promoting awareness and have developed excellent resources in accessible formats. There is much to be gained in combining efforts and working in partnership with community and voluntary sector organisations who often are more successful in reaching minority populations where the need is greatest.

Data capture and evaluation are essential in order to measure impact and to learn and adapt campaigns for the future.

We will deliver regular, effective, targeted evidence-based ‘Be Cancer Aware’ campaigns.

We will develop measures to increase uptake of all cancer screening programmes, particularly in seldom heard communities.



Screening

Screening programmes are targeted at large groups of the population, the majority of whom will have no symptoms of cancer. Screening offers the opportunity to diagnose many more cancers at a much earlier stage leading to better outcomes for patients. Three programmes currently exist in NI: breast, bowel and cervical. There is however considerable variation in the uptake of all three programmes, with poorer uptake strongly associated with social deprivation.

Effective IT systems for the call/ recall of people for screening are essential for the efficient running of all screening services. The system for cervical screening is particularly vulnerable and an upgrade is urgently required.

The UK National Screening Committee (UK NSC) makes evidence-based recommendations to UK nations regarding population screening programmes. In the past, Northern Ireland has been slower than other nations in adopting some recommendations made by the UK NSC. This must be addressed as a matter of urgency.

Professor Sir Mike Richards recently published his review of adult screening programmes in England. While most of the recommendations were for England specifically, there are a number of things that should be adopted by devolved screening programmes, including Northern Ireland. This should include NI participation in any new UK screening advisory body, annual publication of routine performance data and quality assurance reports for screening programmes, and high priority given to an integrated approach to increasing uptake and coverage.

Going forward cancer screening programmes will continue to evolve and new programmes are likely to develop for people at higher risk. Currently pilot programmes using low dose CT scans to screen for lung cancer, targeting smokers and ex-smokers, are being established across the UK including an innovative pilot in the Southern Health and Social Care Trust.

It must be emphasised that screening is only effective at reducing morbidity and mortality if there is also timely access to diagnostic and treatment services

Bowel Screening

Bowel cancer is the third most prevalent cancer in Northern Ireland and the second leading cause of cancer death. The bowel screening programme is offered to people aged 60-74. The programme detects 8.3% of all bowel cancers. 67% of cancers detected through bowel screening are at an early stage. Removal of early polyps detected through screening can very often prevent cancer from returning or developing any further.

The qFIT test, is a new easier to use home test for bowel screening which only needs 1 sample instead of the current 3 samples. It has been rolled out in all other UK nations and was introduced in NI in January 2021. First confirmed results from Scotland after their introduction of qFIT showed increased uptake of bowel cancer screening from 55.4% to 63.9%.Importantly, this increased uptake was seen in men, areas of higher deprivation, and in difficult to reach audiences. This increase in uptake means more pre-cancerous changes and cancers are likely to be detected - and at an early stage.

An introductory sensitivity rate of 150ug/g has been agreed for NI. This is the same as Wales but considerably higher than England and particularly Scotland. The UK National Screening Committee has recommended that the starting age for bowel screening be reduced to 50. NHS England has agreed a four year phased approach to mobilisation of age extension across England commencing in April 22.

Going forward it is important to have plans in place for NI to reduce sensitivity levels and extend the age range in line with these recommendations.

The success of the bowel screening programme is highly dependent on access to timely endoscopy services. There are very significant challenges with the capacity of endoscopy services across all trusts. These must be addressed as a priority to cope with existing demands and to be able to accommodate reductions in sensitivity levels and widening of age bands in the future.

There are other emerging tests being rolled out at pace elsewhere in the UK, for example CT-capsule endoscopy. Early adoption of such tests may well be key in terms of developing a sustainable response to the ever increasing demand for endoscopy services.

Breast Screening

Breast screening is the most established cancer screening programme in NI. 29% of breast cancers are diagnosed via the screening programme. Mammography for all women aged 50-70 and registered with a GP is carried out every 3 years via mobile and static units. It is available for women aged over 70 on request. Trials have begun in England to explore broadening the age range from 47-73. This is likely to have a significant impact for NI if it is deemed to be successful. The ongoing success of breast screening services is reliant on responsive symptomatic breast cancer services in all Trust areas.

Cervical Screening

Cervical screening is offered to all women aged 25 - 49 every 3 years and every 5 years for those aged 50-64. 24% of cervical cancers are detected via the screening programme.

Samples are taken in a GP surgery and are analysed in a labratory using a process called cytology. If abnormal cells are detected, the sample is then tested for high risk high-risk Human PapillomaVirus (hr-HPV). hr-HPV is the most common cause of cervical cancer.

In 2016 the National Screening Committee recommended that cervical screening programmes switch to testing for hr-HPV as the primary test. Switching to hr-HPV as the primary test does not require anything different at the point of testing, but does require some reconfiguration of laboratory services. In the short term it is expected to increase referrals for colposcopy investigation. In the longer term HPV testing is a more accurate test than cytology and will ultimately be more cost-effective by enabling a longer interval between tests. This change has been agreed in principle for Northern Ireland with the aim of implementation in 2022/23.

Pilot studies on self-sampling are underway across the world and in some parts of the UK. This may well improve uptake and become more mainstream in the future.