## Carers

Support and care provided by families and informal carers is vital to the wellbeing of patients given their assistance in managing medications, treatment regimes, symptom management, personal care, social and psychological support. However, providing informal care is challenging for many and can have a negative impact on both physical and mental health. Evidence has shown that there is a need to deliver improved services for informal carers of patients with cancer in Northern Ireland.[54] [55] [56] [57] Health care professionals have a responsibility to ensure that carers' needs are assessed and that they can obtain information easily across the illness trajectory with adequate signposting to additional support. Cancer Caring Coping[58] is a co-designed, one-stop, online, multi-medium resource (www.cancercaringcoping.com) tailored to support carers in Northern Ireland from diagnosis to possible bereavement. This resource should be made available to all carers.

In addition people providing unpaid care for loved ones with non-curative cancer and at end of life should have access to support services to meet their own health and wellbeing needs. This includes regular breaks from caring and reliable respite care. There is a wealth of evidence demonstrating that these requirements are not currently being met for many carers.[59]

Whilst carers in all situations face challenges there is a particular need to ensure appropriate support for parents of children and young people with cancer. Services and facilities including overnight accommodation are predominantly funded and provided by charities. There is a clear need for much better partnership working and integration with statutory services to ensure that all families get the support they need across the entire pathway.

Support for staff working in cancer services must also be considered. Research has shown that good staff experience contributes to better patient care. Emphasis should be placed on readily accessible up to date information, support and advice.[60]

[54] Santin, O. Murray, L. Prue, G. Gavin, A. Gormley, G. Donnelly, M. (2015) Self-reported psychosocial needs and health-related quality of life of colorectal cancer survivors. European Journal of Oncology Nursing, 24, 121-129.

[55] Santin, O. Mills, M. C, Treanor. Donnelly, M. (2012) A comparative analysis of the health and wellbeing of cancer survivors to the general population. Journal of Supportive Cancer Care.20.10. 2545-2552

[56] Treanor, C. Santin, O. Mills, M. Donnelly, M. (2012). Cancer survivors with self-reported late effects: their health status, care needs and service utilisation. Psycho-oncology. 22. 2428-35. (Grant*)

[57] Santin, O. Treanor, C. Mills, M. Donnelly, M. (2014) The health status and health service needs of primary caregivers of cancer survivors: a mixed methods approach. European Journal Cancer. Volume 23, Issue 3, pages 333–339

[58] Santin O, McShane T, Hudson P, Prue G. Using a six-step co-design model to develop and test a peer-led web-based resource (PLWR) to support informal carers of cancer patients. Psycho-oncology. 2018 Dec 29. https://doi.org/10.1002/pon.4969

[59] Marie Curie (2018). Lost retirement: The impact on older people of caring for someone with a terminal illness.

[60] Picker/Macmillan, The relationship between cancer patient experience and staff survey results, 2013, Picker Institute Europe.

## Supporting People to live well

Whilst more people than ever in Northern Ireland are surviving after a cancer diagnosis not everyone who has survived is living well. Over half of those diagnosed with cancer today will live for at least 10 years and for some types of cancer the figure is much higher. Contributions from people living with cancer to the development of this strategy has consistently demonstrated that surviving is very different from living well. Research carried out by Macmillan in 2013 found that at least one in four people living with cancer face poor health or disability following treatment for cancer. Many people will make a good recovery following treatment but a significant proportion will continue to live with a wide range of problems. People who have had curative treatment can be left with disabling, chronic long term conditions as a result. As there are no agreed pathways in place their treatment and care is often poorly managed, disjointed and uncoordinated.

A significant proportion  also live with the increased risk of developing cardiac, bone and bowel problems as a direct consequence of their treatment, some of which will not become apparent until many years later. Up to 75% of children and young people who have been treated for cancer will have long term consequences of cancer including a greatly increased risk of developing a second cancer. As more people survive cancer the problems associated with late effects, consequences of treatment and long term follow up will grow. This comes at a high cost to both the individual and to health and social care. Not only is this an issue for the quality of life of those affected, it is

**"I feel that at the end of treatment we were just left."**

**"I feel I am managing well, but the management of my health has been all consuming and has taken over my life due to the severe impact of surgeries and treatments. I had to take early retirement."**

**"I want to live life, I want to have fun. Still have the craic. This is my view and it has been for the last while."**

also a major challenge for Health and Social Care in the timely provision of long term, tailored care and support. Currently services either do not exist or are not resourced to meet the growing demand.

There are many treatments used to manage a diagnosis of cancer including surgery, radiotherapy, chemotherapy, immunotherapy and hormonal therapy. These can be used alone or in combination, often over a prolonged period of time. Side effects are part of any treatment regime but for the purposes of this section the focus is on the longer term, chronic effects of treatment.

A dearth of data to quantify the size and scale of existing barriers to living well with cancer is a serious concern. There is a gap in the knowledge and understanding of late effects and consequences of treatment, particularly in light of an ageing population. Many people live with their problems, often struggling to get the right treatment and support, and many are unaware that help is available assuming that the symptoms are the cost of a cure.

Any data available is likely to be a gross underestimation. Data collection on co-morbidities and consequences of cancer treatment must be mandated as part of any new development on data collection for cancer services.

Whilst we have focused on the most common consequences and late effects of treatment this is by no means an exhaustive list.

## Cardiovascular

The European Society of Medical Oncology (ESMO) consensus paper of 2020[61] states 'with increasing numbers of cancer survivors living longer, oncologists and other health care providers are faced with challenges in managing long-term and late toxicities of therapy, recognizing that cardiovascular issues are significant causes of morbidity and mortality in this population.'

There is robust, compelling international evidence about the growing impact of cancer treatments on cardiovascular health. Next to cancer recurrence, progression and second malignancies the leading cause of death in cancer survivors is cardiovascular diseases (CVDs) due to the intense oncological treatment which many people receive. A significant number of anticancer therapies are associated with some level of cardiovascular toxicity, ranging from asymptomatic and transient to long-term permanent life threatening problems.

In a recent report the American Society of Cardiology[62] states that 'the management of cancer can no longer be limited solely to the active treatment of malignancy….. we must invest in additional research and foster multidisciplinary collaboration to tackle gaps in our knowledge and ultimately improve both cancer- and cardiovascular-related health outcomes in this growing population.'

[61] ESMO Consensus Guidelines 2020

[62] American College of Cardiology Cardiovascular Toxicity in Cancer Survivors: Current Guidelines and Future Directions, Jun 29, 2018 | Carlyn Tan, MD; Crystal Denlinger, MDExpert Analysis

Children and young people, in particular, are at serious risk of premature death in later life from cardiovascular and respiratory failure as a consequence of treatment.[63] Some pathways are currently in place for this cohort but this is not a commissioned service.

Cardiovascular oncology is an emerging specialism with dedicated services developing in other parts of the UK.

In NI increasing numbers of people living with cancer who are at risk of developing cardiovascular disease due to treatment are being referred to cardiology services, which is having a major impact on waiting lists and access to services such as echocardiograms. It is estimated that circa 3000 echocardiograms are done for oncology patients per annum.

## Bone health

Hormonal therapy is a main stay of treatment for both breast and prostate cancers, often resulting in inevitable osteoporosis. This is also the case for people who have prolonged treatment with steroids. Pathways are in place for monitoring bone density for people living with breast cancer but there are no existing pathways for men living with prostate cancer or others at high risk.

Significant numbers of people develop metastatic bone disease which, for many, can be managed over a period of years. Over recent years there has been a steady increase in referrals to orthopaedic services combined with a significant workload managing long bone fractures and spinal cord compression. Access to appropriate palliative care can be an issue for people with long bone fractures who are initially managed in acute orthopaedic wards. There is no commissioned service in place for the management of metastatic spinal cord compression.

## GI consequences of pelvic radiotherapy

Although more people are surviving cancer, problems associated with pelvic radiotherapy are presenting many years (up to 5-10 years) post treatment which has obvious consequences for individuals who have had treatment and for service provision.  Many people report severe and distressing symptoms such as faecal incontinence, urgency, bleeding, flatulence and pain. Given the time from initial treatment often neither the person nor primary care teams are aware that this is a likely late effect of radiotherapy treatment.

[63] Mulrooney DA et al Cardiac Outcomes in a cohort of adult survivors of childhood and adolescent cancer: retrospective analysis of the Childhood Cancer Survivor Study cohort. 2009, BMJ 339;b4606

A regional task and finish group was established to develop guidelines and pathways for the management of the consequences of pelvic radiotherapy. The NICAN GI Consequences of Pelvic Radiotherapy Task and Finish Group Report was published in 2017 but to date has not been implemented in all Trust areas.

Elsewhere in the UK Centres of Excellence for the management of pelvic radiation disease are being established to manage the most complex cases. In addition to the establishment of Trust pathways consideration should be given to the development of a regional service for those with complex problems.

## Sexual Health and Fertility

Cancer treatment can have devastating physical and psychological consequences on sexuality and fertility for many people. There may be a wide range of issues including erectile dysfunction, early menopause, body image issues due to disfiguring surgery, loss of libido, reduced fertility and for some infertility.[64]


No formal, coordinated services or pathways exist and undoubtedly the impact of cancer treatment on sexual health is unreported.

There are particular issues for children and young people diagnosed with cancer. Established pathways to the regional fertility centre are in place which are very responsive when time is of the essence to start cancer treatment. For pre-pubescent children research based interventions are becoming available in Oxford and Edinburgh. Consideration should be given as to how children in NI can avail of these in a timely manner.

At present, as for all cases in NI, people who are infertile because of their cancer are entitled to one cycle of IVF. The recent commitment within New Decade, New Approach to fund 3 cycles of IVF treatment will have a positive impact in this area.

[64] Belfast Health and Social Care Trust (2017) Has Cancer affected your sexuality, sex life and relationships. Belfast: Belfast Health and Social Care Trust; Katz A. (2005) The Sounds of Salience: Sexuality Information for Cancer Patients. Journal of Clinical Oncology, 23(1), 238-241

## Lymphoedema

Lymphoedema can develop when lymph nodes or lymph vessels are removed or damaged. It is a permanent, often disabling condition and cannot be cured. With appropriate support many people are able to manage their condition with a regimen of meticulous skin care, exercise and wearing compression garments. It is commonly associated with breast, head and neck, and gynaecological cancers. There has been a commissioned lymphoedema service in place since 2008 across NI. Referral numbers have increased year on year resulting in long waiting lists. Evidence from the National Cancer Action Team in England shows that investment in lymphoedema services is extremely cost effective and significantly reduces the number of hospital admissions.[65]

## Neuropathy

Surgery and radiotherapy for cancer can damage nerve tissue in the targeted treatment areas, and chemotherapy may affect systems throughout the whole body. Nerve damage may be central - with brain effects of loss of cognition and memory, reduced hearing, vision, taste and smell; and/or autonomic - with changes in heart and blood pressure regulation, poor gut function: and/or peripheral - with reduction of normal sensation and motor function of the limbs, increased abnormal sensation and pain, and increased fatigue from loss of function or difficulties in coping with the burden of altered sensation. Many of these effects of treatment reverse or decrease over time, but many are permanent, causing significant disability. Nerve damage from cancer treatment is enhanced by pre-existing nerve dysfunction due to stroke, injury, diabetes, and other conditions.

Studies show that following chemotherapy, 60% of people experience peripheral neuropathic pain 3 months after treatment, and persists for 30% at 6 months. Overall, between 33% and 40% of cancer survivors suffer from chronic pain.[66]

Specialist palliative care clinicians have an invaluable role to play in the management of cancer pain, not limited to end of life care. There is a need for better integration and collaboration between palliative care, oncology, haematology and pain management teams.

[64] Belfast Health and Social Care Trust (2017) Has Cancer affected your sexuality, sex life and relationships. Belfast: Belfast Health and Social Care Trust; Katz A. (2005) The Sounds of Salience: Sexuality Information for Cancer Patients. Journal of Clinical Oncology, 23(1), 238-241

[65] National Cancer Action Team, Cancer Rehabilitation, Making Excellent Cancer Care Possible 2013

[66] Paice JA. Chronic treatment-related pain in cancer survivors. Pain 2011;152(Supplement):S84– S89.

Seretny M, Currie G L, Sena ES, Ramnarine S, Grant R, MacLeod MR, Colvin L, Fallon M. Incidence, prevalence, and predictors of chemotherapy-induced peripheral neuropathy: A systematic review and meta-analysis. Pain 2014;155(12):2461–2470.

[67] Faculty of pain medicine of the Royal College of Anaesthetists. Framework for pain services cancer and life limiting disease 2019.pdf (fpm.ac.uk)

The Faculty of Pain Medicine of the Royal College of Anaesthetists published 'A Framework for Provision of Pain Services for Adults Across the UK with Cancer or Life-limiting Disease' in 2019. This presents a framework and operational guidance for improving pain services for adults across the UK with cancer or life-limiting disease and should be used to develop services across NI.[67]

## Respiratory

Breathlessness can have many causes including damage to the lung by cancer treatments (radiation pneumonitis, chemotherapy fibrosis and surgical scarring), loss of physical fitness/de-conditioning, disease progression, end of life symptoms and other co-morbidities. There are no formal pathways for treating breathlessness as a consequence of cancer treatment or disease progression. Traditionally, referrals are made later in the patient journey when patients are short of breath at rest. Earlier referrals would improve quality of life and maintain independence for many.

## Mental ill health

Mental ill health cross cuts the entire cancer pathway. Some services are offered by the voluntary sector but outside of this provision, formalised pathways do not exist for cancer patients. A mental health strategy has been developed to address existing inequalities, however we know that psychiatry and psychology in each of the Trusts is overwhelmed, waiting lists are infinite, no clear pathways from cancer services exist and this has a significant impact on primary care workload. Preventing mental health conditions from developing amongst those living with cancer, as well as ensuring adequate management of conditions should they occur are important in the provision of holistic cancer care. The numbers of people needing help with their mental health is likely to grow as more people are living longer following a cancer diagnosis. There are significant gains to be realised both in patient quality of life and savings in health care costs. [68]

The breadth of services needed to help people with a cancer diagnosis adjust to a new normal do not currently exist.

[68] Sharpe M, Walker J, Holm Hansen C, et al., SMaRT (Symptom Management Research Trials) Oncology-2 Team Integrated collaborative care for comorbid major depression in patients with cancer (SMaRT Oncology-2): a multicentre randomised controlled effectiveness trial. Lancet2014;384:1099-108

## Chronic Fatigue

Cancer related fatigue (CRF) is the most commonly reported symptom affecting quality of life and ability to function. Fatigue affects large numbers of people after cancer treatment but for some it persists as a chronic long term condition. Due to difficulties with identification, problems can often go unreported and as a result, unaddressed. No formal commissioned services exist - where support exists it is often an add-on to other services, tumour dependant or provided by charities. Simple interventions such as physical activity have been shown to significantly reduce levels of fatigue.

## Continence

Surgery, radiotherapy or disease progression can result in bladder and bowel incontinence, affecting both male and female, and can be seriously life changing. Conservative services (e.g. lifestyle advice, pads etc.) are available but do not actively treat the condition. BHSCT successfully piloted the physiotherapy management of continence due to prostate cancer, and is now an award-winning service. Similar charity sponsored pilots are ongoing for the therapeutic management of incontinence related to colorectal and gynaecological causes; these are not yet commissioned.

We will make sure that all people starting cancer treatment have their health status assessed and recorded and a plan developed to mitigate potential late effects and consequences of their treatment.

We will develop an agreed regional, multidisciplinary approach to the identification and management of all people at risk of late effects and consequences of their cancer treatment.

We will identify people deemed to be at highest risk for late cardiovascular effects and enrol them in a follow up programme with appropriate imaging and with access to cardiology intervention as necessary.

We will regularly screen children to detect early, subtle cardiac abnormalities that might be treated, or may be reversible. In addition, where children are treated with anthracyclines or cardiac radiation they will have lifelong screening every 3 to 5 years.

## Caring when Cancer can't be cured

Cancer is the largest cause of death in Northern Ireland. The most up to date figures are circa 4,500 deaths per year with slightly more men than women dying from cancer. The most common causes of cancer death for men are lung, prostate and bowel and for women are lung, breast and bowel.

Findings from the Northern Ireland Health Inequalities report for the period 2017-2019 show that among people aged under-75, the death rate from cancer in the most deprived areas was greater than the least deprived areas by a factor of 1.7.

Numbers of children and young people are small, with on average 9 children and 7 young adults dying annually.

### Average Number of Cancer Deaths in Children & Young Adults recorded in NI by Age Band for the period: 2014 – 2018

| | Age Band | | |
|---|---|---|---|
| | 0 - 15 | 16 – 24 | TOTAL |
| Average Cases per Year | 9 | 7 | 16 |
| TOTAL | 43 | 33 | 76 |

NOTE:- Annual averages based upon several years have been rounded to the nearest integer. Sums of numbers in table rows or columns may thus differ slightly from the given total.

Living Matters, Dying Matters a Palliative and End of Life Care Strategy for Northern Ireland was published in March 2010. The vision of this strategy is that any person with an advanced non-curative condition, lives well and dies well irrespective of their condition or care setting.

This requires a philosophy of palliative and end of life care that is person-centred and which takes a holistic approach to planning, co-ordinating and delivering high quality reliable care, enabling people to retain control, dignity and crucially, choice in how and where their care is delivered to the end of their life.

> **"Everyone has a right to palliative care and a dignified passing, both for them and their family…"**

It means being sensitive to the personal beliefs, cultures and practices of individuals and their families and carers and recognising the contribution good palliative and end of life care can make to the quality of their lives.

It means that where the person's preference is to receive care, and where possible to die at home, that the infrastructure and opportunities are in place to make such a choice real and viable. In Living Matters Dying Matters palliative care is defined as: 'the active, holistic care of patients with advanced progressive illness.' Management of pain and other symptoms and provision of psychological, social and spiritual support is paramount. Many aspects of palliative care are also applicable earlier in the course of the illness in conjunction with other treatments. More recently the importance of 'early identification and impeccable assessment' has been added to this definition as it is thought that problems at the end of life can have their origins at an earlier time in the progression of the illness and should therefore be recognised and dealt with sooner.

Palliative care can in some cases mean a shift from a curative focus towards an approach which seeks to alleviate and prevent the escalation of symptoms. The transition between curative and palliative care is often blurred, which emphasises the importance of communication between the individual and the health care professional with regards to the intention of treatment. Identifying this transition informs thoughtful decision-making about the appropriateness of proposed treatment options and explores the provision of further social and spiritual support to address emotional, psychological and practical needs, invaluable to the individual, their family and carers in managing the condition.

End of life is described as the period of time during which an individual's condition deteriorates to the point where death is either probable or would not be an unexpected event within the ensuing 12 months, however a specific timescale cannot always be applied. This point will be different for each individual and will often depend on an assessment of their condition by health and social care professionals, carers and/or the patient themselves. Identifying the point at which illness becomes advanced or reaches the end of life phase allows health and social care providers to

## Number of Cancer Deaths in Children & Young Adults recorded in NI by Place of Death for the period: 2014 – 2018

| | Age Band | | |
|---|---|---|---|
| | 0 - 15 | 16 – 24 | TOTAL |
| HOME | 19 | 12 | 31 |
| HOSPITAL | 19 | 15 | 34 |
| HOSPICE | 5 | 6 | 11 |
| TOTAL | 43 | 33 | 76 |

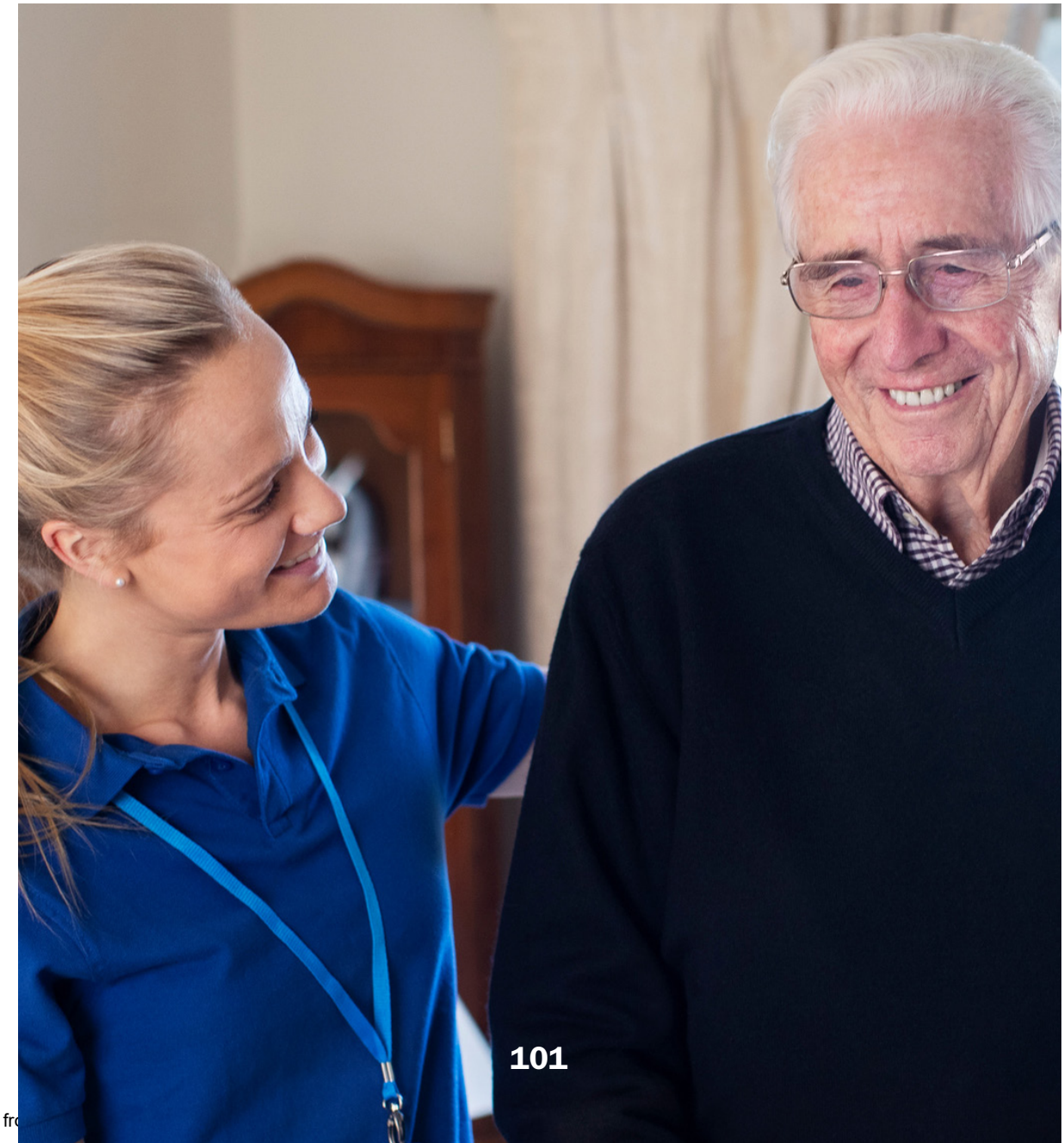
NOTE:- Annual averages based upon several years have been rounded to the nearest integer. Sums of numbers in table rows or columns may thus differ slightly from the given total.

plan best care with people in order to meet their needs and those of their families and carers throughout the last phase of life and the experience of bereavement. As with palliative care, end of life care also includes physical care, management of pain and other symptoms and provision of psychological, social, spiritual and practical support.

Palliative and end of life care is provided in many settings: at home, in hospitals, in care homes and hospices. Whilst much of the formalised care is provided by multidisciplinary teams of health and social care professionals, families, carers and volunteers continue to be the crucial cornerstone of this care. The majority of children and young people die either at home or in hospital.

Within this strategy we refer to people with ‘non-curative cancer’. By this we do not mean every patient whose cancer cannot be fully treated, but those with a non-curative diagnosis who have been identified as potentially benefiting from a palliative care approach. Increasingly people are living with non-curative cancer for prolonged periods of time. This has been termed ‘treatable but not curable cancer,’ and includes many blood cancers, metastatic cancers including breast, bowel and prostate cancer. Growing numbers of people will receive life prolonging treatment over many years and may require palliative care input on an episodic basis over a more prolonged period of time.  Existing pathways and criteria are not always flexible enough to ensure people can access palliative care services when and where they need them. If alternative services were available this could avoid unnecessary attendance at hospital and admission for some people.

COVID-19 has significantly disrupted key cancer services which is resulting in more people presenting with advanced disease. This raises challenges for the provision of palliative care service delivery in the short to medium term.



## Identification of palliative care needs

There are a number of benefits from the early introduction of palliative care for people living with cancer, including integration alongside active treatment. Timely access to palliative cancer care can result in better quality of life, lower rates of depression, longer survival and higher satisfaction with care among patients. Access to palliative care is, however dependent on both clinicians and patients and carers recognising and accepting that they could benefit from this approach. It also requires close, integrated working between key HSC disciplines, for example oncology and palliative medicine.

In practice it would appear that both cultural and structural barriers are stopping this from happening for some patients, namely:

- the emphasis of many clinicians may be on treatment or survivorship, with a reluctance to refer to palliative care or acknowledge the severity of a patient's prognosis, as this would represent 'giving up'. This may foster an attitude where palliative services are only considered once all active treatment options have been exhausted. Misconceptions about palliative care also exists among patients and their loved ones
- late identification of palliative care needs often means those people, who are still deemed as curative, no matter how small the likelihood, may miss out on receiving palliative care and support services. As a result, some people and those important to them are often shocked by rapid deteriorations and feel unprepared for the end of life.
- late identification also decreases opportunities for advance care planning and steps to facilitate the person's preferred place of care, as well as leading to complex grief in those left behind.

Recent retrospective audits (2019, pre-COVID-19) of people presenting to emergency departments have found between 20-30% of people being admitted to hospital following an attendance at ED have unidentified or unmet palliative care needs. Of those admitted on average 40% of them had advanced cancer.

We will deliver integrated, coordinated and personalised palliative and end of life care to people with non-curative cancer when and where they need it.

## Access to palliative care keyworkers

People are likely to receive care and support from a range of professionals including district nurses, GPs, Allied Health Professionals, social care workers, community pharmacy, specialist palliative care professionals. Care may also be provided from a range of organisations including hospices and charities. Patients and families report that it is often confusing having so many different people involved and that communication between services can be fragmented. Living Matters Dying Matters recommended that palliative care patients should be allocated a key worker to co-ordinate care, support and information. To date this has not been implemented uniformly across all Trusts and for all patients.

We will arrange a palliative care keyworker for all people with non-curative cancer when required.

## Access to generalist and specialist palliative care services

> **This is my dying wish - that I get to have my final days and hours spent in comfort in my own home with my loved ones.**

The NISRA Place of Death statistics for 2019 show that 47% of all deaths in NI occur in hospitals, 19% in Care Homes and 34% in all other places. The 'all other places' for 2019 isn't broken down in the official statistics but we know from previous breakdowns that around 3% of those deaths will have been in hospice and circa 27% in the person's own home.

Socioeconomic factors may have a particular impact on the end of life experience of people in their own homes. Marie Curie's research has shown that people with terminal conditions – including cancer – may be more likely to live in fuel poverty and suffer the damaging consequences of living in cold housing.[69] Elsewhere, wider UK studies have found that people in the most deprived areas are more likely to die in hospital than those in the least deprived.[70] [71]

As a result of the pandemic and the associated restrictions for visiting in care homes, hospitals and hospices, it would appear that in 2020 more palliative patients have been cared for in their own homes. Not only has there been an increase in the number of patients but also a significant increase in the complexity of care required. We need to build on the lessons of the past year to enable all those who wish to die at home to be able to do so.

The delivery of high quality palliative and end of life care requires multidisciplinary input. Specialist palliative care professionals will play an important role, but much of the care that people will receive, including at the end of life, will also be provided by wider 'generalists' – including GPs, district nurses, Allied Health Professionals and social care workers.

The need for education and training for staff, from basic understanding of what palliative care is and when it is appropriate, identifying need, advance care planning, local referral processes and integration with oncology services through to care in the last days of life and bereavement is vital if care and co-ordination is to be improved.

Rounds 1 (2018) and 2(2019) of the National Audit for the Care at the End of Life NI reports recommend increased mandatory/ priority palliative care training for all health care professionals. Despite these drivers, no regional palliative care educational framework has ever been developed or funded in NI.

[69] Marie Curie (2020). The vicious cycle of fuel poverty and terminal illness.

[70] National End of Life Care Intelligence Network (2012). Deprivation and death: Variation in place and cause of death.

[71] Macfarlane, M and Carduff, E (2018). Does place of death vary by deprivation for patients known to specialist palliative care services? BMJ Support Palliat Care, 8 (4).

Out of Hours (OOH) advice and support from specialist palliative care professionals and palliative care pharmacy is not routinely available to all health and social care teams in all locations across Northern Ireland. Where advice is available, this is usually done on an ad hoc, historical or good will basis. Specialist palliative care provision is currently only available on a Monday- Friday 9-5pm basis with no formalised out of hours provision.

In addition there are challenges in ensuring equitable access for all sections of the population, particularly seldom-heard and underrepresented sectors e.g. LGBTQ+ people, those from ethnically diverse backgrounds, people with cognitive impairment such as those with dementia, those experiencing homelessness, people in long-term institutional care including prison care, the ageing and frail population, and those living in rural and remote areas.

We will arrange equitable access to palliative and end of life support and continuity of care for all people with non-curative cancer 24 /7.

## Advance care planning (ACP)

In Northern Ireland, there remains a significant taboo around discussing death and dying. This inevitably can result in conversations about palliative care being put off until the advanced stages of a person's condition, because of the association with the end of life stage. This can foster an attitude where palliative services are only considered once all active treatment options have been exhausted.

Advance Care Planning is an important part of routine health and social care practice, to ensure that people have the opportunity to have realistic and practical discussions about where and how they would like to be cared for at the end of their life. It gives a person the chance to think about what matters to them and to consider and record their wishes and preferences for end of life care including decisions in relation to Advance Decisions to Refuse Treatment (ADRT) and Cardiopulmonary Resuscitation (DNACPR). Advance care planning (ACP) plays an important role in ensuring that a person is given the opportunity to be involved in shared decision making and to state preferences and wishes which can be recorded and communicated to those involved in their care. The development of Regional Advance Care Planning Policy for adults in NI is to be welcomed.

Education and training should equip health and social care staff to have regular, meaningful, timely, realistic and practical conversations with people about their diagnosis, prognosis, treatment options and planning for the future. It is particularly important that communication with patients and loved ones is carried out in a sensitive and compassionate manner.

We will support people and their carers to discuss their wishes and preferences for care at the end of life and ensure that this is recorded in a shareable format with the relevant people.

## Pre-bereavement and bereavement support

Most bereavement services in Northern Ireland are provided by the community and voluntary sector. Capacity is an issue, with long waiting lists in many areas. Capacity issues are also preventing Trust social work teams from offering greater levels of bereavement support, including follow-up services with carers and loved ones. Patients and their loved ones may have access to chaplaincy support in the hospital setting, but these services will normally cease after discharge, so continuity of care does not continue into the community. Day-to-day support is likely to have been provided via the services delivered to their loved one but these are withdrawn after death. The loss of this support network can compound feelings of loneliness and isolation among recently bereaved carers.

Access to pre-bereavement and bereavement support is crucial to meeting the holistic needs of carers and loved ones. It is vital that we adopt a wider approach and ensure that those important to the person living with cancer, including children, are not forgotten. This type of early intervention and support can be helpful in preventing mental health issues connected to early/traumatic loss and complex grief reactions.

> We will arrange timely access for all people living with non-curative cancer, and those important to them, to the bereavement/psychosocial/counselling/chaplaincy services appropriate to their needs and preferences before and after death, across all care settings.

The recommendations outlined for palliative and end of life care align closely with the regional priorities of the Palliative Care in Partnership (PCiP) programme and many are already included in the regional palliative care work plan. The PCiP programme is well established and would be well placed to oversee the implementation and delivery of these recommendations. The recently re-established bereavement group will be taking forward the development of bereavement services for NI and our expectation is that this will include services for cancer.

# Implementing the strategy

## Governance

The Cancer pathway is complex and interfaces with all aspects of health and social care. Effective governance arrangements, combined with a focus on prevention, early diagnosis, evidenced based treatment and support services are crucial, to ensure that the recommendations of the strategy are implemented.

The strategy provides the strategic direction and key steps to achieving the overall vision for a world class cancer service for NI. It presents a comprehensive and challenging programme of service stabilisation and improvement, reliant on collaborative working and new and innovative approaches to the delivery of care. Many of these require coordinated regional approaches and are likely to be challenging to achieve within the current service commissioning and Trust-based delivery structures.

In order to meet these challenges a NI Cancer Programme Board, with strong clinical leadership, will be established which will include people with lived experience of cancer. The Board will align all parts of the existing structure and oversee the delivery of the strategy. A robust suite of regional key performance indicators is necessary to monitor the implementation of the strategy as part of ongoing evaluation arrangements. In addition consideration will be given to linking funding to the delivery of outcomes and achievement of KPI's. This strategy will be a live document which will evolve as new evidence, technologies and information emerges. Formal evaluation and review of progress will be integral to the implementation of the strategy, with reporting required at the end of year 3 and at subsequent intervals, in addition to a formal annual report.

In order for the delivery of the strategy to be realised over the next decade collaboration will be crucial. This will involve maintaining and building on the many successful developments implemented 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 people affected by cancer including families and carers will be a key enabler to effecting meaningful change.

Delivery at this scale and speed will require investment in planning and project support infrastructures both within Trusts and across Clinical Networks, in particular The Northern Ireland Cancer Network (NICaN).

NICaN is a regional clinical network that links together the organisations that provide care for people with cancer across the five Health and Social Care Trust areas. NICaN is a partnership of Health and Social Care organisations, academics, charities, cancer specialists and service users, working in collaboration to deliver safe and effective care, improve cancer clinical outcomes and to enhance patient's and carer's experience and quality of life. NICaN, however is currently under resourced with key posts sitting vacant, which has an impact on its ability to provide an effective service. The dissolution of the HSCB planned for 2022 also creates difficulties in filling posts.

There is also a compelling need for NICaN to have access to an enhanced data analysis function. This would support evidence based decision making for both performance management and strategic decisions regarding service provision.

We will set up a clinically led, managerially supported NI Cancer Programme with sufficient resources to oversee the implementation and delivery of the cancer strategy implementation plan. This will be data driven and will include commissioning of cancer services and further policy development.

We will restructure the NI Cancer Network and ensure it is supported and resourced to implement the strategy and to deliver a world class cancer service.

## Workforce and Training

Many cancer services are struggling to deliver in a timely manner, with escalating waiting lists in many areas including diagnostics and surgery. The immense pressures the HSC, including all those involved in cancer services, have been put under over the past year as a result of COVID-19 is fully recognised, which has served to increase pressure on an already stretched workforce. Creating a sustainable workforce to care for those with a cancer diagnosis must be an integral part of the Cancer Strategy.

Oncology and haematology services were fragile pre-COVID-19 with services often dependent on small teams and in some instances single-handed consultant practice. Multidisciplinary team work is an essential component of cancer care involving a wide range of health and social care professionals across both primary and secondary care. There is, however unequal provision across tumour sites and across Trusts.

Diagnostic services are the first step in confirming a cancer diagnosis. There is currently a UK wide shortage of radiologists which has an impact on the timeliness of investigations and results. Endoscopy services are under extreme pressure across all trusts and are struggling to meet the growing demand. Likewise pathology services continue to struggle with increasing demand which has been compounded by the COVID-19 pandemic. Our ambition to improve diagnostic services and to diagnose more cancers earlier cannot happen without significant investment to modernise and develop the diagnostic workforce.

Oncology services workforce planning and modelling was undertaken as part of the Oncology Services Transformation work in 2019. A blueprint was developed for a range of roles including nursing, pharmacy, allied health professionals and doctors. The implementation of this plan is not progressing as planned due to funding constraints and as a priority must be implemented in full. If we are to ensure sustainability of services for the future a similar workforce plan must be developed for haematology as a matter of urgency.

Looking forward, the role of genomic medicine will have a significant impact on how we deliver cancer care. This will require a substantial increase in clinical scientist expertise.

In order to provide the optimum care and support for people living with cancer we must ensure that all those diagnosed with cancer have the support of a clinical nurse specialist (CNS) across the entire cancer pathway. Currently not all people have a CNS and for many others the support stops after surgery. In particular there is a recognised deficit for those diagnosed with metastatic disease.

Allied health professionals have a key role across the cancer pathway including diagnostics, the provision of prehabilitation and rehabilitation services, providing palliative care and support for people at the end of life.

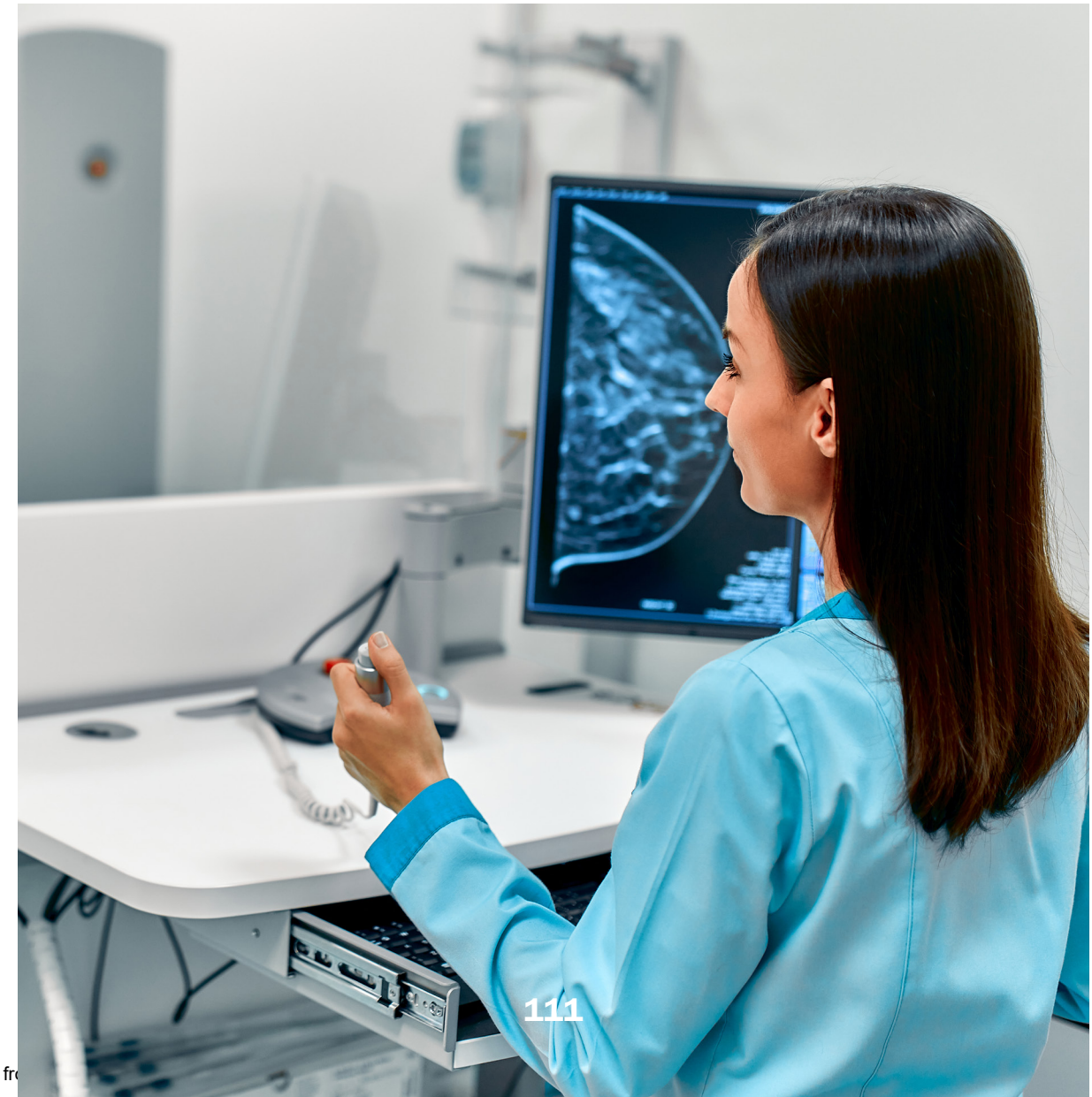
Psychology services are vastly oversubscribed with waiting lists across NI. A new model of service provision is required to ensure that all those who need psychological support have access to appropriate services.

The challenge that lies ahead cannot be underestimated. While workforce planning

has been undertaken or is underway in some specialties or professional groups, there is a compelling need to review the multidisciplinary cancer workforce as a matter of urgency. The workforce has grown in recent years but growth has not kept pace with the exponential rise in demand for diagnosis, treatment and ongoing care.

Over the past decade there have been many major new developments in diagnosing and treating cancer including PET scanning; cytosponge, proton beam radiotherapy, immunotherapy and robotic surgery. Changes in the provision of care, type of treatments and procedures all have an impact on the workforce required to deliver the service.

In addition to an anticipated increase in numbers of staff required, we must address the appropriate skill mix, career pathways, training and retention of staff across the wide range of professions essential for the delivery of effective and efficient cancer services. The current service model for oncology is largely delivered by medical consultants supported by a wide range of other health professionals. The Oncology Services Transformation Plan (2019) clearly demonstrated the need to move towards a consultant led service, with more services delivered by advanced nurse and AHP



practitioners, in line with best practice internationally. As we move towards the new model we need to be mindful of the lead in time required to train and develop staff. It should also be noted that increasing the numbers of non-medical prescribers and advanced nurse and AHP practitioners is associated with a knock on effect on medical consultants who will be tasked with providing training, mentorship and supervision.

Multiprofessional education and training for staff at all levels and in all settings will be an essential enabler for the successful delivery of this plan. A comprehensive training programme must be developed and must be aligned with the new workforce plan adopting a regional approach to training. Our expectation is that multiprofessional training should be the norm going forward.

We will develop and implement a regional, multiprofessional workforce plan to ensure we have the appropriately skilled staff available to deliver cancer services for the future.

We will develop a regional, co-ordinated approach to training aligned with the workforce plan.

## Communicating with people affected by cancer

Communication lies at the heart of health care delivery. What people value most highly are good patient–professional interactions and being treated as a person. There is little doubt that communication between cancer patients and staff could be improved.

Breaking Bad News Regional Guidance For NI was published in 2003.[72] This guidance outlines a pathway for medical and other professional staff to deliver bad news to patients, clients, their families and carers. 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.

Communication skills training is a requirement set out in NICE Guidance from 2004. Staff working in cancer care have access to various approaches and tiers of communication skills training matched to their role and facilitated through a range of providers. The current Advanced Communication Skills Training model has been in place in NI since 2009 and on-going evaluations demonstrate it has been positively received and had a significant impact on patient care and clinical experience. To date, the majority of this training has been provided by charitable funding. There are ongoing issues with releasing staff to attend training and having adequate trainers to deliver the training across the service.

There is a specific challenge for parents who have been diagnosed with cancer in how best to communicate their diagnosis to dependent children,[73] with evidence highlighting a lack of support and guidance from health care professionals (HCPs). Most HCPs (90%) have had no training in initiating and facilitating this parent-child communication.[74] This is also an issue for parents of children who have been diagnosed with cancer in how to communicate the information to siblings.

We will ensure that all health care professionals who are expected to carry out sensitive communication complete an advanced communication skills training programme.

[72] breaking_bad_news.pdf (headandnecktrauma.org)

[73] Semple & McCance Semple CJ & McCance T. (2010) Parents' experience with cancer who have young children: a literature review. Cancer Nursing 33 (2) 110 –118

[74] Semple CJ, McCaughan E & Smith R. (2017) How education on managing parental cancer can improve family communication. Cancer Nursing Practice 16, 34 – 40

## Understanding the experience of people living with cancer

The ambition must be to put people's experience and quality of life on a par with other clinical outcomes such as survival.

Ongoing information from patient groups, third sector organisations and data from service user feedback systems such as Care Opinion and 10,000 Voices is invaluable in highlighting the experience of people living with cancer. There is, however a recognised lack of information on the impact of treatment and long term effects on people's lives. This reflects the lack of simple mechanisms by which patient related outcomes and experience measures can be digitally gleaned and added to clinical records. Reliance on questionnaires, delivered separately or not directly linked to care delivery is inadequate.

At a population level in NI the only tool currently used to measure patient experience is the Cancer Patient Experience Survey (CPES). This has been carried out twice over recent years and both surveys have reported high levels of satisfaction with over 90% of people reporting their care as excellent or very good but has been postponed for 2021 due to the pandemic. CPES provides insight into the experience of people living with cancer locally and can be benchmarked with similar studies elsewhere in the UK. The methodology is reliant on participants being willing and able to take part, and as a result people with less survivable cancers, and those from more marginalised communities tend to be poorly represented. To date, the inclusion criteria is for those over 18 years of age. Consideration must therefore be given as to how the experience of younger people can be measured.

Patient Reported Outcome Measures (PROMs) represent a more person centred approach to capture and address unmet supportive care needs. While interest exists in PROMS within clinical practice, there is no consistency in the tools or approach taken. The Scottish Cancer Recovery Plan (2020)[75] has committed to provide national support to assessing the potential and value of digital PROMs. Learning from this will be invaluable going forward. In addition NHS England has committed to the introduction of an innovative quality of life metric to track and respond to the long-term impact of cancer. When available, consideration should be given to adopting this for use in NI.

A key outcome of this strategy must be improved experience for all people living with cancer in NI and in order to achieve this we need effective means of gathering the information.

We will undertake a Cancer Patient Experience Survey every 2 years to measure the experience of people living with cancer across NI.

We will ensure a regional approach to the implementation and measurement of Patient Reported Outcome Measures.

[75] Recovery and redesign: cancer services - action plan - gov.scot (www.gov.scot)

## Data

Cancer can affect all aspects of a person's life, therefore the information we collect is crucial to understanding how the delivery of services can be improved for the future.

While HSC currently collects a huge amount of data using a myriad of both manual and electronic formats COVID-19 highlighted difficulties in using this data. Northern Ireland lags behind other UK nations in the range of cancer data it collects, ease of access to and use of the data that is collected, and linking of data which may be collected in different ways. This has led to widespread frustration and dissatisfaction with the inability to link this information and to access routinely collected information from all of the information technology systems.

Accurate data is vital to underpin all decisions including: commissioning; service improvement and development; performance management and future planning. It is vital that common data sets are developed, agreed and used uniformly across the service.

The collection of data on cancer treatment in England was a cornerstone of their first cancer strategy in 2000, initially with the development of the National Cancer Intelligence Network, and more recently, the implementation of the mandatory COSSD reporting system for cancer. This provides "real-time" data to inform cancer commissioning and results in the annual publication of National Cancer Audits.

The lack of routine prospective data collection of cancer treatments and outcomes in Northern Ireland makes assessment of the organisation and effectiveness of cancer services difficult. This highlights the need for Northern Ireland to routinely collect data against the defined minimum datasets for cancer and to submit to National Cancer Audits, to allow, not only benchmarking against cancer outcomes elsewhere in the UK, but also interpretation of local data on service provision required to inform and deliver service improvements.

Whilst primary legislation to allow the secondary use of data is in place, the subsequent establishment of a regulatory and legislative framework has not been completed. These regulations are necessary to allow the legal submission of NI data to National Cancer Audits. Work to progress this legislation is currently underway and is expected to be presented to the Executive in due course.

Developing a method of collecting information once, and making it easily accessible to all stakeholders is paramount. There are multiple stakeholders who need better information in order to provide safe and effective care. The current systems in place are often old, technologically separated and poorly suited to the task, with significant challenges in the extraction of data and visualisation of trends.

Paper records remain dominant, and records are rarely formally linked from primary care through to secondary care and vice versa. Additionally, we need effective integration of data from services provided in the independent sector. This often goes unrecorded unless patient care reverts to HSC organisations.

Data security and privacy are of critical importance; however, fears about the use of data should not limit our ambition. Good data governance allows data to be used for

the benefit of both patients and the service.

The NI Cancer Registry (NICR) is located in the Centre for Public Health, Queen's University Belfast and is funded by the Public Health Agency for Northern Ireland. The registry was established in 1994 and a key function is the production of annual official statistics on cancer incidence, prevalence and survival in NI. This includes data on screening, incidence and survival by age, sex, cancer type, variations due to deprivation, stage of disease, treatment and support services received.

The registry has a wealth of expertise in the coding and analysis of healthcare data in cancerous and precancerous conditions. The level of knowledge within NICR is world leading, and with correct technology support and access to the live working systems of HSCNI their impact could be even greater.

## Encompass/IT Systems

The new Encompass IT system (see page 80) is a critical part of the digital future of HSC. It will be transformational in its scope and will deliver a paper-less system in secondary care and enable much greater integration across acute and community services and social care. Encompass will replace many of the disparate systems in place currently and will add greater functionality.

It will also provide safe and protected individual data on the care provided with every clinical interaction coded in real-time by the care provider. A central component of Encompass is a patient portal, which will bring citizens closer to the care providers and will enable great transparency and communication between everyone involved in the care pathway.

The programme will start in South Eastern Trust in 2022 and roll out across NI over the following 2 years. In the interim there is a compelling need to develop and improve data systems which will be compatible with Encompass going forward.

We will carry out a review of the use of data and alignment with Encompass in cancer healthcare, at a minimum:

a. We will carry out a formal review of the NI Cancer Registry's role and responsibilities and will expand their remit if required.

b. We will fully engage with our stakeholders regarding the optimum use of data in cancer care and ensure that the data we collect is used to ensure that we can provide better care for every patient.

c. We will establish a cancer data coordination function to facilitate a better strategic approach to cancer data in Northern Ireland.

## Research

Within the Health and Social Care sector the provision of high-quality cancer care is a priority. Among all providers, there is a clear focus on the provision of person-centred services and on improving the experience of care. We also know that participation in cancer research improves outcomes for people across all parts of the patient pathway. Research is not an add-on to the delivery of normal care, but it is foundational in the delivery of excellence. There are decades of data demonstrating the link between active research and better outcomes in care delivery.

Northern Ireland has a rich heritage in cancer research. The work of HSC Research and Development (R&D) is based on the principle that the best health and social care must be underpinned by knowledge; based on well-conducted research, which can then be applied to the delivery of care. Cancer research in NI is conducted across a wide range of organisations including the NI Cancer Registry; HSC trusts; universities; cancer charities; private sector, and not for profit organisations. It is funded from a variety of sources, but there is potential for better co-ordination across organisations and an opportunity to influence research priorities for the future.

Challenges exist due to the lack of recurrent funding, fixed term contracts and no career structure for staff. Many consultants do not have protected time in their job plans to develop research interests. Barriers can also exist in implementing research findings into clinical practice.

The All Ireland Cancer Consortium (AICC) was set up in 1999 with the core aim of reducing cancer incidence and mortality on the Island of Ireland through cross-border and transatlantic collaborations in cancer research and education. This is a collaborative partnership between the Department of Health NI, Department of Health Ireland and the National Cancer Institute in the United States. Going forward the AICC has a crucial role to play in the development and implementation of evidence based outcomes for people affected by cancer in NI and beyond.

It is inevitable that there will be many significant advances in technology and new treatments over the life of this strategy. The pace of change in all aspects of cancer means that we must have more agile systems in place to adopt new innovations in a timely manner.

For the successful delivery of this strategy we must embed a culture in which data, research and intelligence are seen as core components for increasing public awareness, an improved uptake in screening, more efficient and timely diagnosis services, better treatment and care, and ultimately better outcomes for people living with cancer. It is therefore paramount that we optimise the involvement of people affected by cancer in formulating and developing research proposals.

We will develop an appropriate infrastructure to deliver a robust research function.

We will engage with universities and industry to ensure our workforce can deliver a world class cancer service and improve the outcomes for people affected by cancer.

## Quality and Innovation

The Cancer Strategy aligns with the approach taken by the DoH 10-year Quality 2020 strategy and defines quality under three main headings:

- Safety – avoiding and preventing harm to patients and clients from the care, treatment and support that is intended to help them.
- Effectiveness – the degree to which each patient and client receives the right care (according to scientific knowledge and evidence-based assessment), at the right time in the right place, with the best outcome.
- Patient and Client Focus – all patients and clients are entitled to be treated with dignity and respect and should be fully involved in decisions affecting their treatment, care and support.

These themes cut across a number of key recommendations in the strategy, and in delivering the strategy we will enable a whole system quality assurance approach regarding the performance and quality of cancer care services and associated programmes across NI.

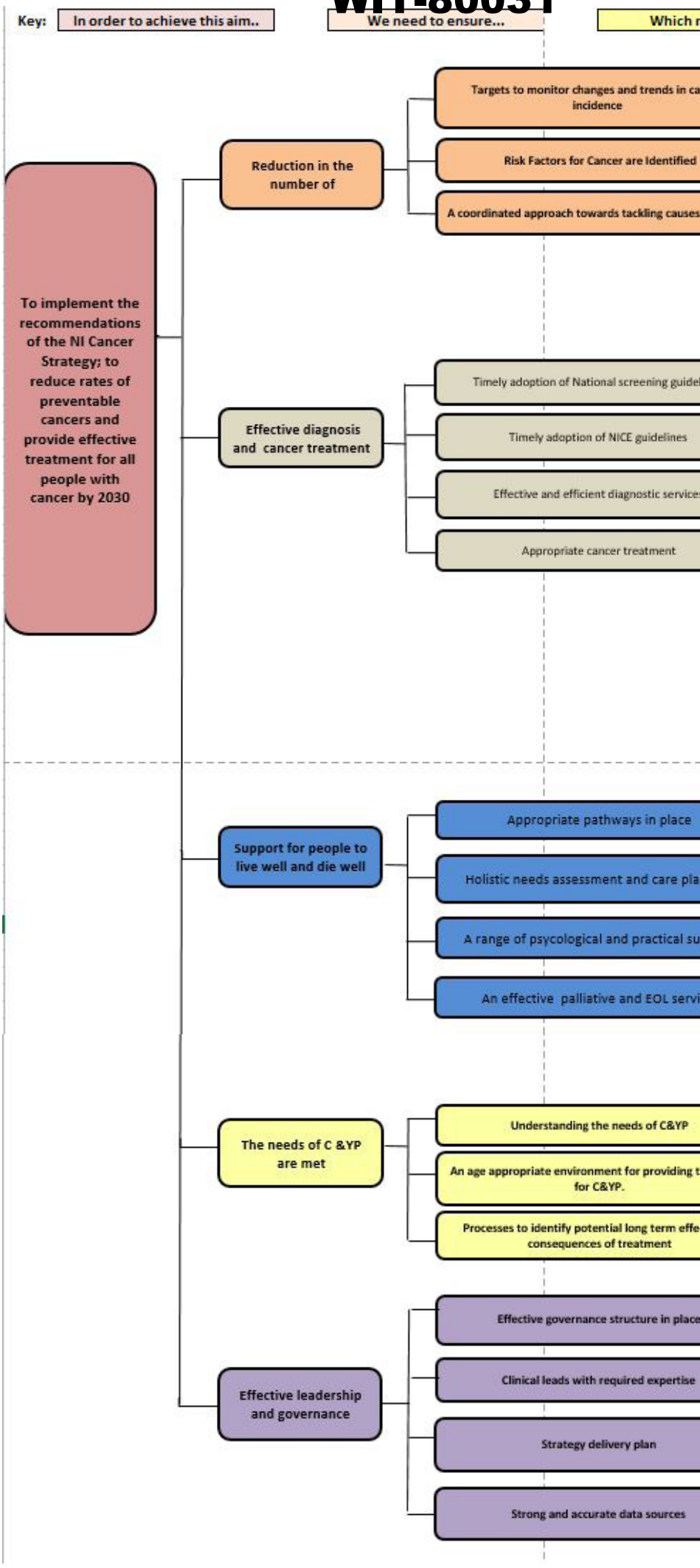
Data – our review of cancer service data requirements has highlighted that provision of accurate and timely information is a central requirement for any effective strategy of cancer control. Such information underpins evidence-based and informed decision making by policy makers, researchers, health professionals and patients.

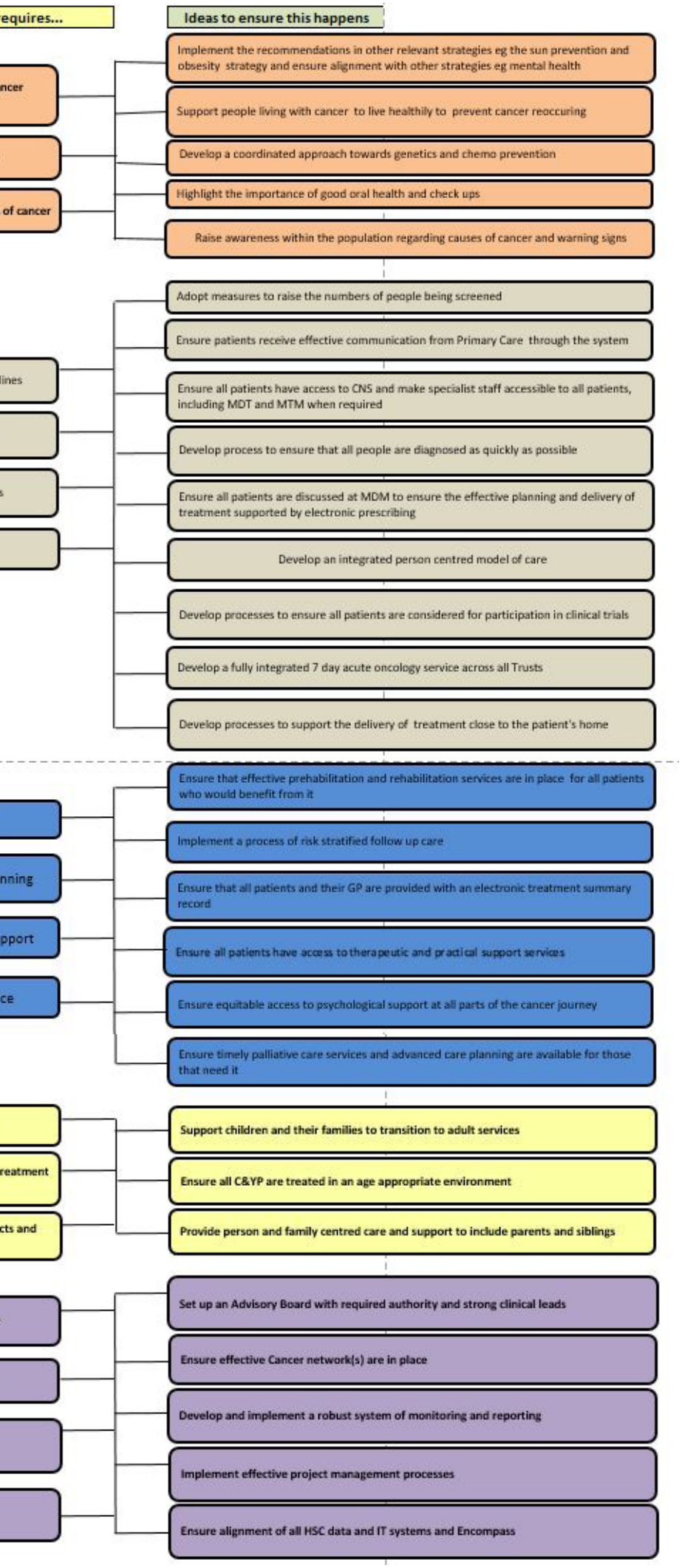
Workforce – our development of a regional, multiprofessional workforce plan to deliver cancer services together with an aligned comprehensive training programme will ensure that appropriate skill mix and safe levels of staffing are maintained across all specialisms.

Governance – the setting up of effective assurance and accountability arrangements across the HSC system will ensure that regular monitoring and reporting of the implementation of the strategy will take place and that the aims and direction continue to be appropriate to deliver optimum outcomes for patients.

Key Performance Indicators (KPIs) will be deceloped to measure how the health system is delivering on the objective for improvements in cancer care outlined in this strategy. They are essential to monitor the impact of the various elements of cancer control across the patient pathway and direct focus on improvement.  Moreover quality indicators, including measuring patient experience and those focused on process and activity, are critical to provide systematic governance oversight of performance and capacity.

KPIs will also be used to focus attention on reducing unwarranted variation in performance and patient outcomes across organisations. The information gatheed will inform decision making in areas such as policy and resource allocation. Therefore, information must be collected, collated, analysed and reported to inform evidence based decision making.





# Appendices

# Appendix 1 Cancer Strategy Recommendations

## Preventing Cancer

1. 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.

2. 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.

3. 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.

4. We will take account of the learning and progress made through the implementation of the substance use strategy. We will raise public awareness of the links between substance use and cancer.

5. 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.

6. 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.

7. We will develop a co-ordinated approach towards chemoprevention and implement NICE guidance within an agreed timeframe.

8. 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.

9. 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.

## Diagnosing and Treating Cancer

10. We will deliver regular, effective, targeted evidence-based 'Be Cancer Aware' campaigns.

11. We will develop measures to increase uptake of all cancer screening programmes, particularly in seldom heard communities.

12. We will ensure that all UK National Screening Committee recommendations are implemented within an agreed timeframe.

13. We will review specialist screening IT systems and will allocate funding to upgrade/replace where needed.

14. We will work towards the implementation of NG12 or the most current NICE referral guidelines by 2024.

15. We will implement new diagnostic tests within an agreed timeframe after approval and recommendation.

16. We will ensure that people who have cancer are diagnosed as quickly as possible, with adequate staffing, infrastructure and equipment in place; this will include the development of diagnostic hubs.

17. To increase our regional cancer diagnostic capacity and meet increasing demand through innovation, transformation and modernisation we will develop effective working relationships with the Regional Medical Imaging Board, the Pathology Network and Endoscopy Network.

18. We will introduce a 28-day diagnosis standard which tracks the time for all people from first referral for suspected cancer to confirmation of a cancer diagnosis, and includes all diagnostic and staging investigations.

19. We will give consideration to the delivery of cancer surgical services alongside any future recommendations for the delivery of emergency and elective surgery.

20. We will develop a plan for the introduction and implementation of new surgical technology over the next 10 years.

21. We will develop and implement prehabilitation and rehabilitation services on a regional basis for all those who will benefit.

22. We will implement Enhanced Recovery After Surgery programmes on a regional basis for all appropriate major cancer surgery.

23. We will implement in full the recommendations of the Oncology Service Transformation Project and the Oncology Haematology stabilisation plan by 2026.

24. We will agree a person centred model of care, which is effective and efficient, and which is built on learning from COVID 19 with increasing use of telehealth and technology and with standard operating procedures by 2022.

25. We will put in place service level agreements to ensure timely treatment where services cannot be provided in Northern Ireland due to specialist nature of services, technology constraints and low numbers of patients.

26. We will develop near to home phlebotomy services by 2023

27. We will review our model of delivery for Systematic Anti-Cancer Treatment services including the delivery of near/ close to home SACT treatments to patients by 2024 in line with the cancer recovery plan.

28. We will ensure that a safe and robust electronic prescribing system is used for all Systemic Anti Cancer Treatment regimes.

29. We will develop a robust and coordinated 24/7 metastatic spinal cord compression service with rapid access to gold standard imaging and treatment.

30. We will develop a fully integrated equitable 7 day acute oncology service across all Trusts.

31. We will commit to delivering genetic and genomic testing in cancer pathways in line with NICE recommendations

32. We will develop ambulatory care haematology units within each of the five Trusts and establish near to home treatment services for suitable patients.

33. We will ensure that all people including children and young adults are cared for in an environment appropriate to their needs.

34. We will ensure that future capital requirements of the level 3 haematology centre at Belfast Trust meets NICE NG 47 guidance.

35. We will consider the development of CAR-T services for NI.

36. We will ensure the development of appropriate pathways and services for older people with cancer, rarer cancers, teenage and young adults and people seldom heard.

37. We will ensure that every child diagnosed with cancer, and their carers, have access to staff with the specialist skills to provide holistic person centred care.

38. We will explore the potential for greater collaboration between Northern Ireland, Great Britain and the Republic of Ireland in the provision of children's oncology services.

39. We will review the provision of services for teenage and young adults in NI including transition arrangements, age appropriate environments, psychosocial support and long term follow up.

40. We will ensure that an effective Multi-Disciplinary Team meeting is held for all people diagnosed with cancer including cancer of unknown primary and metastatic disease.

41. We will facilitate as many people as possible; including children and young people to gain access to clinical trials

## Supporting People to Live Well and Die Well

42. We will make sure that all people are offered a holistic needs assessment, an appropriate care plan is developed and they are signposted to relevant sources of help and support.

43. We will develop a comprehensive treatment summary record for all people diagnosed with cancer. On completion of their treatment, this will be provided to them and their GP.

44. We will make sure that all people are assessed and risk stratified to appropriate, high quality, follow-up pathways on completion of treatment.

45. We will ensure that all patients, including children and young people, diagnosed with cancer have access to a Clinical Nurse Specialist throughout the entire care pathway.

46. We will make sure that all people with cancer have equitable access to psychological support which is tailored and specific to their needs.

47. We will make certain that all those with a cancer diagnosis are referred to a Cancer Information and Support Service at diagnosis and advised of the range of services available across their entire cancer pathway.

48. We will ensure timely and appropriate access to therapeutic and practical support services for people affected by cancer targeting emotional, physical and social needs

49. We will make sure that all people starting cancer treatment have their health status assessed and recorded and a plan developed to mitigate potential late effects and consequences of their treatment.

50. We will develop an agreed regional, multidisciplinary approach to the identification and management of all people at risk of late effects and consequences of their cancer treatment.

51. We will identify people deemed to be at highest risk for late cardiovascular effects and enrol them in a follow up programme with appropriate imaging and with access to cardiology intervention as necessary.

52. We will regularly screen children to detect early, subtle cardiac abnormalities that might be treated, or may be reversible. In addition, where children are treated with anthracyclines or cardiac radiation they will have lifelong screening every 3 to 5 years.

53. We will deliver integrated, coordinated and personalised palliative and end of life care to people with non-curative cancer when and where they need it.

54. We will arrange a palliative care keyworker for all people with non-curative cancer when required.

55. We will arrange equitable access to palliative and end of life support and continuity of care for all people with non-curative cancer 24 /7.

56. We will support people and their carers to discuss their wishes and preferences for care at the end of life and ensure that this is recorded in a shareable format with the relevant people.

57. We will arrange timely access for all people living with non-curative cancer, and those important to them, to the bereavement/psychosocial/counselling/chaplaincy services appropriate to their needs and preferences before and after death, across all care settings.

## Implementing the Strategy

58. We will set up a clinically led, managerially supported NI Cancer Programme with sufficient resources to oversee the implementation and delivery of the cancer strategy implementation plan. This will be data driven and will include commissioning of cancer services and further policy development.

59. We will restructure the NI Cancer Network and ensure it is supported and resourced to implement the strategy and to deliver a world class cancer service.

60. We will develop and implement a regional, multiprofessional workforce plan to ensure we have the appropriately skilled staff available to deliver cancer services for the future.

61. We will develop a regional, co-ordinated approach to training aligned with the workforce plan.

62. We will ensure that all health care professionals who are expected to carry out sensitive communication complete an advanced communication skills training programme.

63. We will undertake a Cancer Patient Experience Survey every 2 years to measure the experience of people living with cancer across NI.

64. We will ensure a regional approach to the implementation and measurement of Patient Reported Outcome Measures.

65. We will carry out a review of the use of data and alignment with Encompass in cancer healthcare, at a minimum:

    a. We will carry out a formal review of the NI Cancer Registry's role and responsibilities and will expand their remit if required.

b. We will fully engage with our stakeholders regarding the optimum use of data in cancer care and ensure that the data we collect is used to ensure that we can provide better care for every patient.

c. We will establish a cancer data coordination function to facilitate a better strategic approach to cancer data in Northern Ireland.

66. We will develop an appropriate infrastructure to deliver a robust research function.

67. We will engage with universities and industry to ensure our workforce can deliver a world class cancer service and improve the outcomes for people affected by cancer.

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# Appendix 3 Glossary of terms

### Age standardised
The rates are calculated by applying the age-specific rates for the location being studied to a theoretical world-wide standard population, usually expressed per 100,000 persons per year.

### Adjuvant Therapy
Another treatment used together with the primary treatment. Its purpose is to assist the primary treatment. Also called adjunctive or adjunct therapy.

### Benign
Not cancerous. Benign tumours may grow larger but do not spread to other parts of the body.

### Brachytherapy
A type of radiation therapy where a radioactive source is placed in or near a cancerous tissue.

### Cancer Incidence Rate
The number of new cancers of a specific site/type occurring in a specified population during a year, usually expressed as the number of cancers per 100,000 population.

### Cancer Prevalence
The number of people now living who have ever been diagnosed with cancer. It includes people diagnosed with cancer in the past as well those who were recently diagnosed.

### Clinical Nurse Specialist or CNS
A clinical nurse specialist (CNS) is a nurse specially trained to provide expert advice on treatment and care for a particular type of cancer.

### Colposcopy
A procedure that allows a physician to take a closer look at a woman's cervix and vagina. It is used to check for precancerous or abnormal areas.

### Cytosponge
A single-use device used to collect cells from the lining of the oesophagus. It is known as a 'sponge on a string' pill test. Cytosponge consists of a spherical sponge in a dissolvable capsule, which is attached to a thread.

### Digital pathology
Means that pathology samples can be shared and interpreted in digital environment. This means that samples such as biopsies can be reviewed anywhere and allows greater flexibility in how we utilise our pathology staffing.

### Endoscopy
A nonsurgical procedure used to examine a person's digestive tract using a long, thin, flexible tube called an endoscope.

### Genomics
A discipline in genetics that applies recombinant DNA, DNA sequencing methods, and bioinformatics to sequence, assemble, and analyse the function and structure of genomes (the complete set of DNA within a single cell of an organism,

### qFIT or the Faecal Immunochemical Test
A stool test designed to identify possible signs of bowel disease. It detects minute amounts of blood in the faeces and can help to identifying patient who may be at risk of bowel cancer.

### Haematological malignancies
Types of blood cancers

### Health and Social Care Board (HSCB)
A statutory organisation that arranges or 'commission' health and social care services for the population of Northern Ireland.

### Holistic Needs Assessment (HNA)
A questionnaire that enables professionals involved in supporting patients to understand all of the care and support needs a patient might have from concerns about their physical health through to issues around emotional, spiritual and social support.

### HPV or Human papillomavirus
A virus that can cause cervical and other cancers.

### Immunotherapy
A treatment which uses the immune system to fight cancer. It works by helping the immune system recognise and attack cancer cells.

### Invasive cancer
Cancer that has spread beyond the layer of tissue in which it developed and is growing into surrounding, healthy tissues.

### KPI or Key Performance Indicator
A quantifiable measure used to evaluate the success of an organization, employee, etc. in meeting objectives for performance.

### Metastatic Cancer
The spread of cancer from the primary site to other places in the body.

### Molecular Diagnostics
A technique used to analyse biological markers in the individual's genetic code in order to diagnose and monitor disease, detect risk, and decide which therapies will work best for individual patients.

### Mortality rate
The number of deaths occurring in a specified population during a year, usually expressed as the number of deaths per 100,000 population.

### Multidisciplinary teams
A group of health care workers who are members of different disciplines or professions each providing specific services to the patient.

### Northern Ireland Cancer Network (NICaN)
Brings together Health and Social Care organisations, charities, cancer specialists and service users, to improve cancer outcomes and experiences for patients.

### Prehabilitation
The process of supporting patients to enhance their functional capacity or fitness ahead of treatment to enable them to cope with the treatment and to improve their outcomes after treatment.

### Public Health Agency (PHA)
The major regional organisation for health protection and health and social wellbeing improvement.

### Rapid diagnostic centres/hubs
Are designed to provide earlier and faster cancer diagnosis by providing a single point of access to diagnostic tests for all patients with symptoms that might suggest cancer.

### Safety netting
Is about ensuring that there is a management system in place to ensure that patients receive the appropriate diagnostics and treatment in a timely way.

## Stage of presentation

The stage at presentation describes the severity of a person's cancer based on the size and/or extent of the primary tumour and whether or not cancer has spread in the body.

## Survival rate

The percentage of people in a study or treatment group who are alive for a given period of time after diagnosis

## Systemic Anti-Cancer Treatment (SACT)

The two main types of systemic therapy are chemotherapy (which uses drugs) and hormone therapy (which uses hormones). It can be given to increase long-term survival, control tumour growth and sometimes manage symptoms arising from the cancer.

# Appendix 4 Abbreviations

**ACE programme**
Accelerate Coordinate Evaluate programme

**ACP**
Advance Care Planning

**ADRT**
Advance Decisions to Refuse Treatment

**ADOG**
All Department's Officials Group

**AHP**
Allied Health Professionals

**AICC**
The All Ireland Cancer Consortium

**AOS**
Acute Oncology Service

**BAME**
Black, Asian and minority ethnic

**CAR-T**
Chimeric Antigen Receptor T cell Therapy

**CaPPS**
Cancer Patient Pathway System

**CCR**
Cancer Care Review

**COSD**
Cancer Outcomes and Services Dataset

**CPES**
2018 Cancer Patient Experience Survey

**CRUK**
Cancer Research UK

**DNACPR**
Do not attempt Cardiopulmonary Resuscitation

**CT scans**
Computerized tomography scans

**ERAS**
Enhanced Recovery After Surgery

**HDU**
High dependency units

**HNA**
Holistic Needs Assessment

**ICU**
Intensive Care Unit

**JCVI**
Joint Committee on Vaccination and Immunisation

**KPI or Key Performance Indicator**
A quantifiable measure used to evaluate the success of an organization, employee, etc. in meeting objectives for performance.

**LINAC**
A medical linear accelerator

**LGBTQ+**
Lesbian, gay, bisexual, and transgender queer and questioning

**MRI Scan**
Magnetic Resonance Imaging scan

**MSCC**
Malignant spinal cord compression

**MDMs**
Multidisciplinary meetings

**NCEPOD**
National Confidential Enquiry into Patient Outcome and Death

**NICaN**
Northern Ireland Cancer Network

**NCIN**
National Cancer Intelligence Network

**NICTN**
Northern Ireland Cancer Trials Network

**NMSC**
non-melanoma skin cancer

**OST**
Oncology Services Transformation Programme

**PCiP**
Palliative Care in Partnership programme

**PET**
Positron emission tomography

**PROMs**
Patient Reported Outcome Measures

**PREMs**
Patient Reported Experience Measures

**PTC**
Principle treatment centres

**q-FIT**
Faecal Immunochemical Test

**TSR**
Treatment Summary Records

**WHO**
World Health Organisation

# Appendix 5 Steering Group Members

| Name | Organisation / job Title |
|---|---|
| Charlotte McArdle | Chief Nursing Officer, Department of Health Chair |
| Brid Farrell | Public Health Agency, Public Health |
| Cathy Harrison | Chief Pharmacist, Department of Health |
| Dr Anna Gavin | Northern Ireland Cancer Registry |
| Dr Anne Kilgallen | Chief Executive Representative, Western Health & Social Care Trust |
| Dr Martin Eatock | Oncology, Belfast Health & Social Care Trust |
| Dr Miriam McCarthy/ Cara Anderson | Public Health Agency, Commissioning |
| Dr Naresh Chada | Deputy Chief Medical Officer, Department of Health |
| Dr Paul Molloy | General Practitioner Representative |
| Gay Ireland | Head of Cancer Policy/Cancer Strategy Project Manager, Department of Health |
| Heather Monteverde | Macmillan Cancer support/Chief Nursing Adviser, Department of Health |
| Ivan McMinn | Lived with experience/ Co-chair |
| Joan McEwan | Marie Curie |
| Joanne McClean | Public Health Agency, Paediatrics |
| Loretta Gribben | Public Health Agency, Nursing |
| Margaret Carr | Cancer Research UK |
| Mary Jo Thompson | Nurse Manager, South Eastern Health & Social Care Trust |
| Michael Bloomfield | Chair of Northern Ireland Cancer Network Board |
| Vivian McConvey | Patient Client Council |


**Pre-consultation Zoom Meeting with Parents of Children with Cancer. Artwork by Lucy aged 8.**

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

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

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# contents

## 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,<br>Consultant Palliative Medicine | Marie Curie Cancer Care, Belfast. |
| Dr Bernie Corcoran,<br>Consultant Palliative Medicine | Belfast City Hospital Trust |
| Dr Kiran Kaur,<br>Consultant Palliative Medicine | Northern Ireland Hospice/Royal Group Hospitals Trust |
| Dr Yvonne Duff,<br>Consultant Palliative Medicine | United Hospitals Trust |
| Pauline Douglas<br>Allied Health Professions Representative | Belfast City Hospital Trust |
| Dr Jenny Jingles,<br>Consultant Public Health Medicine | Eastern Health and Social Services Board |
| Heather Monteverde<br>Service Development Manager | Macmillan Cancer Relief |
| Jane Graham,<br>Chief Officer | Eastern Health and Social Services Council |
| Dr Brid Farrell,<br>Consultant Public Health Medicine | Southern Health and Social Services Board |
| Mary Hinds,<br>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.<br>• Mentally rehearse the interview including likely questions and potential responses.<br>• 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.<br>• 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.<br>• 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?"*<br>• 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.<br>• Use non-technical words such as 'spread' instead of 'metastases'.<br>• Avoid excessive bluntness, as it is likely to leave the patient isolated and later angry.<br>• Set the tone. *"I am afraid I have some bad news"*<br>• 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?"*<br>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?"*<br>• 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."*<br>• Allow the patient time to express their emotions and let the patient know you understand and acknowledge their emotions.<br>• 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.<br>• 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.

[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

[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)<br>Paul Kavanagh, Nurse Consultant (Chair) (from December 2011) |
| Belfast HSC Trust | Nicki Patterson, Co-Director of Nursing (until July 2013)<br>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)<br>Sharon McRoberts, Assistant Director of Nursing (from September 2013) |
| Southern HSC Trust | Glynis Henry, Assistant Director of Nursing (until end of August 2011)<br>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)<br>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)<br>Kathy Fodey, Nursing Officer (until February 2013)<br>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.<br><br>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.<br><br>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.<br><br>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.<br><br>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.<br><br>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.<br><br>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.<br><br>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]. |

[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. |

[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<br>• (Patient activity counted as Consultant led on PAS) | **7/8**<br>*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 | **8.5 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** |

## 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<br>• Average number of patients per clinic | **2**<br>*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*<br>*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*<br>*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*<br>*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** |

**HIGH-LEVEL JOB PLAN**

## 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** |

**HIGH-LEVEL JOB PLAN**

## 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** |

**HIGH-LEVEL JOB PLAN**

## 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.

[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**<br>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.<br><br>**NMC Code theme:** Practise Effectively, Preserve Safety, Promote Professionalism and Trust.<br>**KSF Core Dimensions:** Communication, Personal and People Development, Health and Safety, Quality. | | | |
|---|---|---|---|
| **Core Learning Outcomes** | **LD** | **SD** | **WD** |
| **The Palliative Care Specialist Nurse will:**<br>• 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.<br>• 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.<br>• 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.<br>• Complete a comprehensive and systematic patient-centred holistic assessment using relevant tools/frameworks, taking into account physical, psychological, social, cultural, spiritual and environmental aspects.<br>• 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.<br>• 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.<br>• 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.<br>• 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.<br>• 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.<br>• 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.<br>• 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.<br>• 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.<br>• Identify and manage risks and contribute to multi-professional and interagency discussions related to critical, serious and adverse incidents, and/or root cause analysis.<br>• 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.<br>• Contribute to the development and review of protocols and standard operating procedures.<br>• 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.<br>• 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:**<br>• Accept personal responsibility for professional development and the maintenance of professional competence and credibility.<br>• Facilitate an effective learning environment to support the professional development of staff and students.<br>• Engage in clinical supervision, reflective practice and self-evaluation and use this to improve care and practice.<br>• Participate in formal and informal inter-professional teaching.<br>• Utilise appropriate learning opportunities to facilitate others to care for patients their families/carers and those important to them.<br>• Supervise and support others within the scope of each individual's role, competence and capability.<br>• 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.<br>• 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:**<br>• 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.<br>• Critically appraise research in specialist palliative and end of life care and use knowledge of relevant findings to inform clinical decision making.<br>• Work collaboratively with others to facilitate the implementation of research, quality improvement and audit findings into practice.<br>• Use knowledge of specialist palliative and end of life care to identify areas of potential research, quality improvement and audit.<br>• Contribute to audit, quality improvement, research design, data collection and analysis.<br>• 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**<br>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.<br><br>**NMC Code theme**: Prioritise People, Preserve Safety, Promote Professionalism and Trust.<br>**KSF Core Dimension**: Communication, Service Improvement, Equality & Diversity. | | | |
|---|---|---|---|
| **Core Learning Outcomes:** | **LD** | **SD** | **WD** |
| **The Palliative and End of Life Care Specialist Nurse will:**<br>• Work collaboratively to identify gaps in service provision within own setting and across geographical and organisational boundaries.<br>• 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.<br>• Act as a change agent and encourage staff and service users to contribute ideas and solutions for quality improvement and innovation.<br>• Contribute to Patient and Public Involvement through co- design and co-production initiatives and activities.<br>• Contribute to relevant professional networks.<br>• Negotiate and influence locally in relation to professional practice.<br>• Respond in a transparent and structured way to any complaints about care or services.<br>• Promote teamwork with defined areas of responsibility.<br>• Demonstrate effective management and leadership skills by sharing own knowledge and experience with other members of the team.<br>• 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) |
| NIPEC | Cathy McCusker (Project Lead) |
| Macmillan | Genevieve Murphy |
| Belfast HSC Trust | Lesley Rutherford<br>Jean Maguire<br>Maureen Begley |
| Northern HSC Trust | Sally Convery |
| South Eastern HSC Trust | Denise Cranston |
| Southern HSC Trust | Aileen Mulligan<br>Martina Thompson |
| Western HSC Trust | Emma King |
| Foyle Hospice | Brigeen McCloskey |
| NI Hospice | Hilary Maguire<br>Barbara Watson |
| Southern Hospice | Carmel Campbell |
| Marie Curie Centre | Miriam McKeown |
| Department of Health | Heather Finlay |

Southern Health and Social Care Trust

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

# '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].

[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,

[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

[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;

[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

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

Southern Health and Social Care Trust

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# 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

## *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 Personal Information redacted by USI
- Chief Executive direct line Personal Information redacted by USI
- Non –Executive Director contacted through the Chair's office
  (See Appendix 2 for names) direct line Personal Information redacted by USI

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 <u>externally</u>

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

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

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

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

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

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

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

**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

## 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

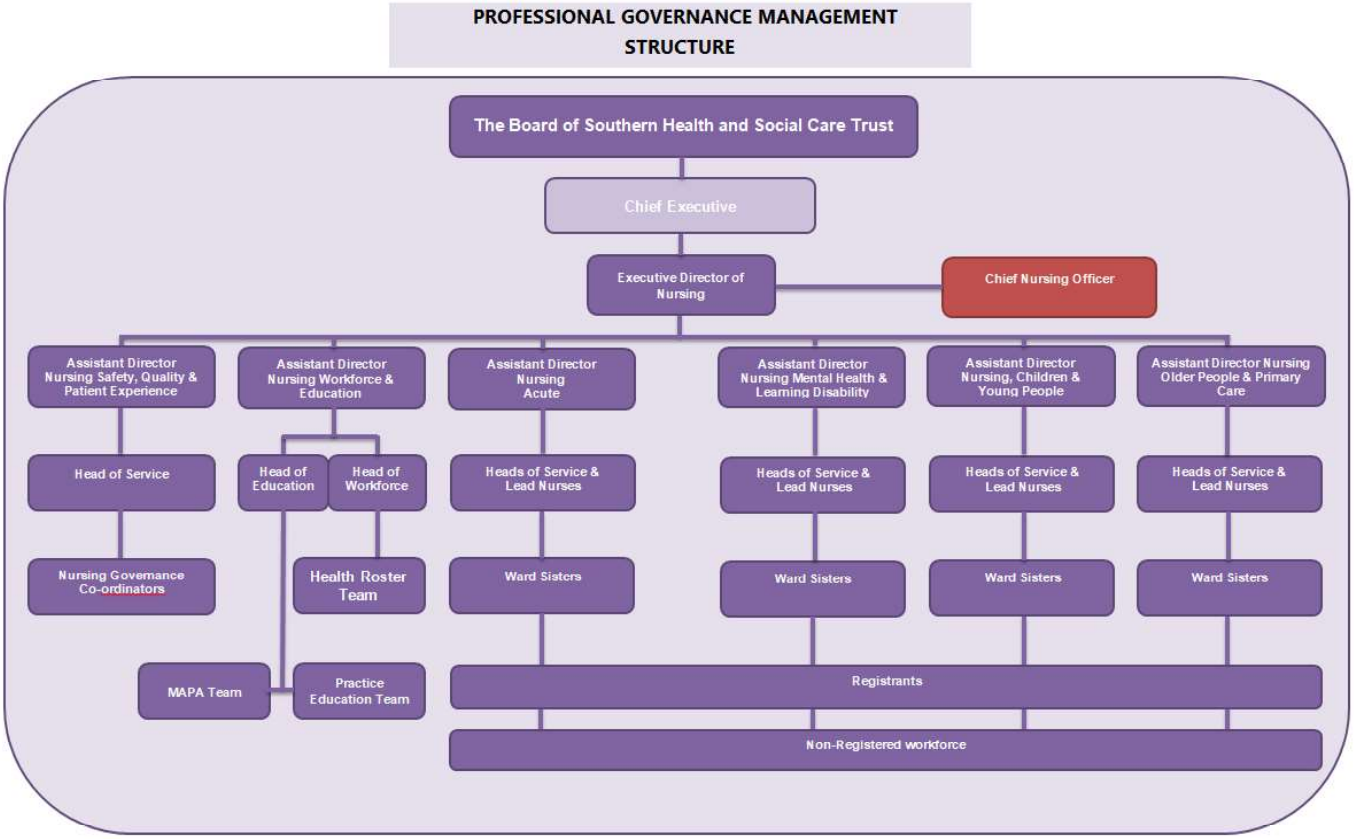
The Trust has a range of mechanisms in place to support assurance and accountability of the Nursing and Midwifery workforce.


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.




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<br><br>Quarterly reports to the Performance Committee | • Senior Nursing and Midwifery Governance Forum (SNMGF)<br>• Trust Senior Management Team<br>• Performance Committee<br>• Trust Board |
| Induction status reporting | Compliance with Trust Nursing and Midwifery Induction Requirements<br>- New registrants<br>- Registrants<br>- Role specific | Biannual | • Directorate Nursing and Midwifery Governance Fora.<br>• Senior Nursing and Midwifery Governance Forum (SNMGF)<br>• Performance Committee |
| Preceptorship requirements reporting | Compliance Nursing and Midwifery preceptorship requirements | Quarterly | • Directorate Nursing and Midwifery Governance Fora.<br>• Senior Nursing and Midwifery Governance Forum (SNMGF)<br>• Trust Senior Management Team<br>• 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<br>• Directorate Nursing and Midwifery Governance Fora.<br>• 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.<br>• Senior Nursing and Midwifery Governance Forum (SNMGF)<br>• 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.<br>• Senior Nursing and Midwifery Governance Forum (SNMGF) |
| Compliance with Standards for Learning and Assessment in Practice (NMC, 2008) | Mentor register reports<br><br>Placement evaluation reports<br><br>Educational Audits | Biannual<br><br>Biannual<br><br>Biannual | • Practice Education Team<br>• Directorate Nursing and Midwifery Governance Fora.<br>• Senior Nursing and Midwifery Governance Forum (SNMGF)<br>• 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<br>• SNMGF<br>• Performance committee |
| Audit of Compliance with Normative Staffing | Monitoring report Phases 1-6 | Biannual | • Directorate Nursing and Midwifery Governance Fora.<br>• 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<br>• Directorate Nursing and Midwifery Governance Fora<br>• Senior Nursing and Midwifery Governance Forum (SNMGF)<br>• Trust Performance committee |
| Fitness to Practice | Summary of Nursing and Midwifery staff referred to NMC | Bi annual | • Performance committee<br>• SNMGF<br>• 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<br>• Lead Nurses |
| | | Quarterly | • Directorate Nursing and Midwifery Governance Fora<br>• Operational Director<br>• Senior Nursing and Midwifery Governance Forum (SNMGF)<br>• 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<br>• Operational Director |
| | | Quarterly | • Trust Senior Management Team<br>• Patient and Client Experience Steering Group<br>• Trust Patient and Client Experience Committee |
| Nursing Quality in the Independent Sector | Monitored via the Trust Independent Sector Governance Forum | Bi annual | • Operational Director<br>• 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

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Department of Health, Social Services and Public Safety (2014) Delivering Care: Nurse Staffing in Northern Ireland

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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

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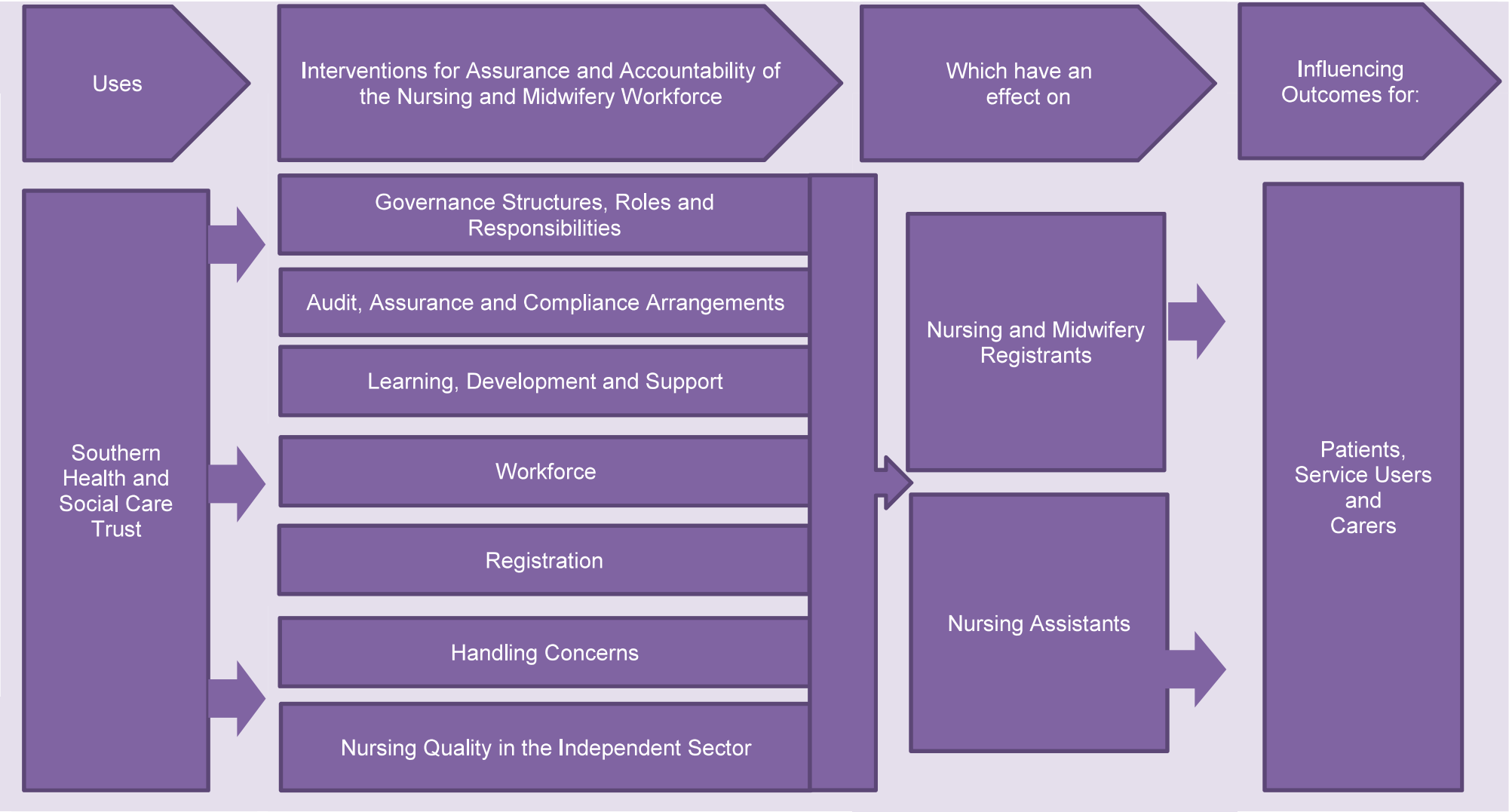
# Nursing and Midwifery Accountability and Assurance

## Logic Models

Southern Health and Social Care Trust

*Quality Care - for you, with you*

# Accountability and Assurance Framework
## Nursing and Midwifery



Southern Health and Social Care Trust
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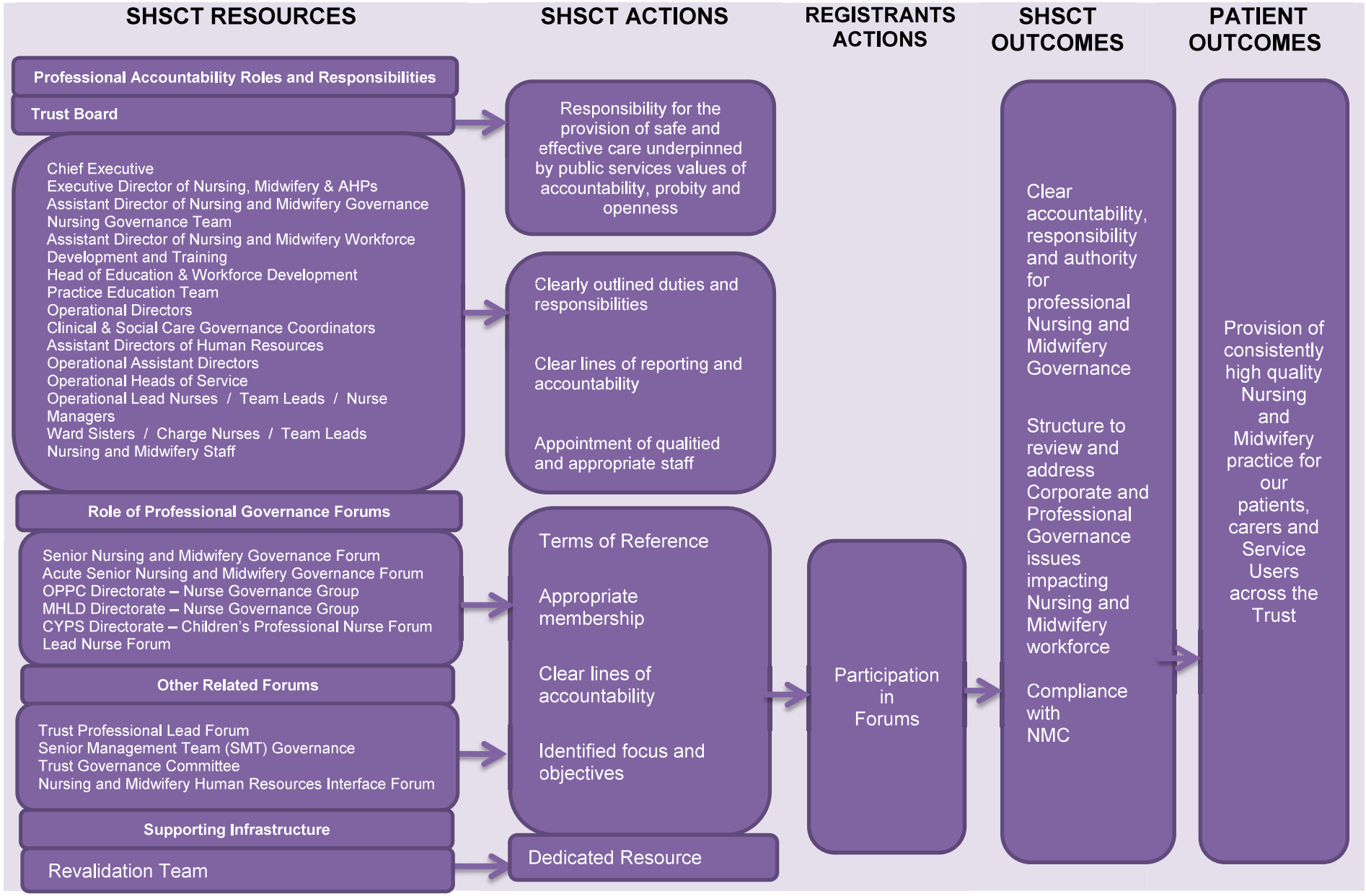
# Accountability and Assurance Framework
## Nursing and Midwifery

## Governance Structures, Roles and Responsibilities



Southern Health and Social Care Trust
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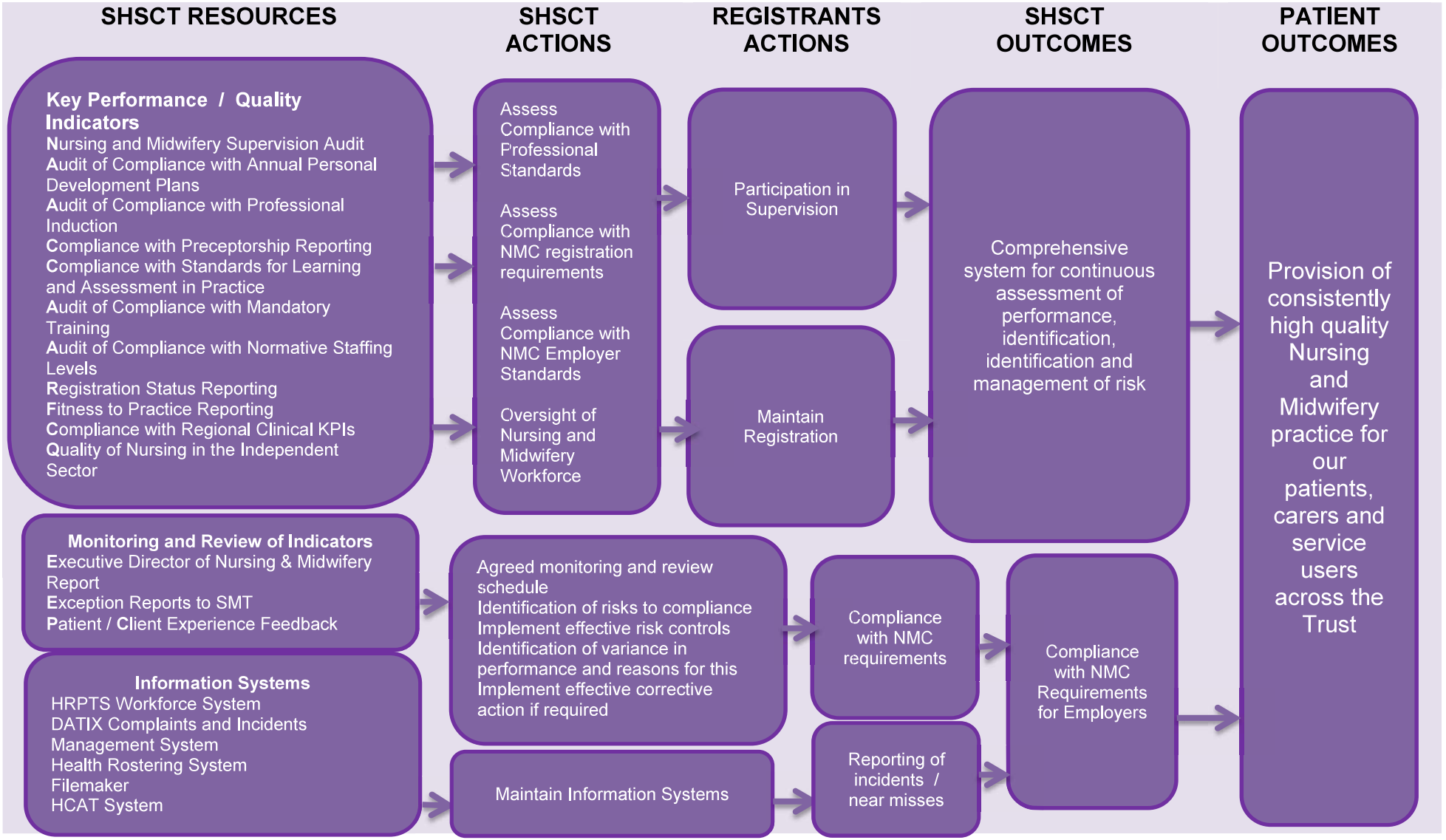
# Accountability and Assurance Framework
## Nursing and Midwifery

## Audit, Assurance and Compliance Arrangements



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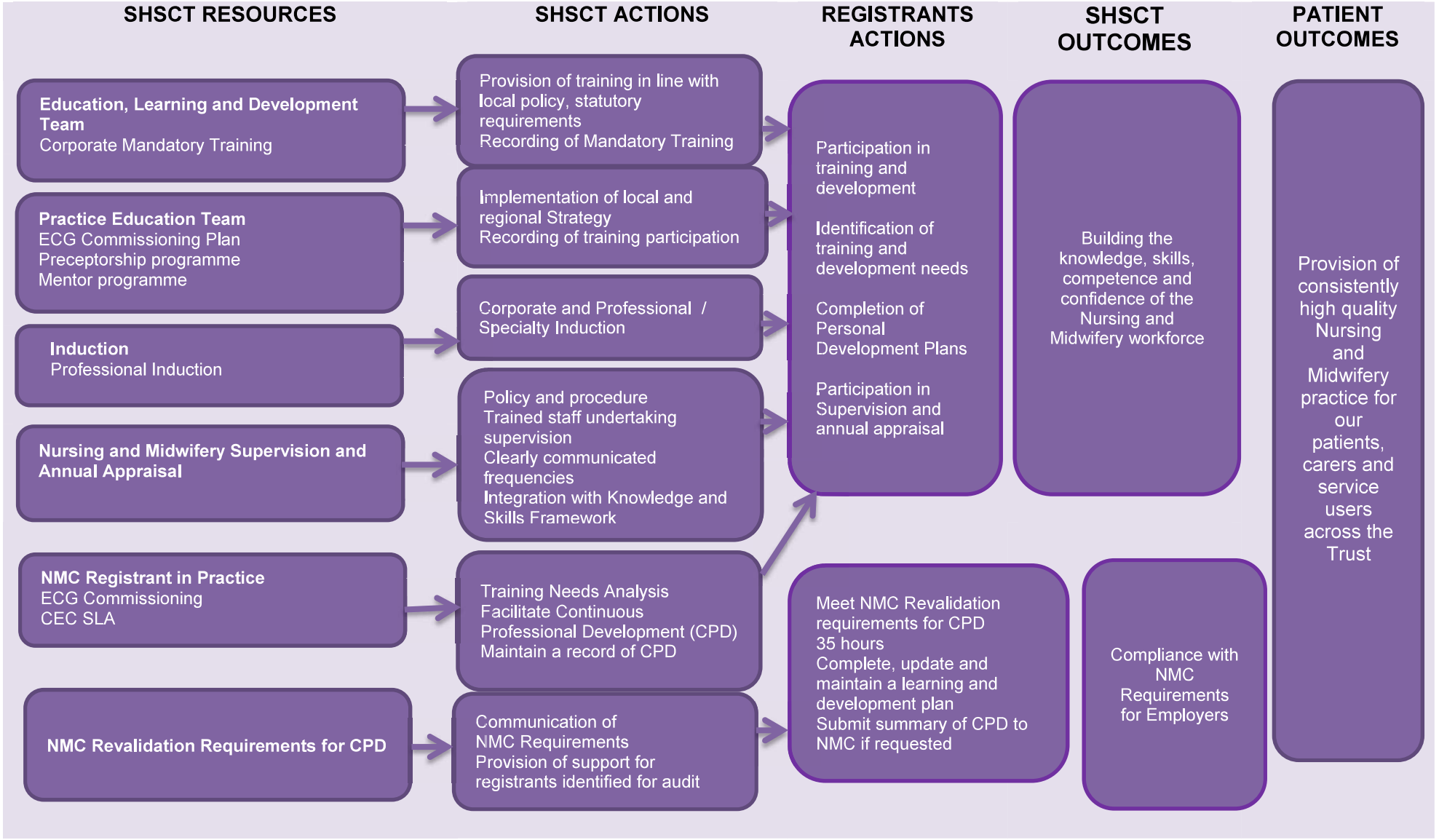
# Accountability and Assurance Framework
## Nursing and Midwifery

## Learning, Development and Support



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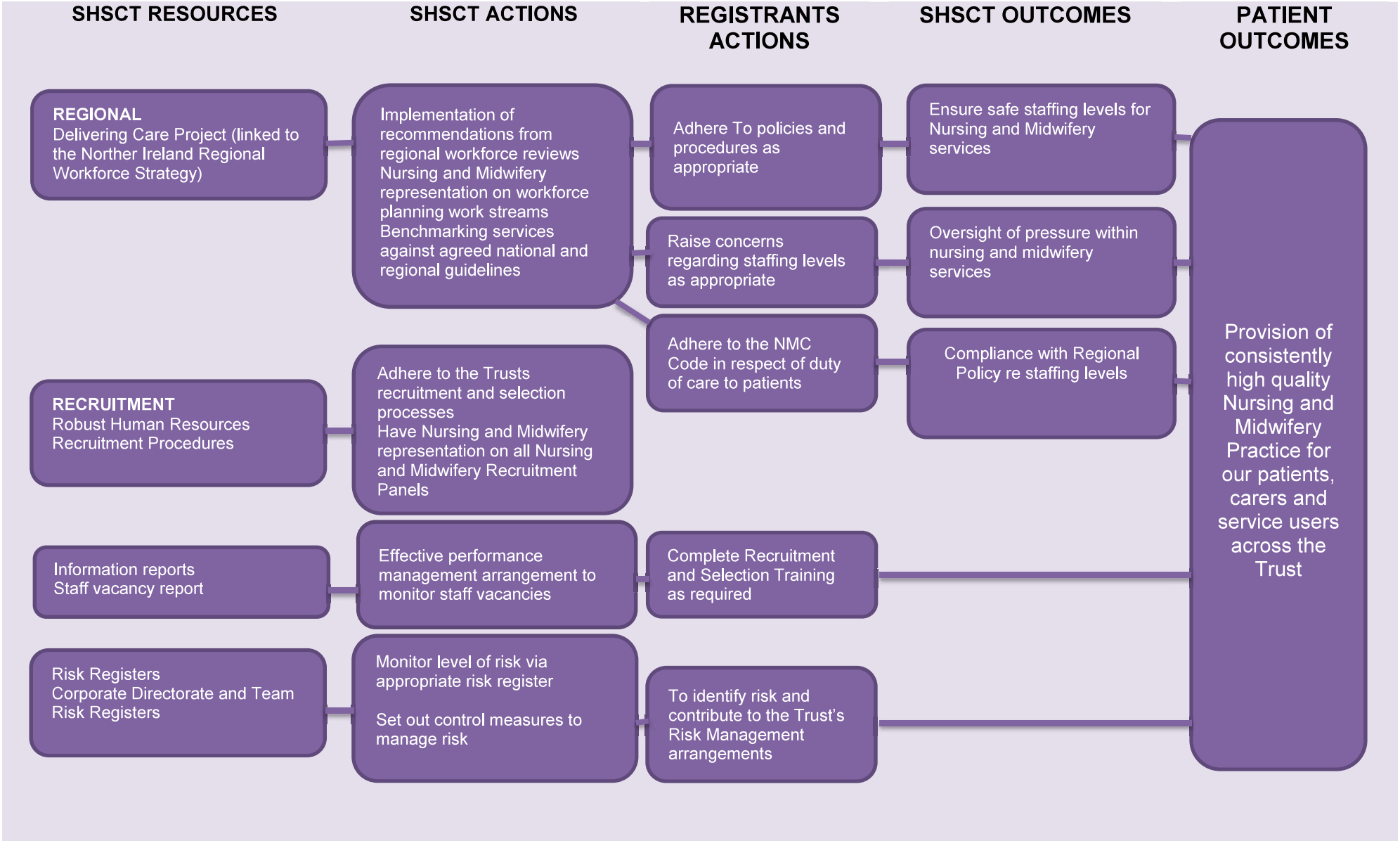
# Accountability and Assurance Framework
## Nursing and Midwifery

## Workforce



Southern Health and Social Care Trust
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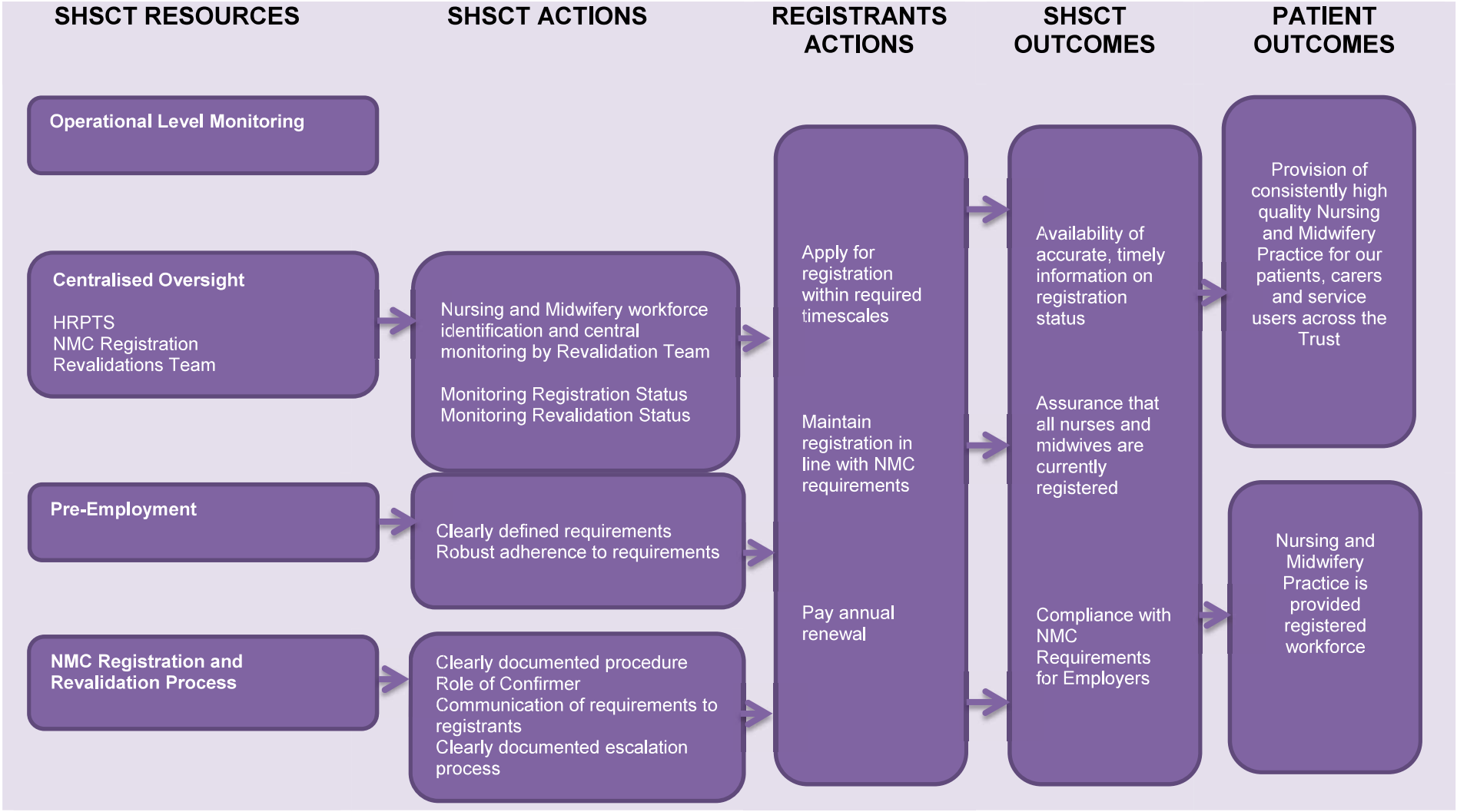
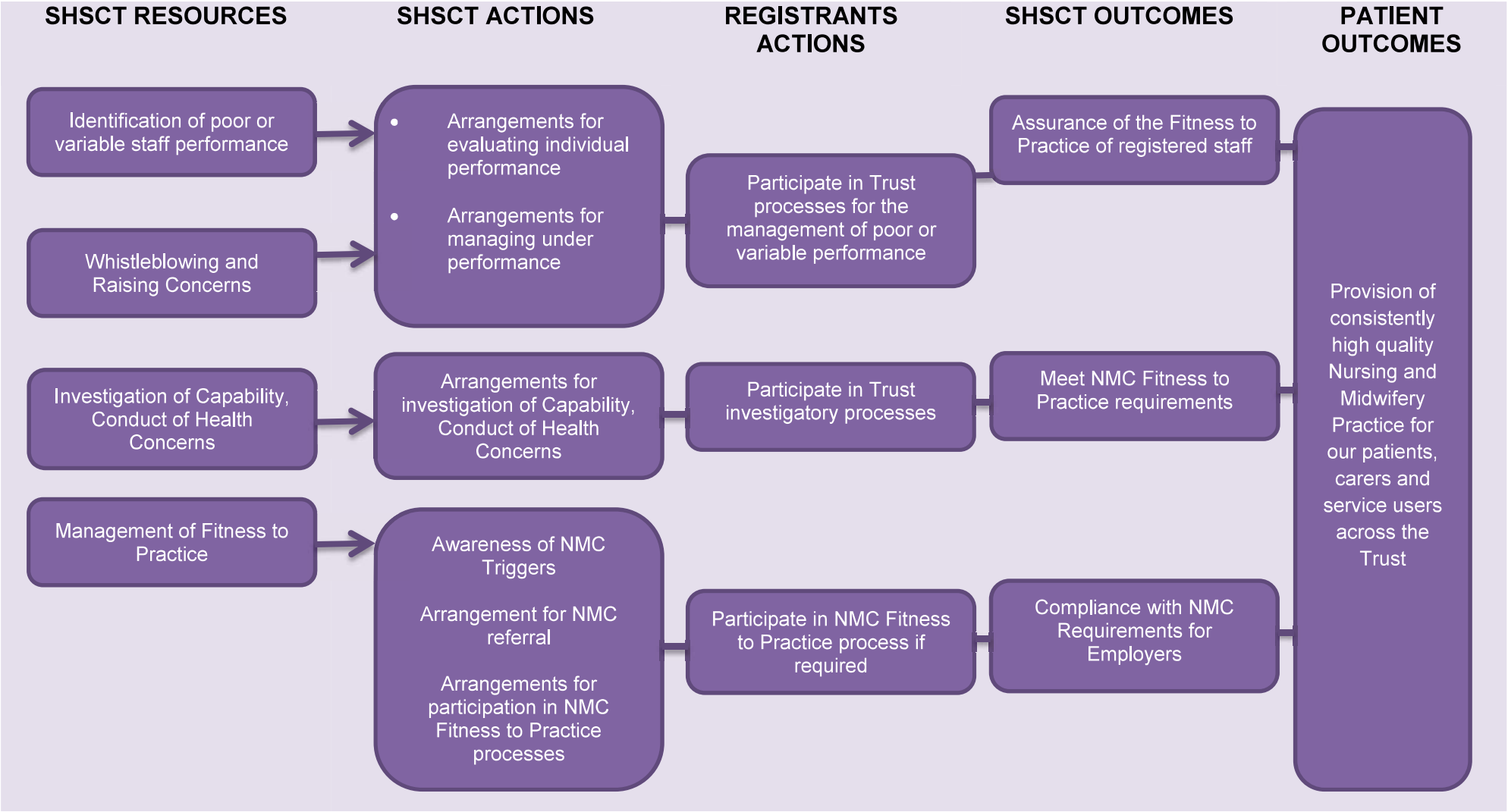
# Accountability and Assurance Framework
## Nursing and Midwifery

## Registration



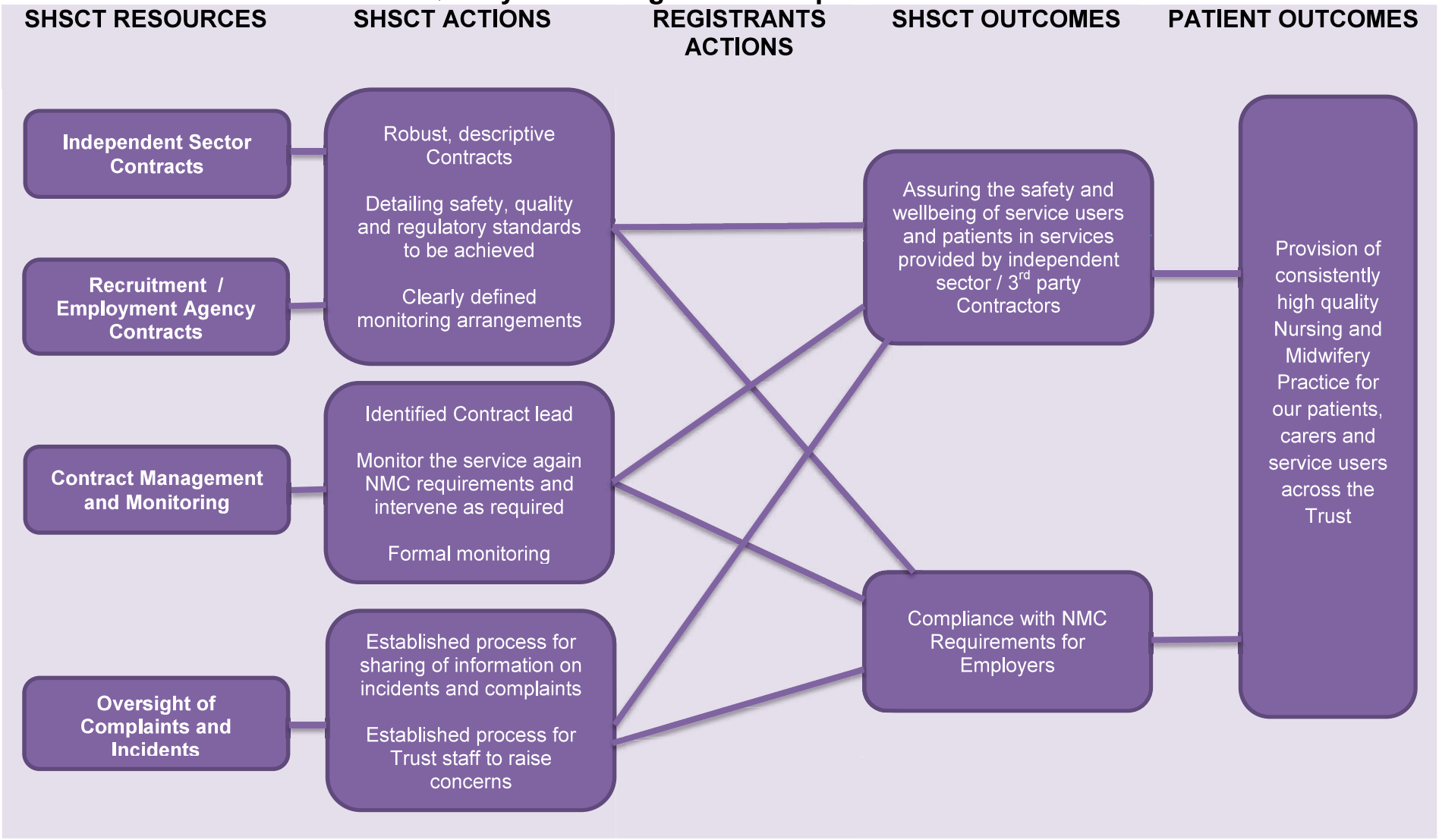
# Handling Concerns



# Accountability and Assurance Framework

## Nursing and Midwifery

## Quality of Nursing in the Independent Sector



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.

Southern Health and Social Care Trust

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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<br>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:<br>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<br>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<br>Date of Referral:10th July 2018<br>Scrutiny Policy Committee Approval 9th July 2018<br>SMT approval (Date) |
| **Circulation** | Issue Date: 20th July 2018<br>Circulated By: Assistant Director of Nursing Governance |
| **Review** | Review Date: September 2019<br>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 |

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## 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.

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

## 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**<br><br>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**<br><br>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**<br><br>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**<br><br>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**<br><br>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**<br><br>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**<br><br>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**<br><br>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**<br><br>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.<br>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<br>• Prepared for the session and will have considered and identified practice areas for open discussion<br>• 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<br>• Maintain strict confidentiality by not disclosing or discussing information provided by any other members of a group<br>• Be supportive of other members of the group<br>• Listen to and allow other members of the group to speak<br>• Maintain mutual respect<br>• Have an attitude of open learning<br>• Be open to constructive feedback<br>• Engage in reflective practice<br>• Deal appropriately with areas of disagreement according to the ground rules<br>• Ensure that identified unsafe, unethical or illegal practice is dealt with supportively via appropriate procedures<br>• All parties must be informed of the intention to disclose, before revealing confidential information<br>• 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<br>• Record and reflect on significant activities using a portfolio approach<br>• Evaluate the perceived benefit of the session<br>• Maintain and store records in line with Trust policy |
| **After the session** the **SUPERVISOR** will: - |
| • Complete the Trust's Sessional form(s)<br>• Maintain and store records in line with Trust policy<br>• Provide the supervisees with a copy of the session if not already provided<br>• 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:**<br><br>**SIGNATURE** | |
| **SUPERVISOR** | |
| **PRINT NAME:**<br><br>**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**

**APPENDIX 5**

| | |
|---|---|
| | |
| **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.<br>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.

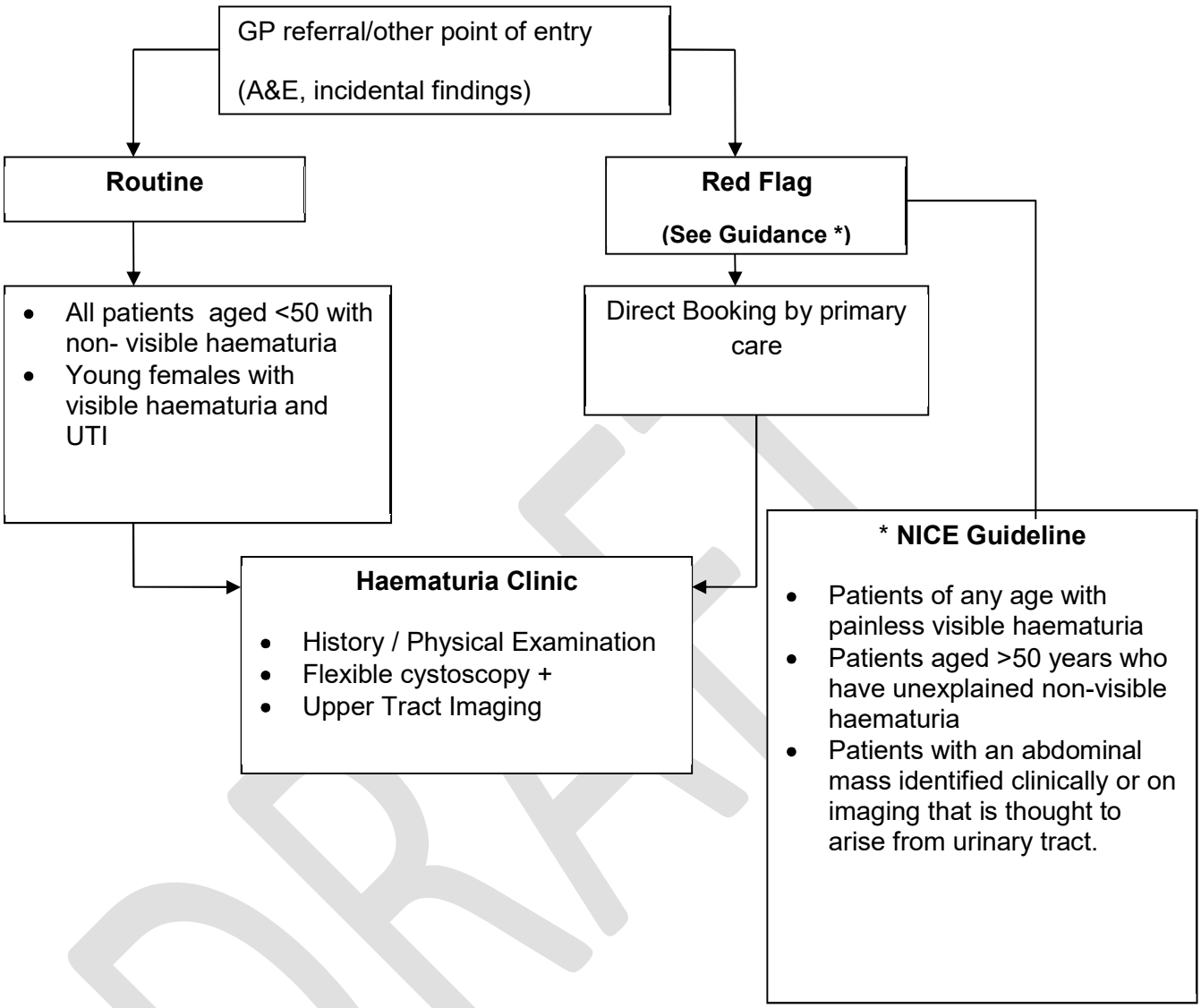
Update locally agreed pathways to include relevant contact information.

**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

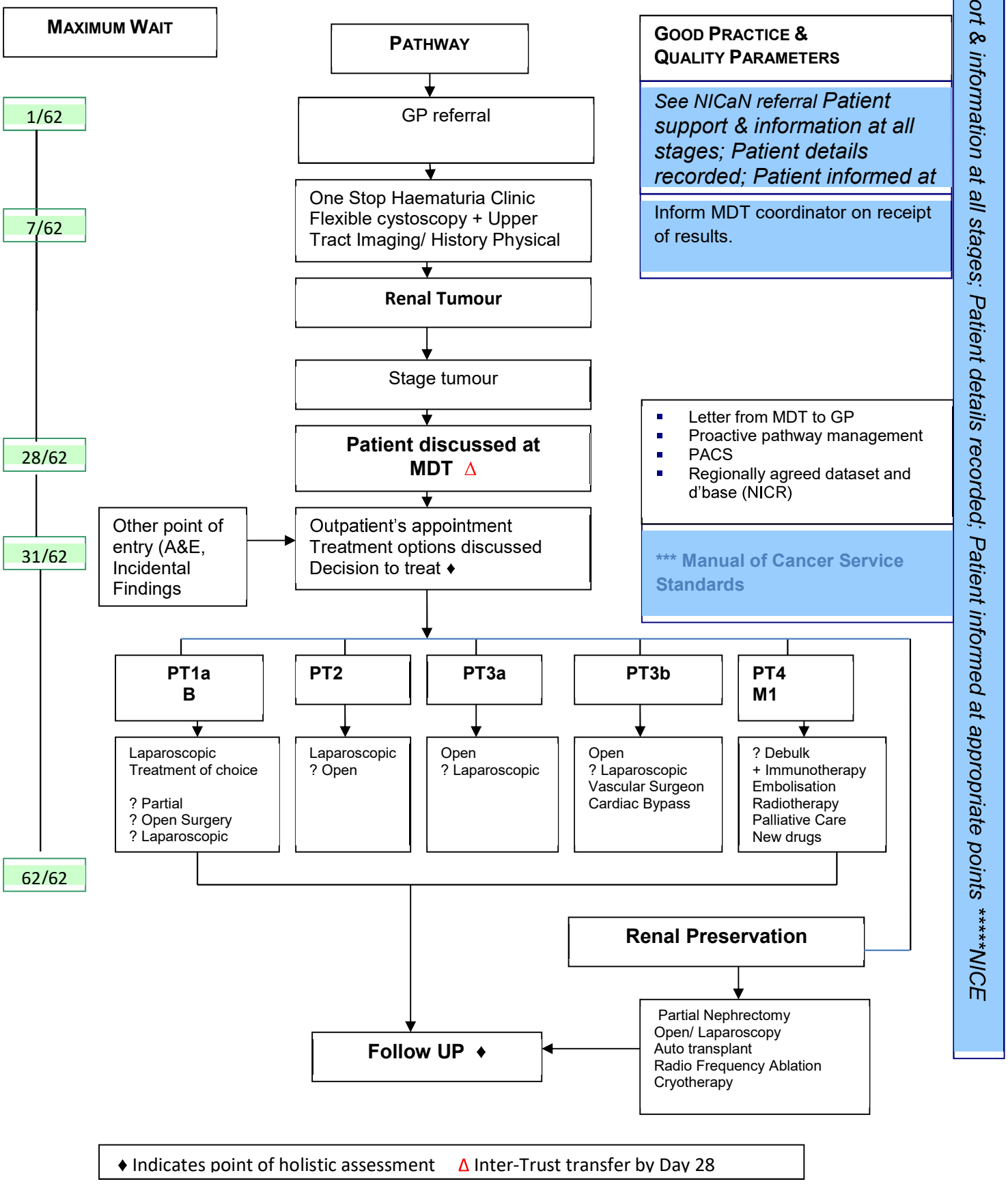



**NOTE: Please Consider Nephrology referral as well as referral to haematuria clinic if the patient has any of the following:**

- Diabetes
- Proteinuria
- Hypertension

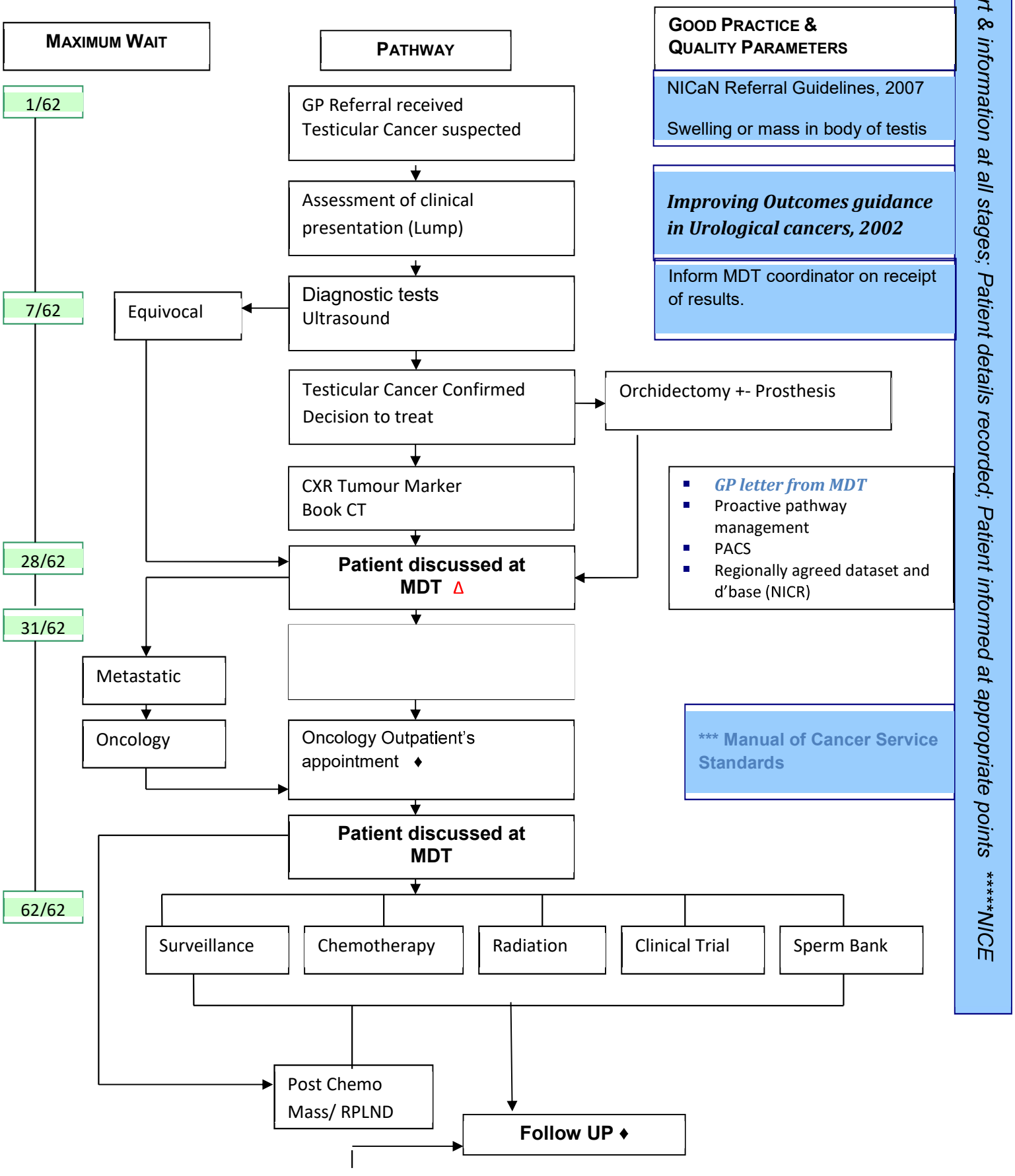
Appendix 3 of NICaN Urology Cancer Clinical Guidelines

# Renal Tumour



Appendix 3 of NICaN Urology Cancer Clinical Guidelines

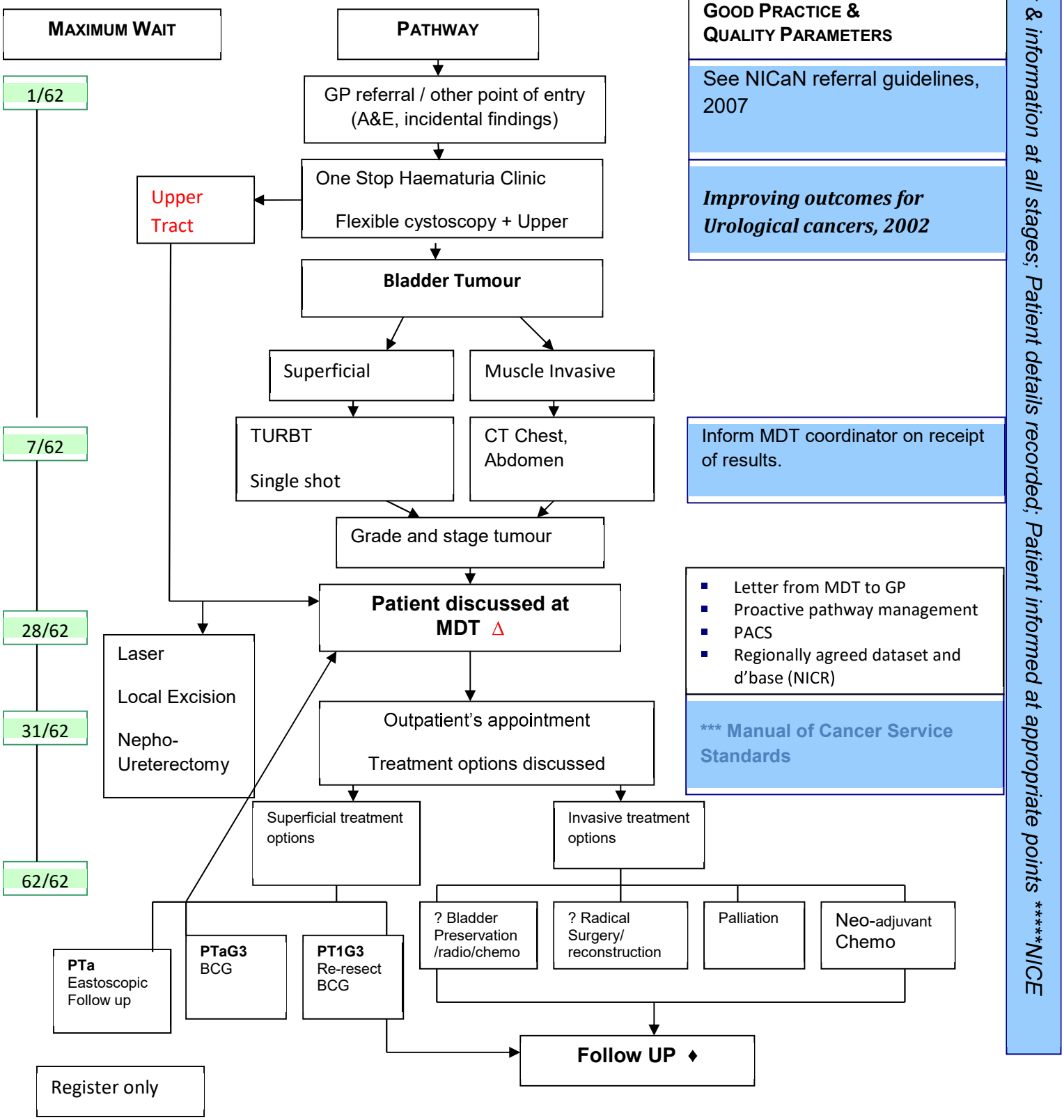
# Testicular Cancer Pathway




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

Appendix 3 of NICaN Urology Cancer Clinical Guidelines

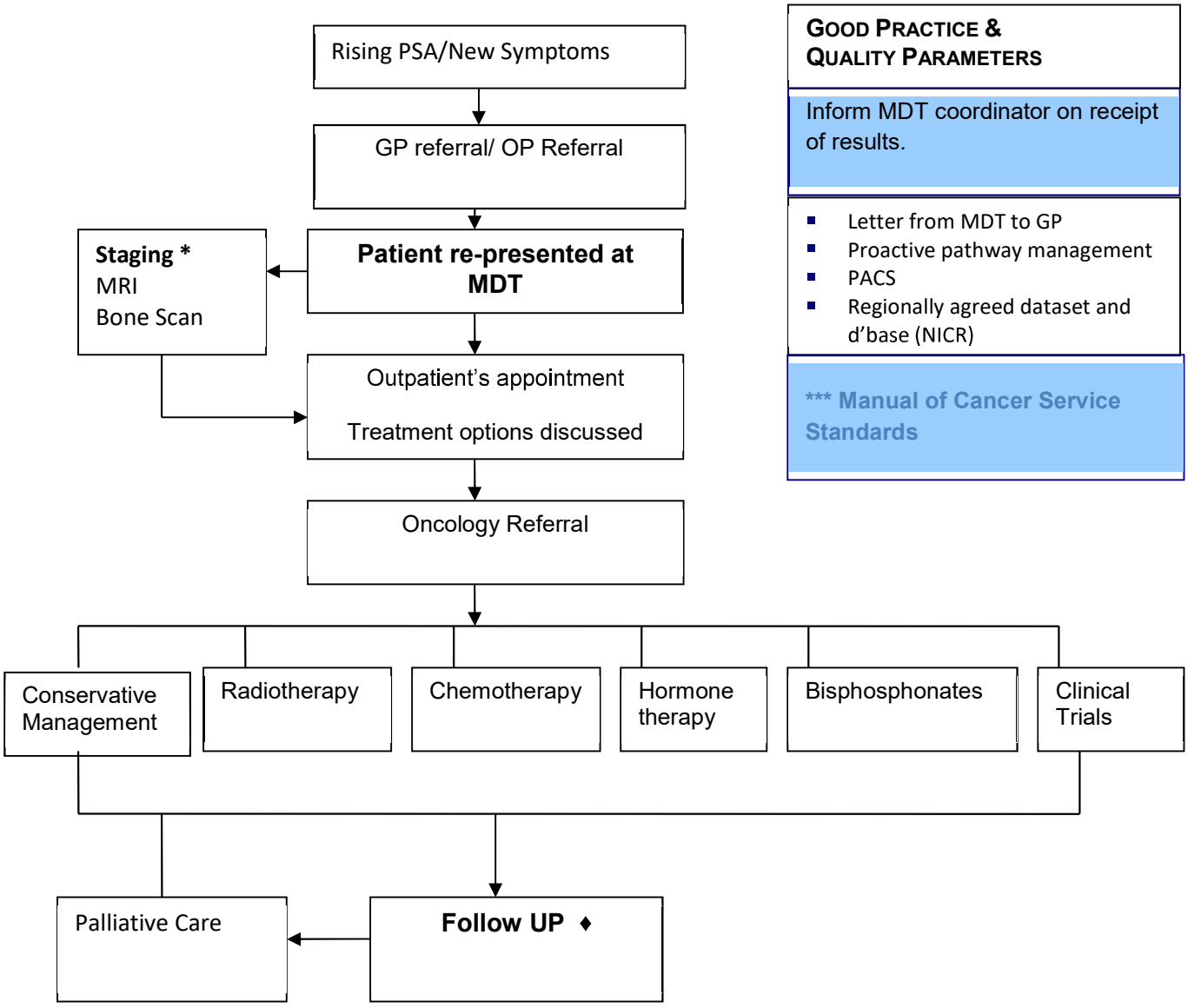
♦ Indicates point of holistic assessment  Δ Inter-Trust transfer by Day 28




Received from SHSCT on 31/10/2022. Annotated by the Urology Services Inquiry.

Appendix 3 of NICaN Urology Cancer Clinical Guidelines

# 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

Received from SHSCT on 31/10/2022. Annotated by the Urology Services Inquiry.

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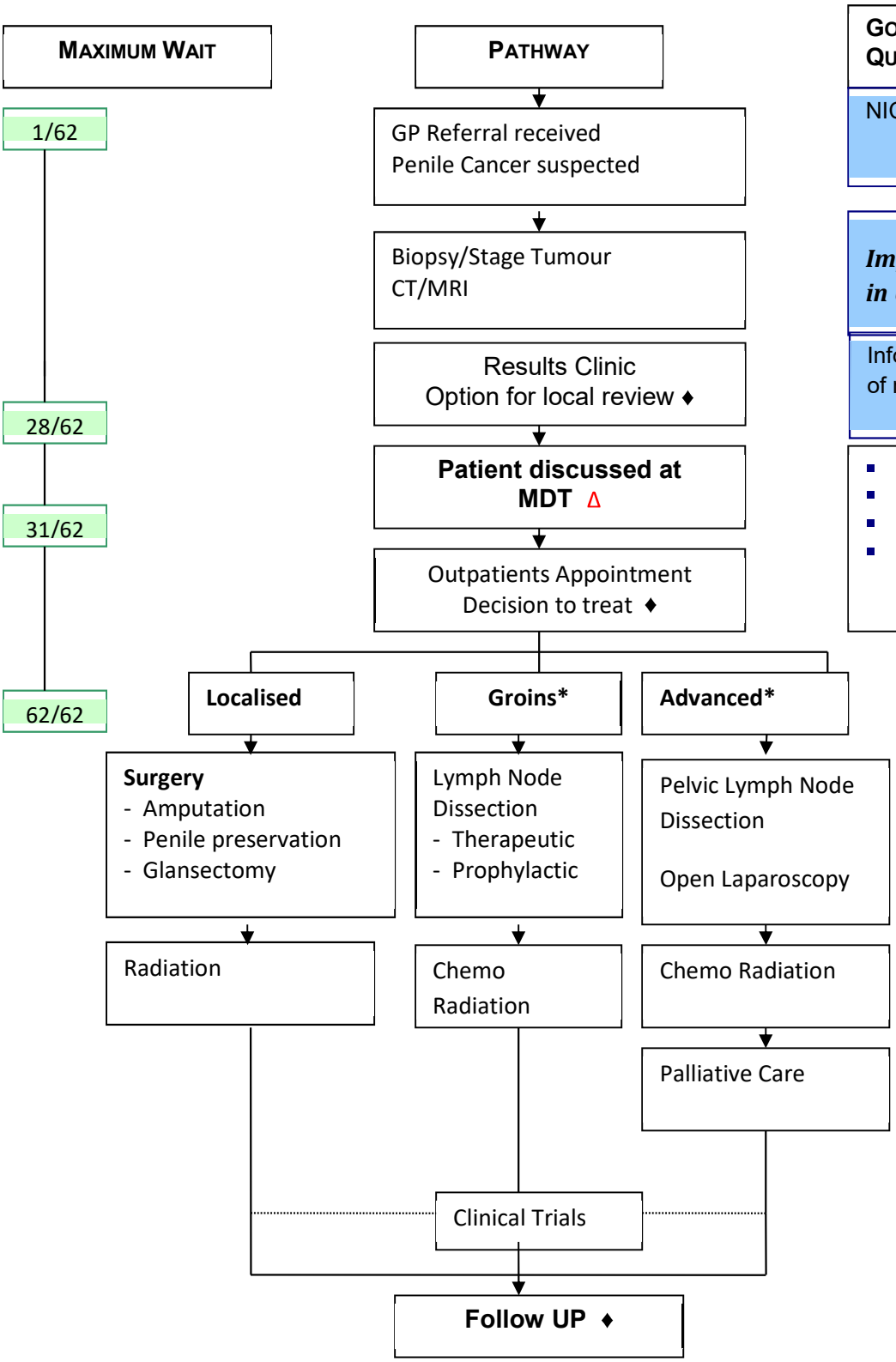
# Penile Cancer Pathway (Currently Under Review as part of development of local penile service 2019)




**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

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| *Policy Code / Reference No:* |
| --- |

Trust Logo

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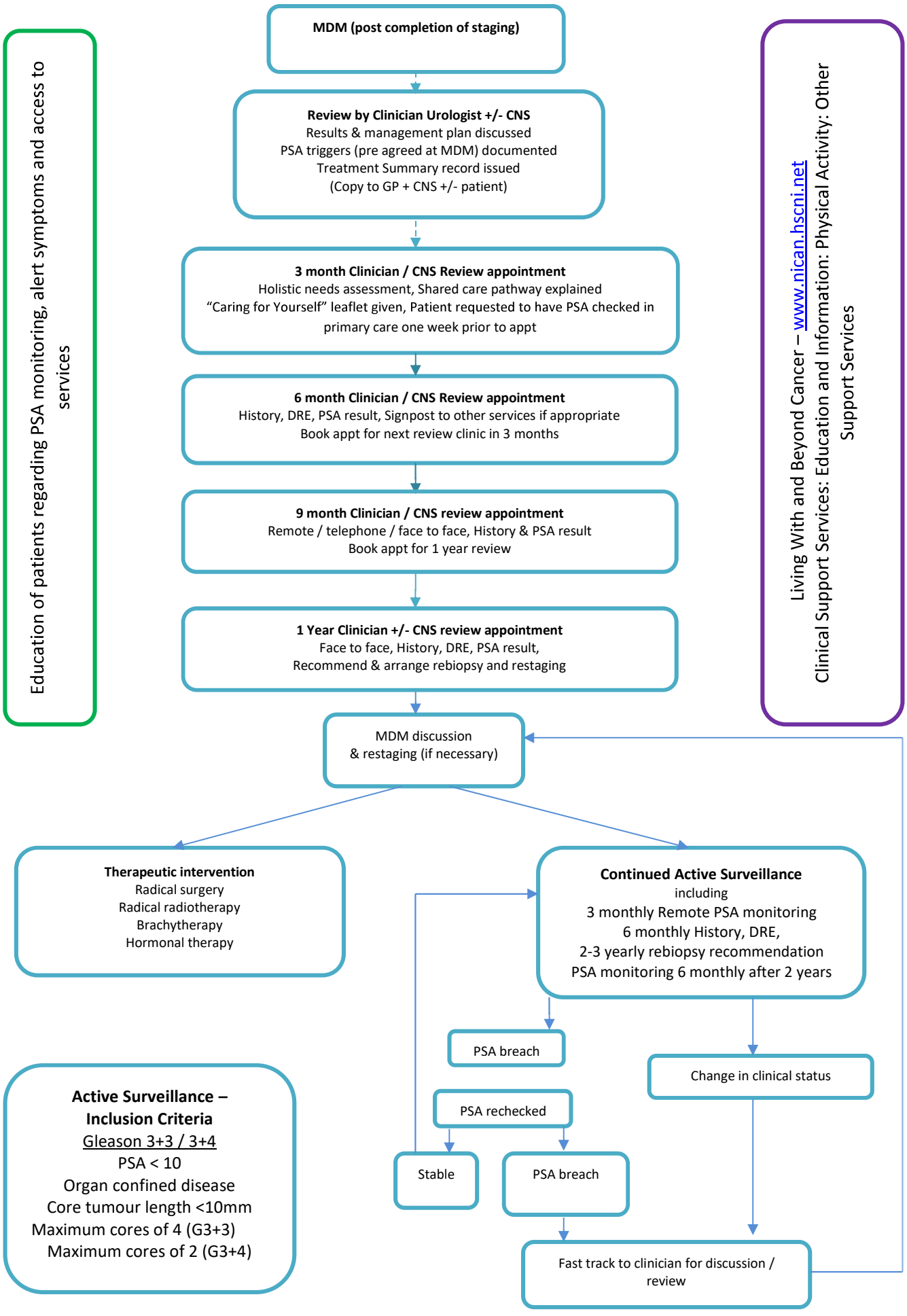
**Pathway 2** **Prostate Cancer: Active Surveillance**



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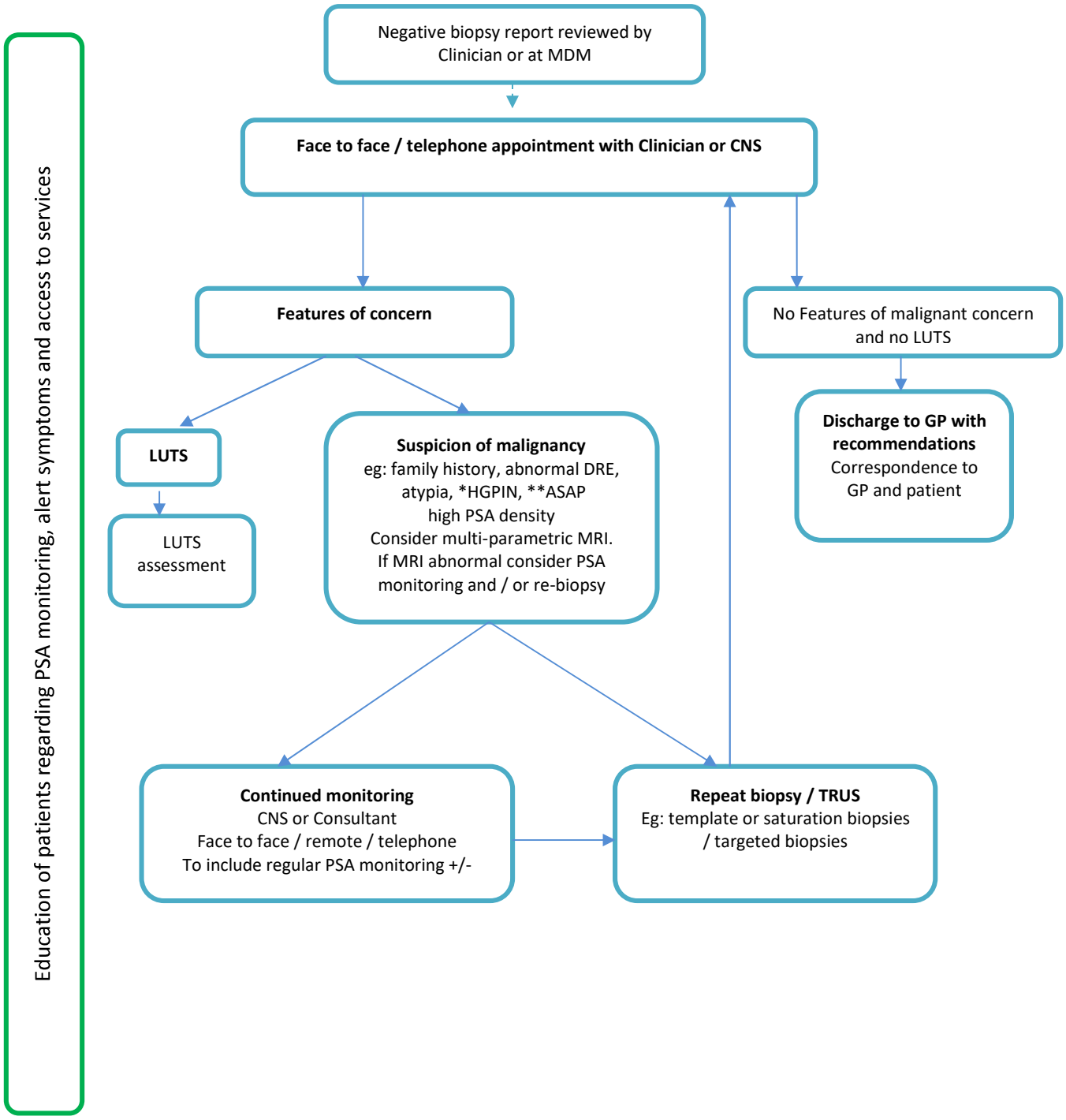
## Pathway 3 Raised PSA & Negative Biopsy




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

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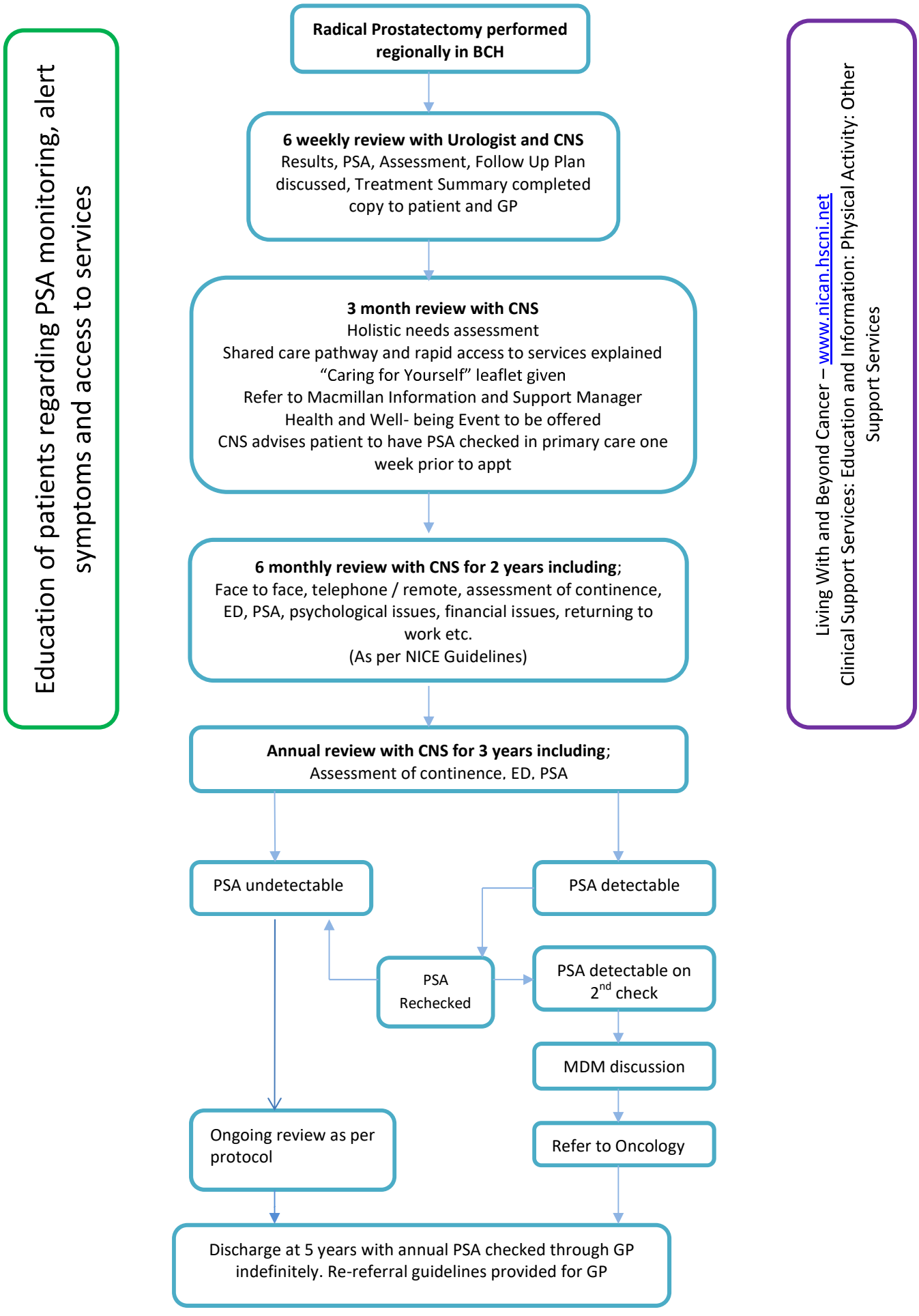
**Pathway 4 Prostate Cancer: Radical Surgery – Negative margins**



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## 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 + FRRT**

**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

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