Urology Clinical Forum

11th March 2015
Welcome and Introductions

Justin Vale, Chair of the LCA Urology Pathway Group
Progress of the Urology Pathway Group

Justin Vale, Chair of the LCA Urology Pathway Group
Progress update: The Urology Pathway Group

- Leading implementation within primary care of a **new pan LCA 2ww form** for suspected urological cancers

- 2\textsuperscript{nd} phase of **Urology CNS mapping exercise** and development of recommendations

- Review of **specialised urological cancer surgery configuration** across the LCA

- **Pan LCA bladder pathology audit** – to assess compliance against best practice recommendations

- Launch of **pan-LCA HNA pre-screening tool** for low risk urological cancers
LCA Metrics and performance

*Baseline position of LCA providers*

Steven Scott, Informatics Lead, London Cancer Alliance
Overview of areas

• Updates from current metrics
  – Cancer Waiting Times
    • 2 week wait performance
    • 62 day performance
  – COSD MDT feed data quality
    • Staging completeness
    • CNS field

– SACT dataset
  • Data quality

– HNA at diagnosis – latest figures

Data slides available for LCA providers upon request to either CaitrionaLiebenberg@nhs.net or StephenScott@nhs.net
Questions?
Configuration of specialised urological cancer surgery in the LCA

*Development of recommendations*

Justin Vale, Chair of the LCA Urology Pathway Group
Urology – Model of care recommendations

• Specialist bladder, prostate and renal surgery should be co-located on the same hospital site

• Each provider should each serve a population of at least two million

• Providers should seek to carry out a minimum cumulative total of 100 radical procedures for bladder and prostate cancer a year

• Complex bladder and prostate surgery should be commissioned from five providers for London
Applying the LCA standardised surgical reconfiguration process

- **Activity**
  - PG make recommendations regarding minimum surgeon volumes for procedures
  - Agreed profile of activity of current providers in comparison to minimum volumes – endorsed by the PG

- **Demand and catchment**
  - Agreed profile of current providers population and catchment including ‘out of area’ inflow

- **Service structure**
  - Complete profile of LCA centres in comparison to the ‘optimal’

- **Quality & outcomes**
  - Complete profile of performance against key quality indicators for specialist surgeries

Recommendations from the PG regarding the optimal configuration
## Review and development – timeline to date

<table>
<thead>
<tr>
<th>Month</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>May 14</strong></td>
<td>• Model of care response considered by Clinical Board  &lt;br&gt; • Next steps and reconfiguration principles workshop at Clinical Forum  &lt;br&gt; • Original co-dependencies framework reviewed by Pathway Group  &lt;br&gt; • Population and activity analysis updated and reviewed by Pathway Group</td>
</tr>
<tr>
<td><strong>Jun 14</strong></td>
<td>• Co-dependencies framework template developed and completed  &lt;br&gt; • Population and activity analysis updated and reviewed by Pathway Group</td>
</tr>
<tr>
<td><strong>Jul 14</strong></td>
<td>• Co-dependencies framework presented at Clinical Forum  &lt;br&gt; • Pathway group workshop to agree consensus co-dependencies framework</td>
</tr>
<tr>
<td><strong>Sep 14</strong></td>
<td>• Co-dependencies framework updated and approved following feedback from Clinical Forum  &lt;br&gt; • Quality indicators for specialised urological surgery agreed by Pathway Group</td>
</tr>
<tr>
<td><strong>Oct 14</strong></td>
<td>• Trust self-assessment against co-dependencies framework completed  &lt;br&gt; • Quality indicators – initial data analysis reviewed by Pathway Group</td>
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<tr>
<td><strong>Nov 14</strong></td>
<td>• Outline draft of recommendations paper reviewed by Pathway Group  &lt;br&gt; • Activity, quality and population data analysis reviewed by Pathway Group</td>
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<tr>
<td><strong>Dec 14</strong></td>
<td>• Conclusions of self-assessment against co-dependencies framework agreed by Pathway Group  &lt;br&gt; • Updated activity, quality and population data analysis reviewed by Pathway Group  &lt;br&gt; • 1st draft of recommendations paper reviewed by Pathway Group</td>
</tr>
<tr>
<td><strong>Jan 15</strong></td>
<td>• 2nd draft of recommendations paper reviewed by Pathway Group</td>
</tr>
<tr>
<td><strong>Feb 15</strong></td>
<td>• All Trusts confirmed sign off of activity data in recommendations paper  &lt;br&gt; • Sign off of recommendations paper agreed in principle by Pathway Group</td>
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</table>
CNS Mapping

*Findings of the Urology CNS audit*

*Follow up analysis*

Janette Kinsella, Advanced Nurse Practitioner, The Royal Marsden NHS Foundation Trust
Areas of comparison

• Patient caseload
• Advanced practice
• Nurse Specialist practice
• Administrative workload
• Flexibility for direct patient contact
### Summary – independent clinical practice

Number of different independent clinical activities undertaken by a single CNS

<table>
<thead>
<tr>
<th>Activity</th>
<th>None</th>
<th>1 only</th>
<th>Up to 3</th>
<th>Up to 4</th>
<th>Up to 5</th>
<th>6+</th>
<th>All</th>
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<tbody>
<tr>
<td>MDT Prostate</td>
<td>18</td>
<td>3</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>1</td>
<td>1</td>
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<td>MDT Bladder</td>
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<tr>
<td>MDT Renal</td>
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<td>MDT Testis</td>
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<td>MDT Uro-Oncology</td>
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<td>Medical Oncology</td>
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<tr>
<td>Advanced practice</td>
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<td>Flexible Cystoscopy</td>
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<tr>
<td>Transperineal prostate biopsy</td>
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<tr>
<td>Sexual dysfunction / Andrology (Cancer patients)</td>
<td></td>
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<td>TRUS Biopsy</td>
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<td>Histology / Results review clinic</td>
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<td>Testicular Ultrasound and follow up</td>
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<tr>
<td>CNS practice</td>
<td></td>
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<tr>
<td>Small renal mass follow up</td>
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<td>Continence/ LUTS (Cancer patients)</td>
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<td>Chemotherapy</td>
<td></td>
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<tr>
<td>Pre or Post treatment education clinics / seminars</td>
<td>5</td>
<td>7</td>
<td>15</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
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<tr>
<td>Enhanced recovery (ward or outpatient based)</td>
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<td>Prostate cancer follow up (PSA follow up)</td>
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<td>Survivorship clinic</td>
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Administrative workload and meeting attendance

- 11 individuals report an administrative workload that equates to one day a week
- The majority of respondents report a minimum of 3 hours per week spent dealing with non-clinical admin tasks
- Not all CNS’ have designated admin sessions in a working week – 6 reported having none, 11 reported one designated session, 9 reported having 2 designated sessions and one reported having 4 designated sessions

- The majority of CNS’ spend between 1 and 3 hours attending MDT or other clinical meetings
- A limited number of CNS’ spend more time in attendance at these meetings – this may be reflective of a more senior grade
The London Cancer Alliance West and South

Availability and patient contact mechanisms

- Availability and access for patients to contact their CNS is variable
- Only 12.5% of respondents indicate that they have a 24/7 telephone helpline for patients
- Only 66% indicated that they have a minimum of a 9-5 telephone helpline

<table>
<thead>
<tr>
<th>Method of contact</th>
<th>Available Y/N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Telephone helpline</td>
<td>82%</td>
</tr>
<tr>
<td>Mobile</td>
<td>29%</td>
</tr>
<tr>
<td>Ward line</td>
<td>25%</td>
</tr>
<tr>
<td>Pager</td>
<td>11%</td>
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<tr>
<td>Bleep</td>
<td>54%</td>
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<tr>
<td>Email</td>
<td>75%</td>
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</table>

Bar chart: Does your team provide a telephone helpline (patients are able to get through to a nurse for advice immediately)?

- Yes: 57.14%
- No: 42.86%

- 9 - 5, 5 days per week
- 24 hours, 7 days per week
- Other
Clinical workload

**Patient caseload**

<table>
<thead>
<tr>
<th>“How many patients each week are you a named key worker for?”</th>
<th>0</th>
<th>1 to 5</th>
<th>5 to 10</th>
<th>10 to 15</th>
<th>15 to 20</th>
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</thead>
<tbody>
<tr>
<td>1</td>
<td>14</td>
<td>8</td>
<td>2</td>
<td>2</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>“How many follow up patients do you see on average, per week?”</th>
<th>&lt;10</th>
<th>&gt;10</th>
<th>&gt;15</th>
<th>&gt;20</th>
<th>&gt;30</th>
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</thead>
<tbody>
<tr>
<td>7</td>
<td>6</td>
<td>3</td>
<td>7</td>
<td>5</td>
<td></td>
</tr>
</tbody>
</table>

- CNS caseload varies hugely, although the majority of respondents indicated that their weekly ‘named key worker’ patient caseload normally ranged between 1 and 5 or 5 and 10.

- Caseload for follow up patients is vary varied, and there is a broadly even split between those CNS’ seeing less than 10 and those seeing more than 30.
Recommendations following presentation at the October forum

• Triangulation exercise of new patients per CNS across LCA providers
• Review of recommendations regarding a minimum new patient caseload ratio to CNS
• Stronger recommendation regarding responsibility of managers to support development of CNS workforce
• Role of CNS in urology services and role of ANP to be explored in existing data set
Areas of focus for secondary analysis

- Comparison of the CNS role in urology services compared to an ANP role
- New patients as named key worker - comparison
- How is time allocated for the CNS role
- Administrative workload by Trust
What’s the difference in a title?

**CNS = Band 7 (National Cancer Action team 2010)**

- Managing complex, individual and changing information and support needs of patients and carers
- Supporting patients in choices around treatment and care
- Enhancing recovery and delivering care flexibly and closer to home
- Facilitating set up of support groups
- Delivering safe, nurse-led services
- Using vigilance of symptoms and drug toxicity to trigger rescue work
- Identifying and taking action to reduce risks
- Facilitating rapid re-entry into acute services, if appropriate
- Intervening to manage treatment side effects and/or symptom control, preventing unplanned admissions
- Providing nurse-led services that free up consultant resource
- Empowering patients to self manage their condition
- Educating the wider healthcare team and acting as a mentor
- Identifying and implementing service improvement and efficiencies
- Determining measurable outcomes, auditing practice, and sharing good practice and innovation

**ANP = Band 8a (RCN 2010)**

- making professionally autonomous decisions, for which they are accountable
- receiving patients with undifferentiated and undiagnosed problems and making an assessment of their health care needs, based on highly-developed nursing knowledge and skills, including skills not usually exercised by nurses, such as physical examination
- screening patients for disease risk factors and early signs of illness making differential diagnoses using decision-making and problem-solving skills
- developing with the patient an ongoing nursing care plan for health, with an emphasis on health education and preventative measures
- ordering necessary investigations, and providing treatment and care both individually, as part of a team, and through referral to other agencies
- having a supportive role in helping people to manage and live with illness having the authority to admit or discharge patients from their caseload, and refer patients to other health care providers as appropriate
- working collaboratively with other health care professionals and disciplines providing a leadership and consultancy function as required.
ANP vs CNS

The Royal College of Nursing considers you an ANP if you are carrying out Independent practice of any of the following procedures:

- TRUS biopsy
- Transperineal prostate biopsy
- Histology results review
- Active surveillance follow up
- Flexible cystoscopy
- Testicular ultrasound
- Symptom management clinics with independent prescribing
Objectives

Objective 1: To obtain an indication of the number of Urology CNS’ who are currently undertaking the role or elements of the role of an ANP.

Objective 2: To understand the approximate time spent by Urology CNS’ undertaking ‘non clinical’ activities
Profiles by Trust

Approximate time allocations awarded to each procedure, and calculated using survey results.

For each Trust it shows the total hours available from their CNS workforce, highlighting where responses were not received.

It shows the breakdown of how time is spent compared to total availability for the ‘CNS’ role.

One nurse led clinic = approx. 3.5hrs

Note – this does take into account time spent supporting clinics as this was not collected.
Results

• 12 out of 28 respondents indicate they undertake advanced practice. 11 of the 12 were B7 CNS’.
• Across the LCA each Trust loses an average of 17 hrs of nursing time to non-clinical activity per week.
  – MDT preparation
  – Completing MDT referrals
  – Making appointments
  – Sending emails/making calls to other departments to chase diagnostic tests
  – Organising clinics
  – Stream-lining clinics
Recommendations (1)

- All Trusts should review the detailed breakdown (available on request) to establish areas of potential improvement or that which requires further analysis.
- All Trusts need to review the amount of advanced practice that is being carried out under the banner of the CNS role.
- All Trusts should ensure that there is support and provision provided by the organisation to support CNS’ in completing additional training / qualifications.
- Administrative support for non-clinical tasks is required for majority of CNS teams. This would free up time for clinical initiatives such as HNA’s.
- The training and capacity of the clinic clerks and MDT co-ordinators should be examined locally to identify whether this role requires review.
- Where a urology cancer service has a single CNS, there should be appropriate cover arrangements in place for annual leave / sickness
Recommendations (2)

• There needs to be a review of all CNS job plans across the LCA to establish and incorporate the following:
  – delivery of health and wellbeing events / clinics within their respective organisations
  – HNAs with their patients.

• All CNS’ should ensure they attend the MDT for relevant tumour groups as appropriate.

• Where hospitals have centralised the delivery of cancer treatments on one site and follow up is carried out locally, the CNS team’s should provide handover to the local CNS team in the form of a care plan.

• All CNS’ working hours should be reviewed on an annual basis as part of their job plan review to ensure their working hours fit the requirements of the service
The benefits of specialist nurses

“Clinical nurse specialists are doing work that might otherwise be done by more expensive resources, and that can represent a real financial benefit,” Jenny Ritchie-Campbell, director of services, strategy and innovation at Macmillan Cancer Support.

“you cannot afford not to invest in the specialist nursing workforce, as a number of the roles that nurse specialists do were roles that were previously done by consultants and now they’re doing it at a fraction of the cost.” Paul Trevatt - Strategic clinical network lead for NHS England
Questions?
Bladder pathology audit

Pan LCA results

Available upon request from the Project Manager – CaitrionaLiebenberg@nhs.net

Cathy Corbishley, Consultant Histopathologist
Workshops

Treatment summaries

Tumour specific content

Justin Vale, Chair of the LCA Urology Pathway Group

Delivering world class cancer care for London
Treatment Summaries - workshop

• Treatment Summaries are intended for use at the end of treatment to provide both GPs and patients with a summary of information about the treatment provided, possible toxicities and side-effects.
• They also provide information about the consequences of treatment and signs and symptoms of recurrence.
• One of the agreed LCA metrics and will also be monitored by commissioners from 15/16.
• All Pathway Groups are tasked with agreeing tumour specific content for inclusion in treatment summaries.
• The Urology Pathway Group is leading on the development of content. Implementation and interface with Trust cancer systems is for local resolution.

Workshop tasks: (please sit in tables according to ‘your tumour type’)
Which treatment types should be considered for your tumour type?
What information should be included?
Priorities for 15/16

Areas of focus for the Urology Pathway Group

Justin Vale, Chair of the LCA Urology Pathway Group
Priorities for 15/16

- Patient experience – patient information seminars
- Survivorship – continuing to support implementation of the recovery package
- Model of care recommendations – next steps
- Guidelines – evaluating compliance, standardising testicular follow up
- Audit priorities
- Early diagnosis – 2ww implementation and evaluation
For discussion

• What else should the Pathway Group be focussing on in 15/16?

• What topics would you like to see at future clinical forums?
Summary and close

Justin Vale, Chair of the LCA Urology Pathway Group
Closing remarks

Keeping you informed in the future:

What is the best way of keeping Trusts and the urological clinical community up to date?

- Email bulletins?
- Information cascade through MDTs?
- Webinars
- Podcasts of clinical forums
- Updates at clinical forums?

What are the challenges regarding attendance?
- Frequency – too frequent
- Content – not relevant to my organisation / speciality / role
- Operational issues – can’t get cover / just too busy
Closing remarks

Thank you all for coming today

Please contact Caitriona Liebenberg, LCA Project Manager for any queries or comments regarding today’s event or the work of the Pathway Group.

If you would like a copy of the slides including the data and metrics, please submit a request from your Trust email account to Caitriona.

Caitrionaliebenberg@nhs.net