

The specialist nursing workforce caring for men with prostate cancer in the UK

Research report 2014

Commissioned by Prostate Cancer UK





Contents

Forewords.....	4
1. Executive summary and recommendations.....	6
2. Introduction.....	8
3. Background.....	10
4. Method.....	12
5. The current specialist nursing workforce in prostate cancer care across the UK.....	14
6. Workload.....	32
7. Working in the multidisciplinary team.....	38
8. Education and development.....	45
9. Recommendations.....	52
10. Areas for further work.....	53
Acknowledgements.....	54
Project group.....	54
References.....	55

Forewords

Foreword from Philippa Aslet



The British Association of Urological Nurses (BAUN) has been delighted to support this research project conducted by Plymouth University, London Southbank University, Mouchel and funded by Prostate Cancer UK, to understand more about the work, activity and needs of specialist nurses working in urology/uro-oncology and in particular prostate cancer. The survey was circulated to all BAUN members and we were encouraged by such an excellent response rate, which has enabled the research team to gain some real insight into current practice and service provision.

It is clear that urology can boast a well-educated workforce doing complex work across the whole prostate cancer journey. However this work has also demonstrated high workload for the nurses with some essential aspects of care, like the Holistic Needs Assessment, not happening in many centres. In addition, the survey has highlighted the need to do more to meet the educational needs of this specialist nursing group.

We have an ageing workforce which will create challenges in the future without significant workforce planning. Interestingly the prostate cancer only workforce makes up a meagre 2% of the UK specialist cancer nursing population, which is similar to the rare cancers. This is a shocking statistic, which I hope will lead to increased investment in Clinical Nurse Specialists in prostate cancer.

Given that we know from cancer patient experience surveys that patients have a much better experience of care if they have access to a specialist nurse, it is a concern that for this patient group there appears to be geographical variation. So access to a specialist nursing service depends on where you live. To get a greater understanding of these issues we will need further research.

I hope that you find the report makes for interesting reading. It should be used to improve the care we give to men with prostate cancer and be a springboard to a greater understanding of the role of the specialist nurse in urology.

A handwritten signature in black ink, appearing to be 'PA', with a long horizontal line extending to the right.

Philippa Aslet
President (2014)
British Association of Urological Nurses (BAUN)

Foreword from Owen Sharp



There is a huge, dual challenge on the horizon: an increasing number of men are being diagnosed with prostate cancer, and the specialist nursing workforce that cares for these men is under threat. Prostate cancer is already the most common cancer in UK men, and by 2030, it is set to be the most common cancer overall. While we have made great strides forward in terms of new treatment to fight the disease, we know that health professionals themselves, and in particular, specialist nurses, play a central role in the experiences of men with prostate cancer. Time and time again men tell us that their Clinical Nurse Specialist was invaluable throughout their care.

The findings of this research not only highlight the challenges to the workforce treating men with prostate cancer in the NHS now, but also paint a very bleak picture of the nursing support available to men in the future if action is not taken. This report reveals the urgent need to plan and develop the nursing workforce in prostate cancer care so that men get the support they need.

Insufficient, variable specialist nursing provision and sometimes huge caseloads, plus a lack of administrative support, are already leading to core elements of care being missed out.

The future looks even more disturbing: almost half of the nurses surveyed plan to leave their role in the next decade, but a new specialist workforce is not being developed to take their place. Trusts and health boards must look at their local populations' health needs and plan their workforce to meet those needs. National commissioners and providers of education must respond to this looming crisis. We call on Chief Nursing Officers across the UK to undertake strategic workforce planning in urology nursing. Local providers must support leadership posts, create development posts and ensure administrative support to enable specialist nurses to do the jobs they are trained to do. We want to see men getting a better deal – all men diagnosed with prostate cancer should have access to a nurse with specialist knowledge, training and experience in prostate cancer care, no matter where they live.

The research team who led on this work and all of the individuals and organisations who either steered the research or participated in the survey deserve a huge thank you for their time and commitment to this project. The quantity and quality of the data collected from this study was only achieved through the vital support of the committee and membership of BAUN. Their hard work has been on behalf of many thousands of men and it is clear that care and outcomes for those men will deteriorate unless all parts of the system take individual and collective action.

A handwritten signature in black ink, appearing to read 'Owen Sharp', written in a cursive style.

Owen Sharp
Chief Executive
Prostate Cancer UK

I. Executive summary and recommendations

Summary of findings

Prostate cancer is the most common cancer in men in the UK accounting for 25% of all new cases of cancer. It is predicted to become the most common cancer overall by 2030.

This survey of the specialist nursing workforce caring for men with prostate cancer was completed across the four countries of the UK during June and July 2014. In total 302 specialist nurses completed the survey and data from 285 was used in the analysis. This is the biggest whole population survey of this workforce in recent years.

The most common job title was Clinical Nurse Specialist (185) and the most common band was Agenda for Change band seven (174). However in Scotland 50% of the respondents stated that they were paid on band six. Over half the group (158) had worked in prostate cancer care for more than 10 years. Few (48) had come into specialist posts from a specific specialist nurse development role.

The specialist cancer nursing community is pivotal to patient experience. The National Cancer Patient Experience Survey (NCPES) in England has demonstrated that patients with cancer who have access to a Clinical Nurse Specialist (CNS) generally report better experiences of care and understanding of the disease. They are less likely to feel isolated and more likely to feel they have their information needs met and are in control of their own decisions. However there is a wide geographic variation in the provision of specialist nursing for men with prostate cancer. This is reflected in available hours and caseload sizes. The respondents reported frozen and vacant posts across the UK. This equated to 58.3 full time equivalents.

The work of specialist nurses caring for men with prostate cancer is clinically complex and appears to cover most key times in the cancer journey. However workload appears to be limiting the care that the nurses are able to provide with over half the respondents (163) saying that they left work undone for patients.

Unlike other cancers there are few specialist nurses dedicated to prostate specific care. The majority of the workforce covers all uro-oncology cancer and benign disease. Despite being a common cancer, prostate cancer specific specialist posts make up only 2% of all cancer specialist posts in England – that's the same level as rare cancers.

The current specialist nursing workforce caring for men with prostate cancer is facing a number of challenges:

- The workforce is ageing and nurses caring for patients with prostate cancer are no exception. In this study 49% (140) of nurses declared that they are eligible for retirement or intending to leave the profession within the next 10 years.
- Variable service provision, high caseloads, unpaid overtime, lack of administrative support, lack of opportunity for progression and constant cycles of management reviews undermine the confidence of the workforce and threaten compliance with best practice in cancer care.
- Workload and culture are presenting barriers to the provision of multidisciplinary cancer care. Fewer than half the respondents (128) felt they worked in a functional multidisciplinary team.
- There are few opportunities to provide development posts to generate the next generation of specialist cancer nurses.
- There are very few opportunities for progression to systems leadership, for example nurse consultant posts.

The workforce is educated and shows an appetite for further development to ensure that cancer nursing practice remains at the forefront of care. However the respondents in this survey reported issues around access to education and further development. Workload, lack of funding and lack of study leave mean that education and development are restricted. There is a reliance on charitable support for education and development.

Recommendations

As prostate cancer is predicted to become the most common cancer overall by 2030, consideration of strategic planning should be given to patterns of care delivery and the future workforce. Capacity to provide cancer nursing care needs to be addressed nationally and locally.

Caseload size and work left undone reported in these findings indicate that there are areas where best practice cancer standards cannot be provided due to workloads. Administrative support should be provided to all specialist nurses to ensure that they can release more paid time for patient care. This should extend beyond support for clinic letters.

Urgent attention needs to be given to strategic workforce planning to develop expertise and ensure that the workforce is a sustainable one. Succession planning is essential and development programmes should be established in order to provide cancer patients with cancer nursing care in the future. This should range from entry level opportunities to systems leadership positions, such as consultant level posts, to retain talent and develop services across care settings and different modes of local delivery.

These findings show that there is an unequal distribution of specialist prostate cancer care across the geographical regions of the UK. This inequality needs to be addressed to ensure timely and effective provision of specialist cancer nursing to all men with prostate cancer who need it.

Constant cycles of specialist nurse workforce reviews without tangible outcomes undermine the confidence of staff providing a frontline service and should be stopped.

Provision of education is not equitable, and is heavily reliant on self-funding or pharmaceutical and charitable support to advance knowledge and skills in prostate cancer nursing practice. Specialist nurses in long-term conditions are effective at the management of care but require specific advanced practice skills such as clinical reasoning, physical assessment and access to prescribing courses. In addition, frontline staff require ongoing support to professionally update. Investment in the development of the current and future workforce is necessary to retain talent and plan for the future. Development programmes in leadership that build resilience and address the cultural issues identified in this study should be provided. Strategic planning of education and development of the workforce is also needed.

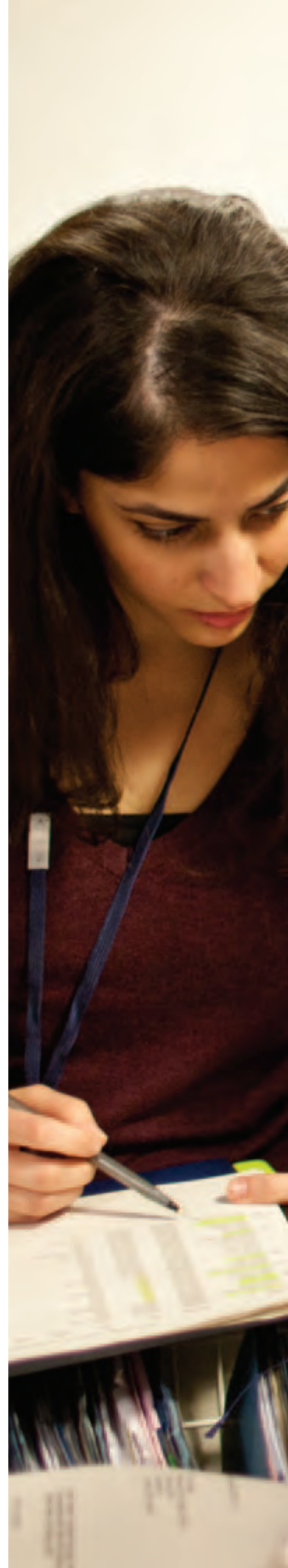
Cultural issues in the provision of multidisciplinary care need urgent attention. Only 128 of the respondents in this survey felt they worked in a functional multidisciplinary team. Workloads, reluctance or inability to address the holistic needs of patients were cited as reasons for suboptimal team working. The multidisciplinary team is the foundation of good cancer care which means that cancer care is at risk of being suboptimal. Work needs to be done to improve multidisciplinary care delivery. The pivotal and complex contribution of the cancer nurse specialist to patient experience and safe, effective care as the key accessible professional should be acknowledged in policy and best practice guidance so that it is clear to colleagues, employers and commissioners of services. Access to leadership development and multidisciplinary team development might also be of benefit.

2. Introduction

Prostate cancer is the most common cancer in men in the UK accounting for 25% of all new cases of cancer and it is predicted to become the most common cancer overall by 2030 (Mistry et al 2011). Over 41,000 men were diagnosed with prostate cancer (114 per day) in the UK in 2011 and over a quarter of a million men are living with and after prostate cancer (Maddams et al 2012). Over the last 40 years prostate cancer incidence rates in Great Britain have more than tripled (CRUK 2014a). Almost three-quarters (74%) of prostate cancer cases are diagnosed in men aged 65 years and over (CRUK 2014b) and it is the second most common cause of cancer death in men, after lung cancer, causing over 10,000 deaths in the UK in 2012 (CRUK 2014c). The National Cancer Patient Experience Survey (NCPES) in England has demonstrated that patients with cancer who have access to a Clinical Nurse Specialist (CNS), generally report better experiences and understanding of the disease (DH 2010, DH 2012, NHS England 2013, NHS England 2014). Despite the known benefits of access to a specialist nurse, the distribution of specialist nurses and incidence-to-nurse ratios vary enormously indicating that there is likely to be inequity of access. In addition, uro-oncology nurses have the highest mean new patient/incidence (159 per WTE) and two year prevalence (247 per WTE) of specialist nurses in England (Macmillan Cancer Support 2014). This work indicates that unlike other cancers, prostate cancer nursing care is rarely provided by a prostate Clinical Nurse Specialist. This is corroborated by the national cancer nursing census which shows that only 2% of the specialist nursing workforce in England is prostate specific – approximately the same number as a rare cancer like sarcoma (Macmillan Cancer Support 2014).

Instead of a dedicated prostate cancer nursing workforce, prostate cancer care is provided by a variety of urology and uro-oncology nurses alongside other specialisms, such as bladder, kidney, testicular and penile cancer, as well as benign disease.

Recent empirical and anecdotal evidence has highlighted issues about the current urology nursing workforce and its ability to meet the future needs of the increasing number of men suffering from prostate cancer and prostate disease. Specialist cancer nursing is widely recognised as an essential part of cancer care, providing technical expertise, meeting information needs, and offering emotional support and coordination (Department of Health 2007). CNSs play a key role in the prostate cancer patient pathway but there is concern that CNS provision is insufficient, inconsistent and inequitable (Trevatt and Leary 2010a), and will be unable to meet increasing demand for specialist cancer nursing care across the UK. In addition there are few opportunities for progression or systems leadership with only three uro-oncology consultant nurse posts currently in England (Macmillan Cancer Support 2014). The challenge must be seen in the wider context of NHS reforms, in particular with respect to tightened budgets and a move to provide more care in the community/primary care settings, rather than in secondary care.





3. Background

Specialist nurse roles have been an informal part of the cancer nursing workforce for many years, with the first formal recognition provided in the Calman-Hine report (DH 1995). A number of drivers have influenced the number and extent of CNS role development over the past two decades including reduced availability of junior doctors, the EU working time directive and the introduction of waiting time targets (DH 1999, 2000). However, in contrast to these reactive drivers for role development, the CNS role was identified as a key component of the English NHS Cancer Plan in 2000. A decade on, the role of the CNS in oncology was reported as ill-defined, with a wide variation in job titles, responsibilities, training and expected competencies (Farrell et al 2011); findings from a study conducted across four NHS Trusts in the UK with uro-oncology nurses working in prostate cancer showed similar wide variation in qualifications, experience and services provided (Ream et al 2009). This is not unique to the UK, with similar problems articulated in Australia (Lowe et al 2012).

Within cancer policy, the value and significance of the post appears to have grown exponentially, from limited referencing in early policy documents (Calman Hine 1995, DH 2000) to more detailed recommendations clearly articulating the role, value, worth and some of the challenges Clinical Nurse Specialists face in terms of variability and access. Later cancer policy (DH 2007, DH 2011) set out clear messages to providers and commissioners about provision and CNS numbers. These documents were further complimented by national reports which defined economic value of the specialist role in terms of quality improvement, increased productivity and efficiency (NCAT 2010, NCAT 2011).

The value and importance of the role was further articulated in The English National Cancer Patient Experience Survey (DH 2010, DH 2012, NHS England 2013, NHS England 2014) which demonstrated a clear relationship between positive patient experience and CNS access. The latest evidence suggests that patient contact with a cancer CNS has increased from 84% (DH 2010) to 89% (NHS England 2014).

Despite all of the English evidence and policy recommendations highlighting role value, CNSs still face challenges from myopic executive boards and trust directors who attempt to make cost savings through reductions of posts or dilution of specialist aspects of the role.

Not all men with prostate cancer are receiving access to a named specialist nurse. Findings from the NCPES in England in 2014 identified that 88% of the 6,288 prostate cancer respondents had been given the name of a CNS who would be in charge of their care, with the poorest trust reporting only 32% (NHS England 2014). According to the National Prostate Cancer Audit, almost all (95%) of the 142 NHS trusts in England provide access to a urological CNS and 67 (47%) provide access to an oncological CNS. The National Cancer Director in England reported that the care provided by nurse specialists was 'one of the most positive aspects of the survey' (Richards 2010). The Welsh Cancer Patient Experience Survey reported that 54% of men in Wales with prostate cancer were given the name and contact details of their key worker (Welsh Government 2014). In Scotland, 76% of prostate cancer patients were given the name of a specialist nurse (Prostate Cancer UK 2013). We do not currently have such data for Northern Ireland, however the first cancer patient experience survey for Northern Ireland was carried out at the end of 2013. The results were not available at the time of writing.

Nurse specialists working in oncology have a key role to play in the provision of palliative care. A recent study has demonstrated that patients who were enrolled in palliative care programmes early after diagnosis of a terminal illness experienced significant improvements in their quality of life and mood, survived longer and had less aggressive care at the end-of-life than patients receiving standard care (Temel et al 2010). Nurse specialists also provide care for cancer survivors, an under-provisioned part of the prostate cancer pathway (Skolarus et al 2013). A specialist nurse-led telephone follow up service for men with prostate cancer, to monitor patients on long-term PSA follow-up, resulted in high levels of satisfaction (Anderson 2010). Whilst this service was initially driven by the desire to reduce the number of patients attending the outpatients' department (Anderson 2010), it has been embedded in the NICE guidelines for the diagnosis and treatment of prostate cancer as a key strategy for follow-up in men with a stable PSA and no significant treatment complications (NICE 2014). A randomised controlled trial (RCT), in which patients with prostate or breast cancer in the experimental arm received internet-based support, found that the most highly-valued part of the online service was email contact with a nurse (Ruland et al 2013).

The need to provide economic evidence of impact is highlighted by the reduction in nurse specialist posts in the US, as part of cost-cutting measures (Dunphy et al 2009). Examples of the economic benefit of CNS roles demonstrated in the UK include: prevention of unnecessary inpatient stay (Graham et al 2012); reduction in unplanned hospital admissions (Baxter and Leary 2011) and readmissions (Petkar et al 2011); in patient pain management (Stenner et al 2011); and improvements in care for people with dementia (Crabtree and Mack 2010). In the field of cancer care, nurse specialists have also developed systems to detect and manage life-threatening complications that patients may suffer whilst at home between treatment cycles (Weaver et al 2007). Whilst the economic evaluation of such improvements in service delivery or patient flow is often rudimentary, an independent report commissioned by the Department of Health identified that one-to-one specialist care for people with cancer could cut the costs of cancer care by £19 million per year (net) (Frontier Economics 2010).

From a workforce perspective, retention of staff in specialist areas is a key concern. Autonomy and empowerment have been identified as key 'magnet factors' in attracting and keeping high quality staff (Armstrong and Laschinger 2006). The examples of CNS activity provided above indicate that nurse specialists in some areas are able to exercise these attributes. However, these features of the role may at the same time alienate the CNS from the managerial structure in which workforce planning is conducted. This points to a clear need to articulate the (economic and patient experience) value of CNS roles to planners and budget holders, such as clinical commissioning groups in England. There is some evidence from England to suggest that conversations are slowly taking place between commissioners about provision of specialist cancer nursing, but this is happening in an inconsistent and fragmented manner (Trevatt and Leary 2010b) and would benefit from national guidance and service specifications.

4. Method

A 24 item survey questionnaire validated in the specialist nursing community was developed for this population. This was transferred to an online survey tool (Survey Monkey secure account). Ethical approval was sought and granted by Plymouth University ethics committee. The survey was developed during April and May 2014 and distributed through formal and informal networks, mailing lists, the nursing press, targeted interest groups such as BAUN, NHS Contact, Help, Advice and Information Network (CHAIN), the UK Oncology Nursing Society (UKONS) and social media (Twitter) during June and July of 2014. Data was exported into Excel and modelled by Mouchel.



There were 302 respondents in total. After cleaning, the data from 285 respondents was used. The other records were removed as they were incomplete submissions or submissions from countries outside of the UK.

Participants in the survey were also invited to provide additional information on areas such as education, workload or any other issues they felt relevant. These free text comments were analysed using thematic content analysis. Each comment was coded and themes emerged from the codes. Data excerpts are included below alongside quantitative findings, to provide context. Excerpts are annotated according to job title and pay band (e.g. CNS/band 6).

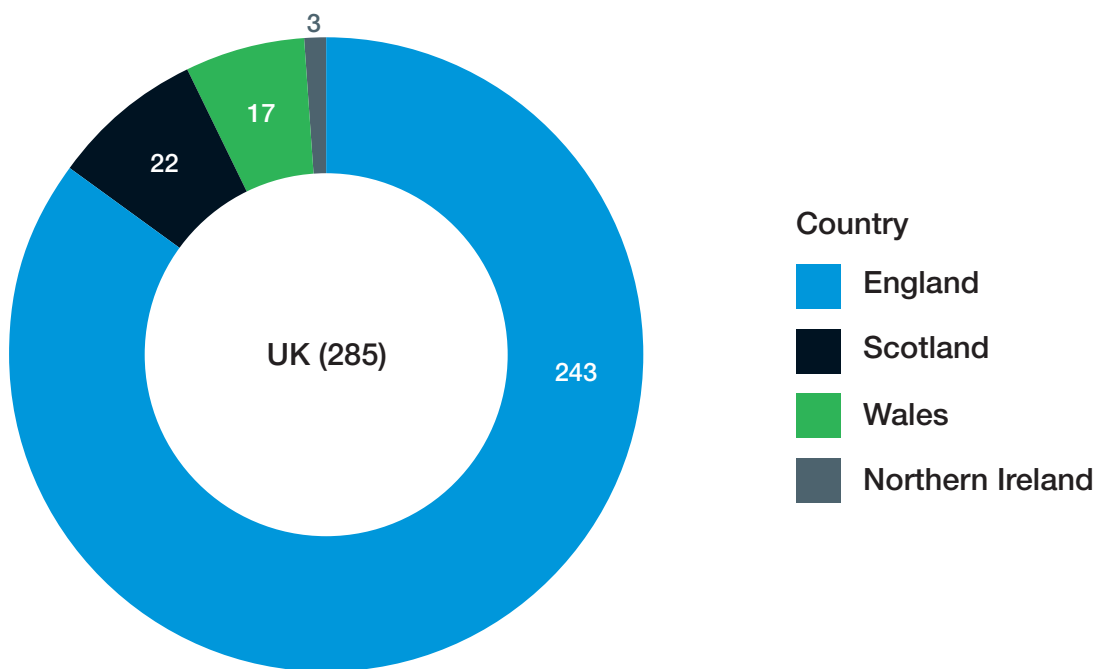


5. The current specialist nursing workforce in prostate cancer care across the UK

This survey was completed across the UK however it should be noted that the four countries of the UK have different cancer policies and systems to deliver cancer care. In addition, the size of the workforce varies significantly and this is reflected in the number of response from each country. Wales and Northern Ireland had the lowest number of responses (Figure 1).

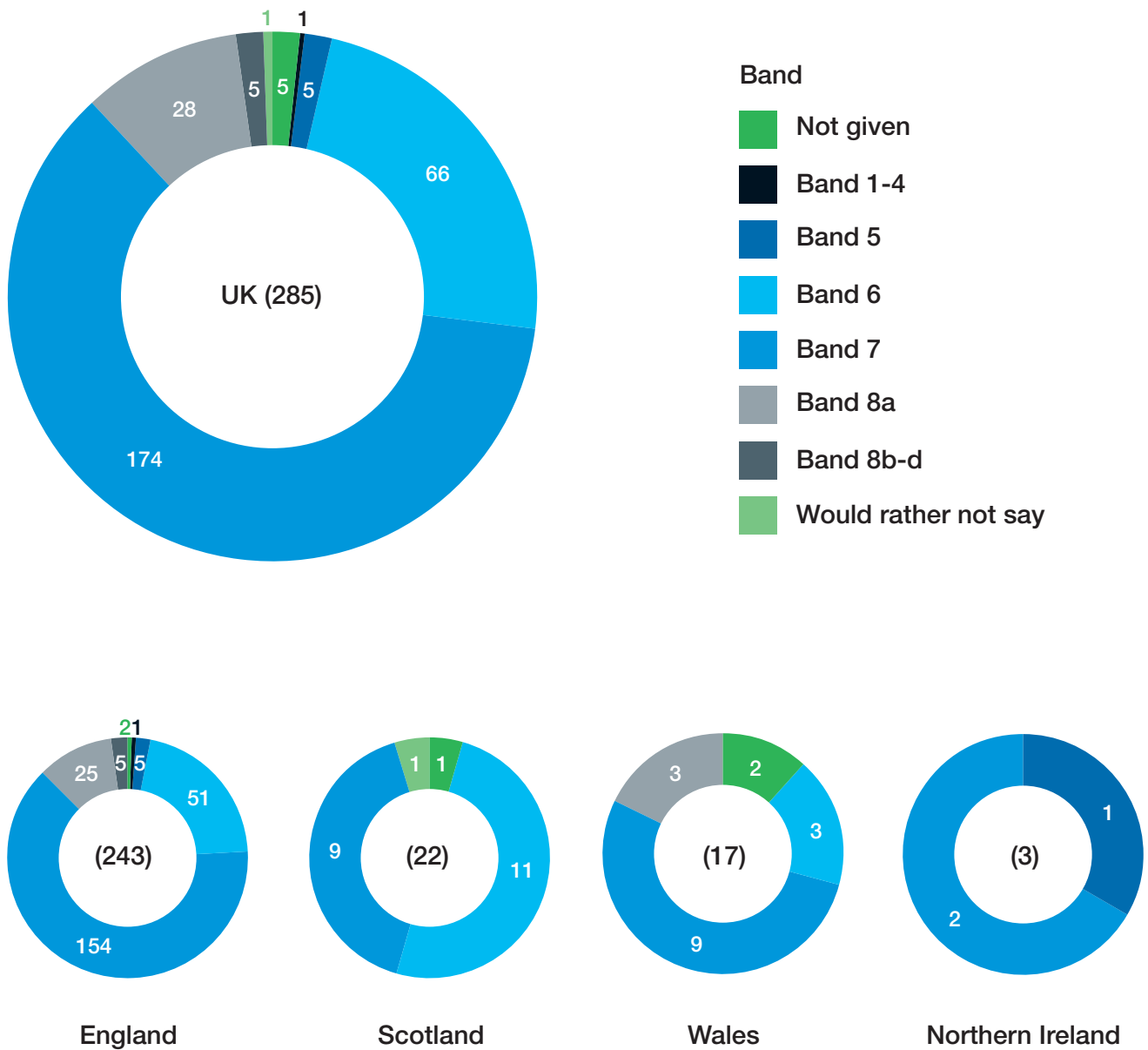
According to the survey results, the number of nurses providing specialist care to men with prostate cancer across the UK is shown in Figure 1.

Figure 1: Response by country



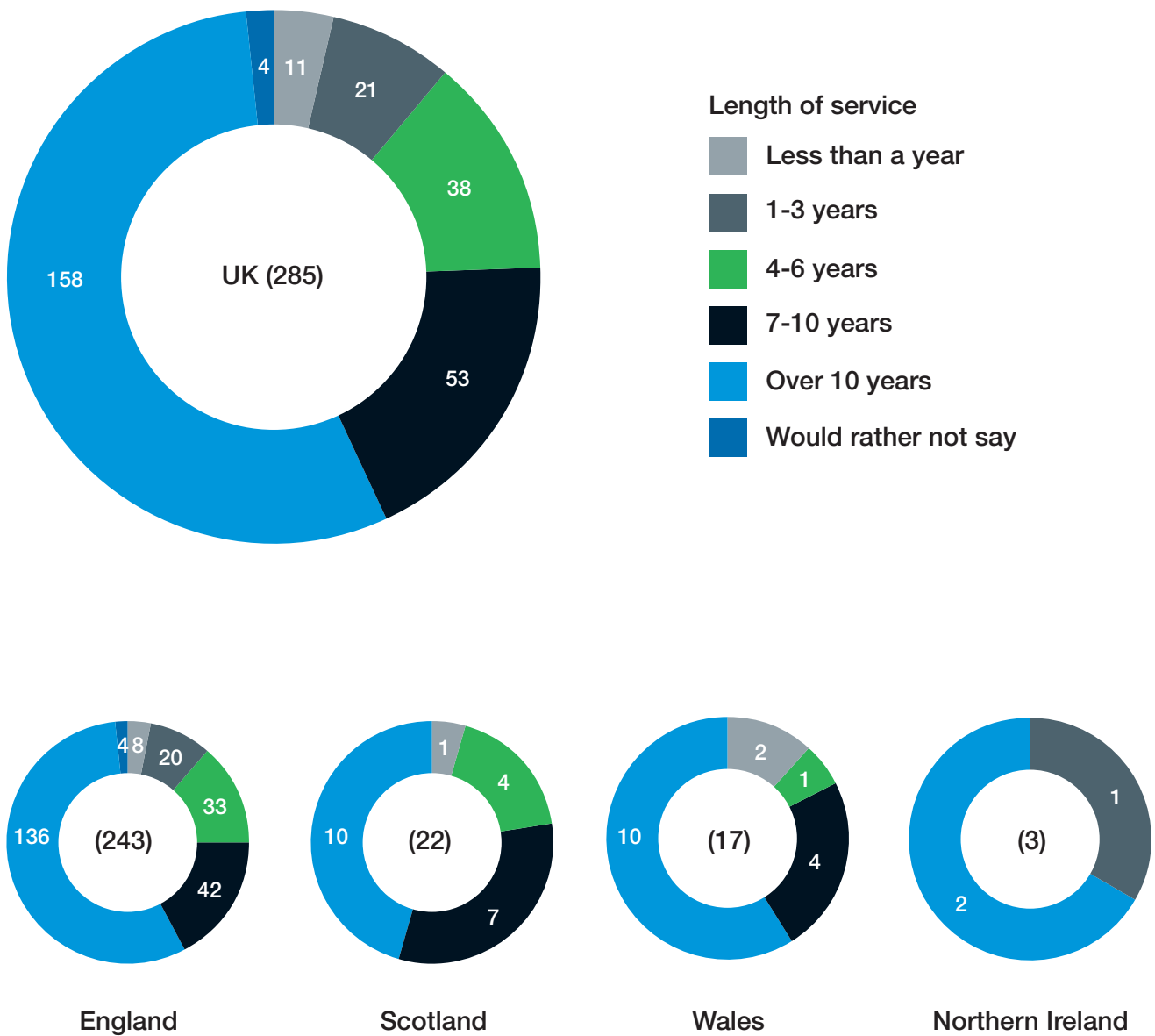
The majority of the group is at band 7 (174). However there are 66 band 6 posts. In Scotland, band 6 is the most frequently declared grading – representing 50% of the declared posts (Figure 2).

Figure 2: Pay band by headcount by country



158 (55%) of the 285 respondents said they had been in post for 10 years or more (Figure 3). Only in Scotland were there more than 50% of nurses who had been in post less than 10 years.

Figure 3: Workforce by country and length of service



Caseloads of 201-300 patients and greater than 600 patients were the most commonly recorded by respondents (Figure 4).

Figure 4: Caseload by band

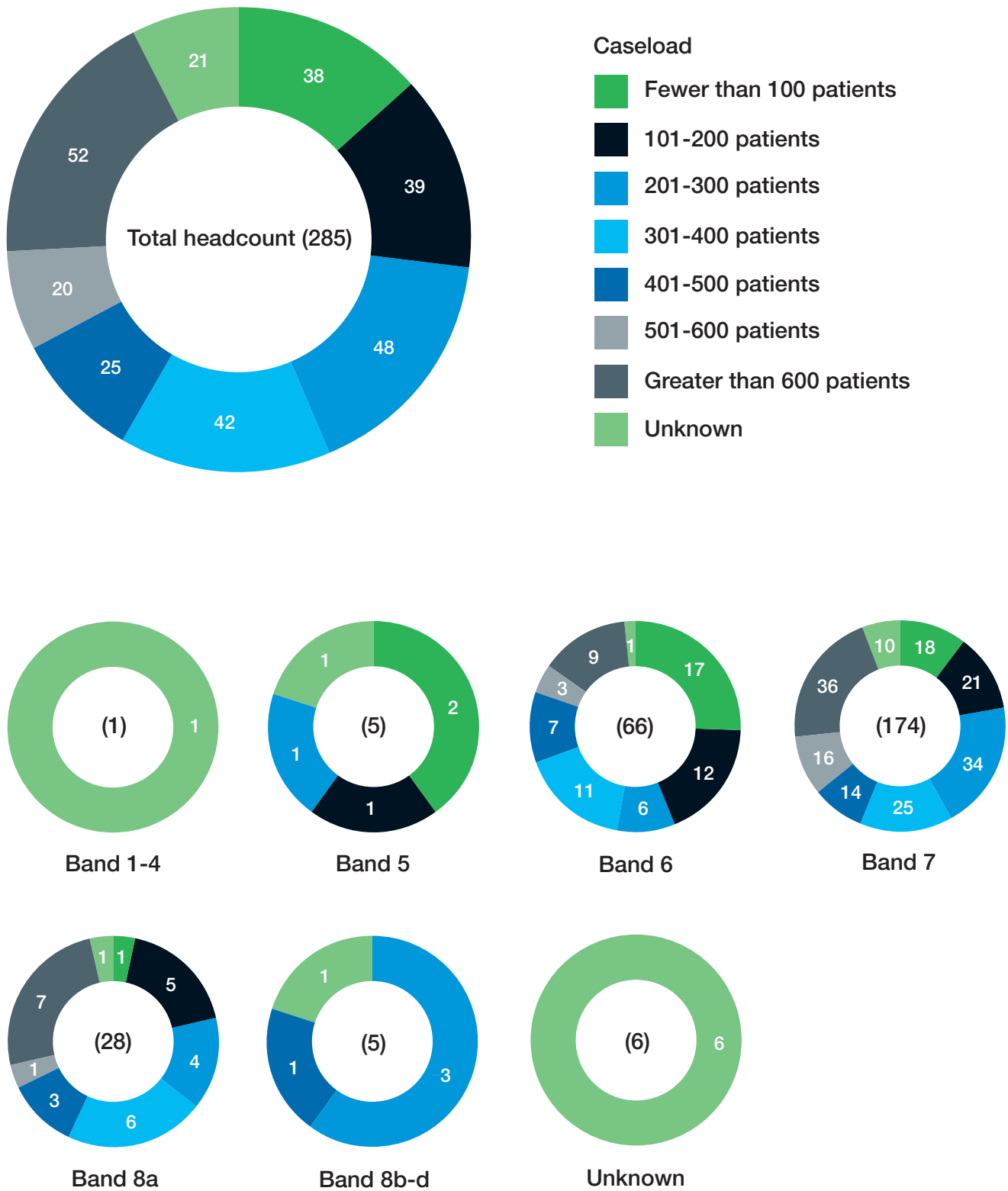
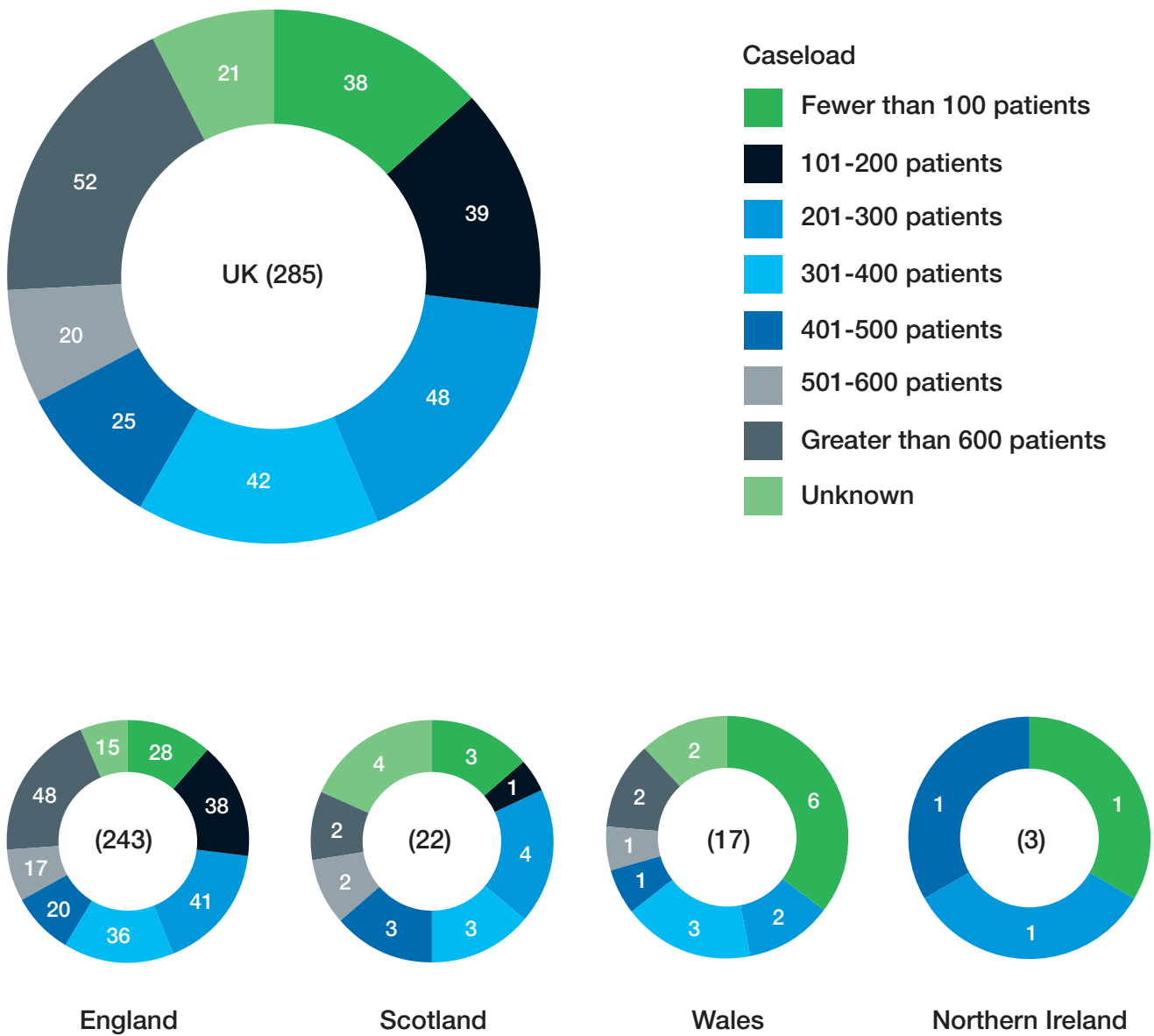


Figure 5: Caseload by country





Don't Ask to Thrive
LCCJ
Preston Clinical Nurse Specialist
George Clark

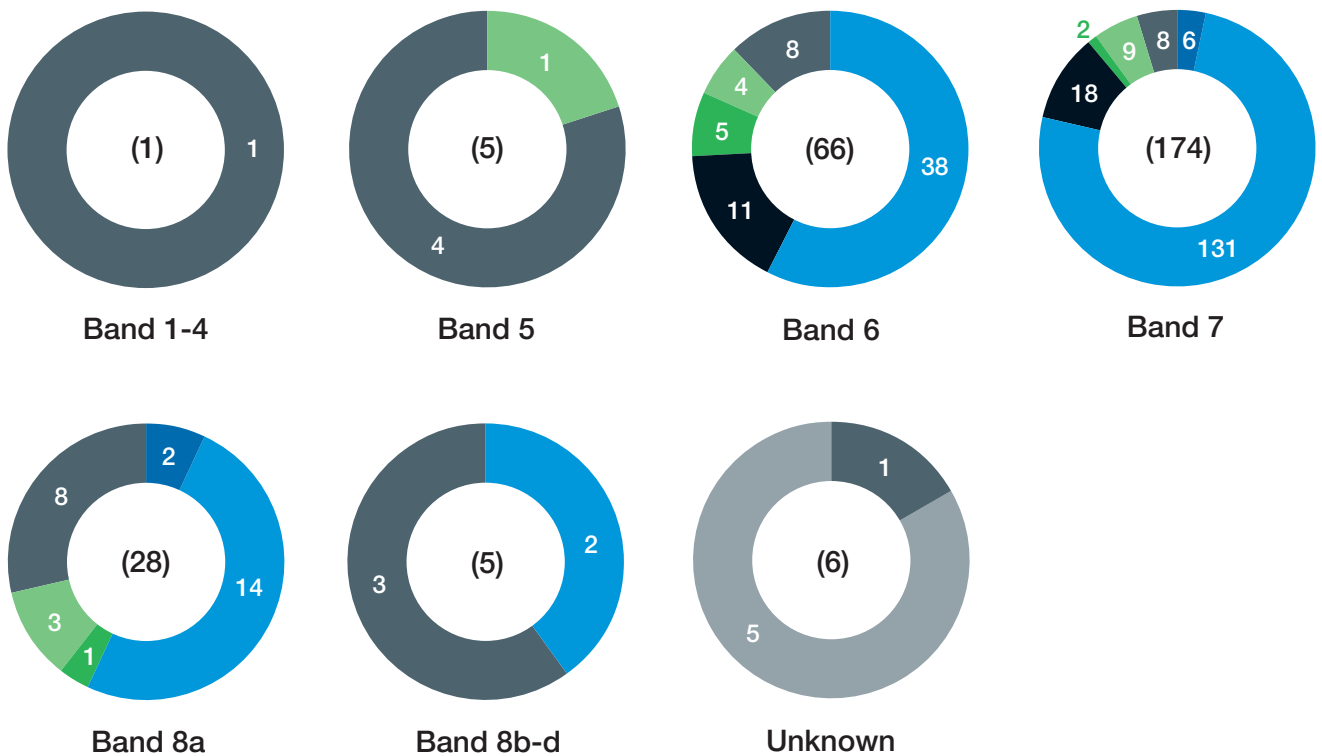
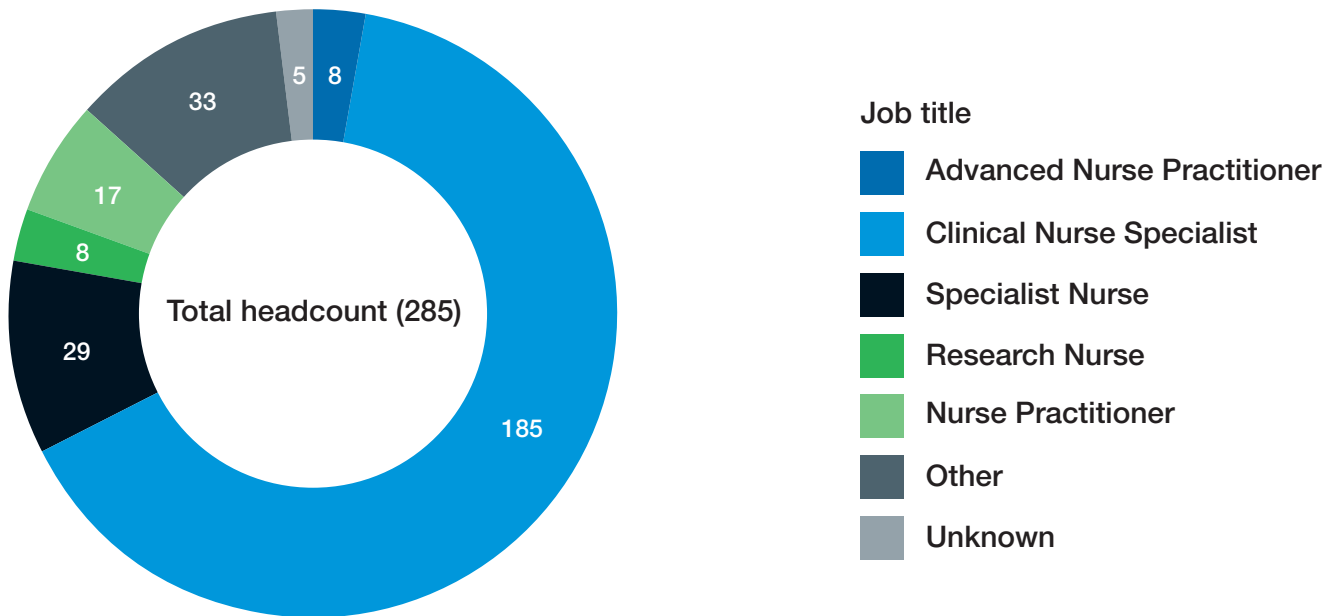
British Uro-oncology Group (BUG)

BRITISH URO-ONCOLOGY GROUP (BUG)

Preston Clinical Nurse Specialist
George Clark

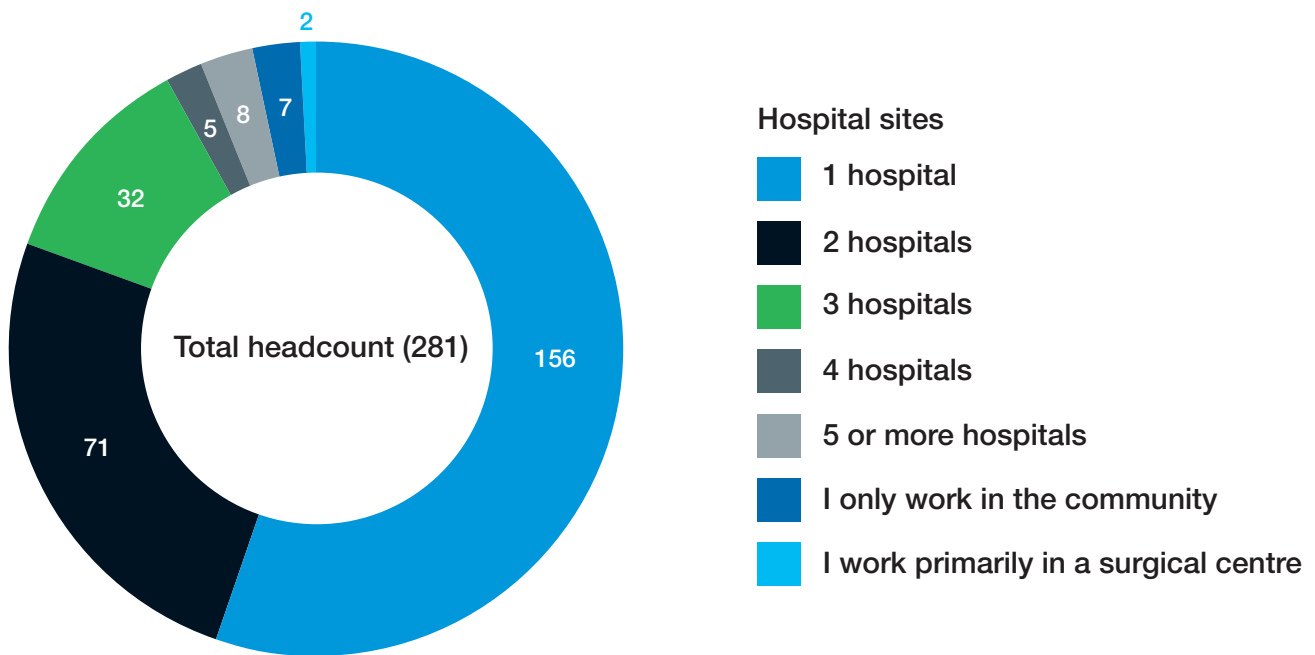
In line with the UK specialist cancer nursing census (Macmillan Cancer Support 2014) the most common job title was Clinical Nurse Specialist with a count of 185 (Figure 6). It is interesting to note the presence of one band 5 and four band 6 Nurse Practitioners. This role is usually associated with advanced practice roles.

Figure 6: Job title by pay band



Respondents were asked how many hospital sites they covered. 281 nurses responded to this question. Most nurses (156) cover one hospital site, however eight cover more than five hospital sites (Figure 7).

Figure 7: The number of hospital sites covered by each respondent



The free text responses also indicated that mergers in response to financial pressures presented challenges to multi-site working:



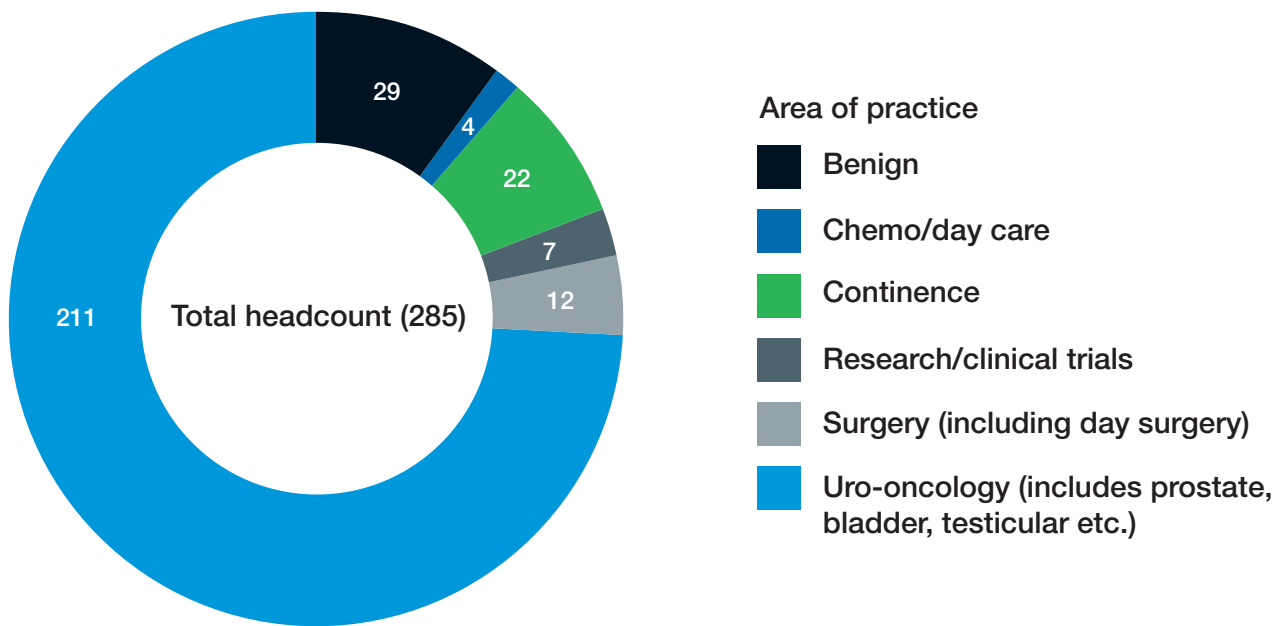
Between a team of three uro-oncology CNSs who cover all five urological cancer sites we cross cover each other when a CNS is on leave which includes cross covering all CNS nurse-led clinics. Our nurse-led clinics are rarely cancelled.

(CNS, band 7)

Area of practice

Respondents were asked to declare their main area of practice – the setting in which they spent over 50% of their time. 285 responded to this question. The majority worked in a uro-oncology setting (Figure 8) but there is an interesting mix of those working in benign and continence settings. Unlike other cancer sites, which have disease specific specialist nurses, prostate cancer care is delivered by a range of practitioner groups.

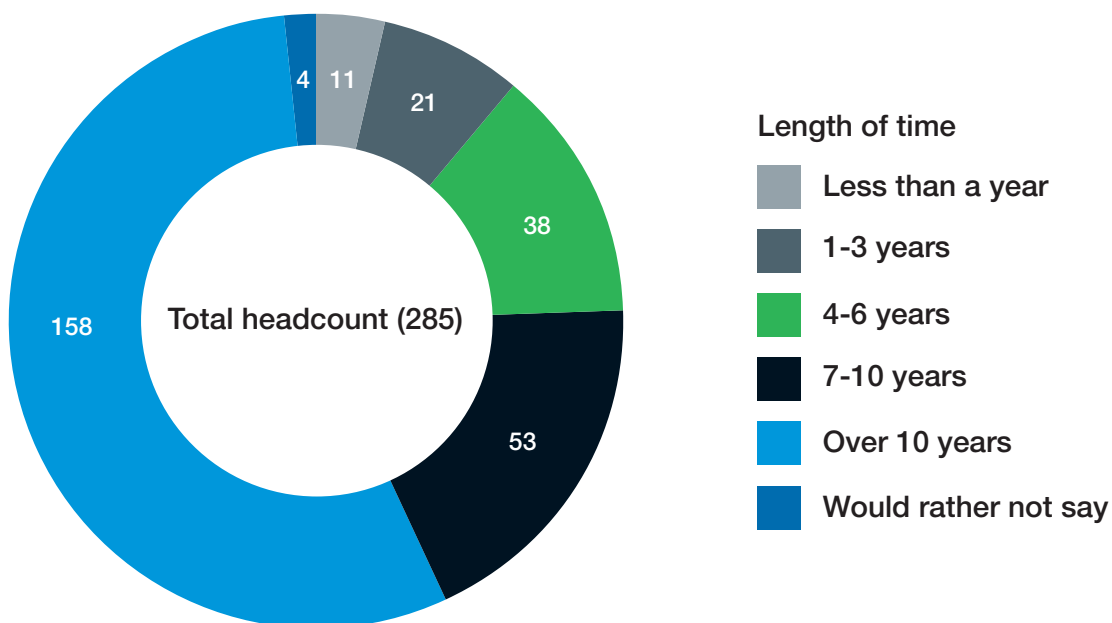
Figure 8: The declared main area of practice



Time spent working in prostate cancer care

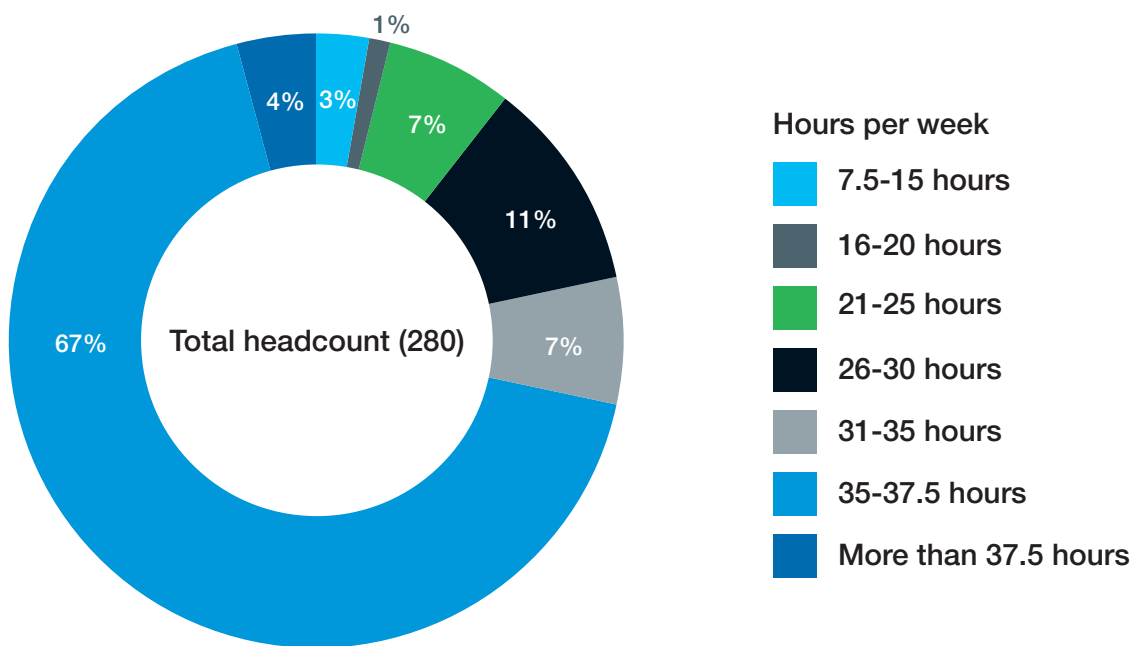
The group declared a range of years working in prostate cancer care. 158 had worked in the field for more than 10 years. Only 32 had worked in the field for less than 3 years (11%) (Figure 9).

Figure 9: The declared length of time in prostate cancer care



Of the 280 nurses who responded to the question relating to hours of work, 189 were contracted for 37.5 hours per week. 11 were contracted for over 37.5 hours per week (Figure 10).

Figure 10: Hours of work



The majority of posts were full time (189), however the range of time spent working with prostate cancer patients was variable (Figures 11 and 12). Only 23 posts spent 100% of their time caring for men with prostate cancer. 35 nurses spent less than 30% of their time caring for men with prostate cancer, offering some specific services such as continence or erectile dysfunction services, or because no uro-oncology post was available (see Figure 14 on p26).

Figure 11: Proportion of week nurses spent working on prostate cancer

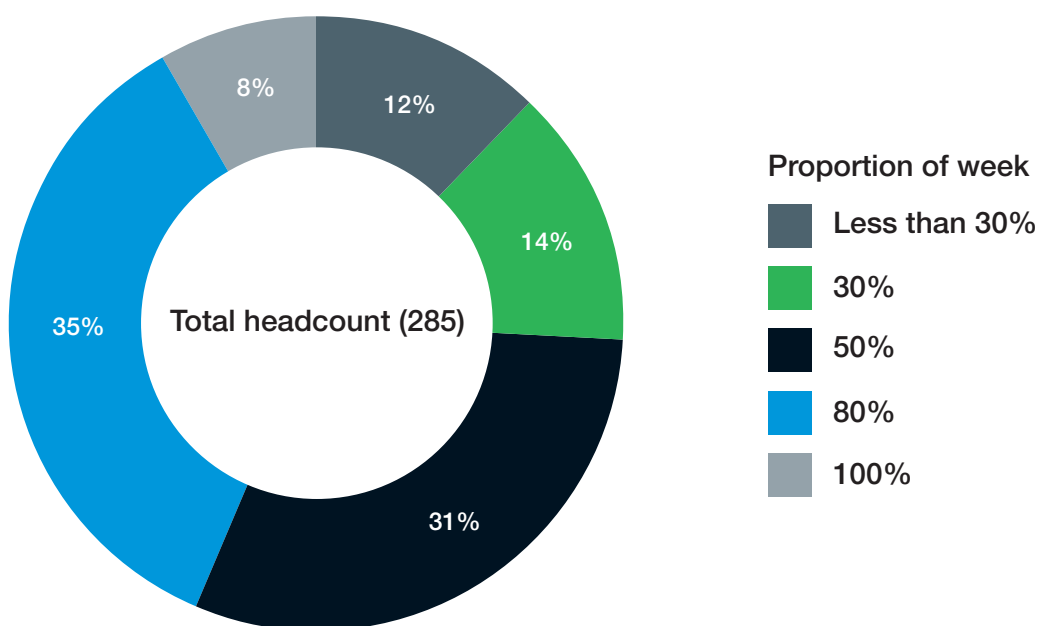
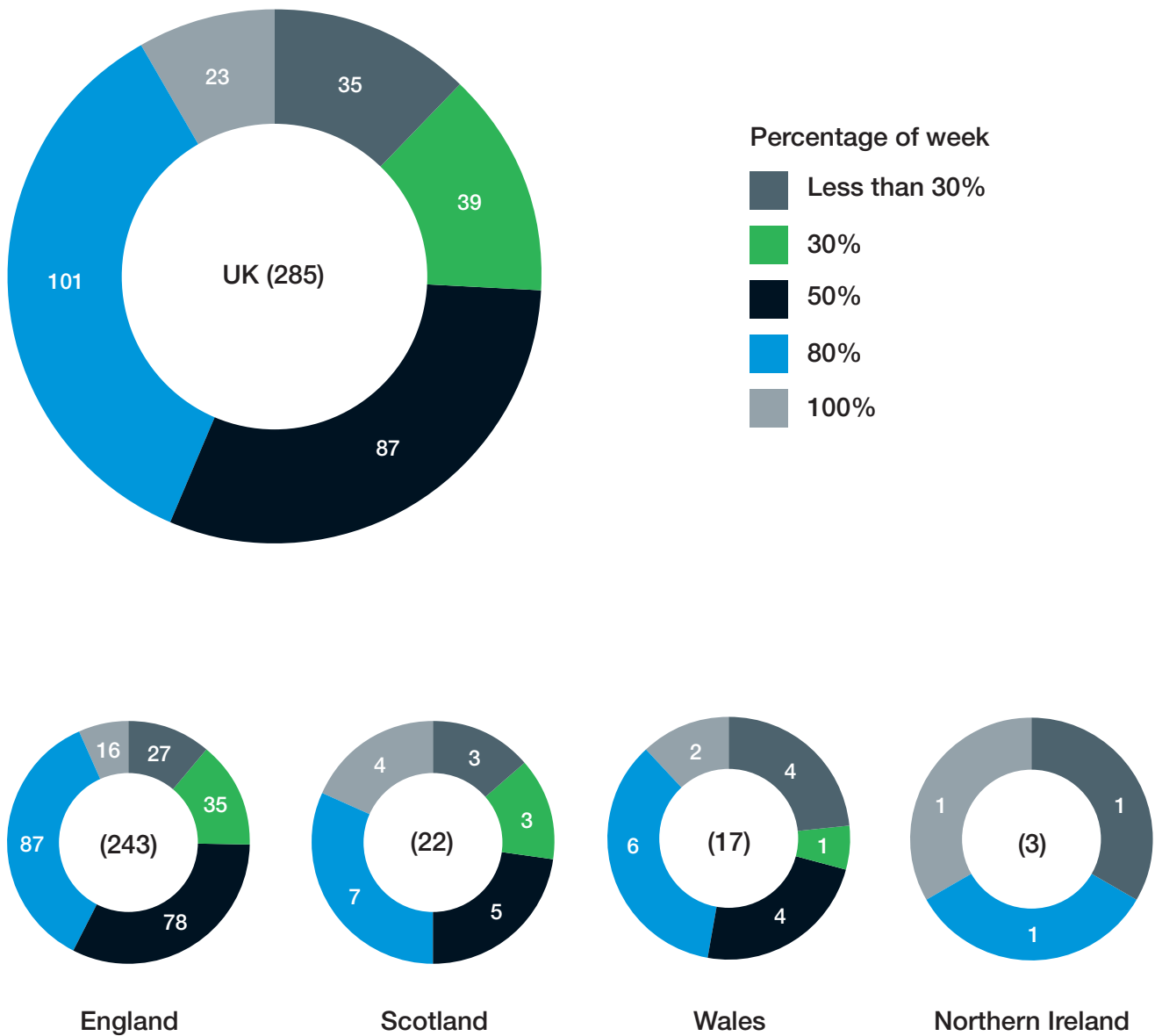


Figure 12: Percentage of week nurses spent working on prostate cancer by country



The free text responses also reflected the challenge of covering multiple services:



I work with benign and cancer patients. Find it difficult to give the cancer patients the time that they may need due to the workload balance. Currently trying to bid for administration hours and more nursing hours for the benign patients.

From these data it is possible to look at a calculated Whole Time Equivalent (WTE) delivering prostate cancer care by geography. This distribution can be seen in Figure 14.

Figure 13: Proportion of week nurses spent working on prostate cancer by pay band

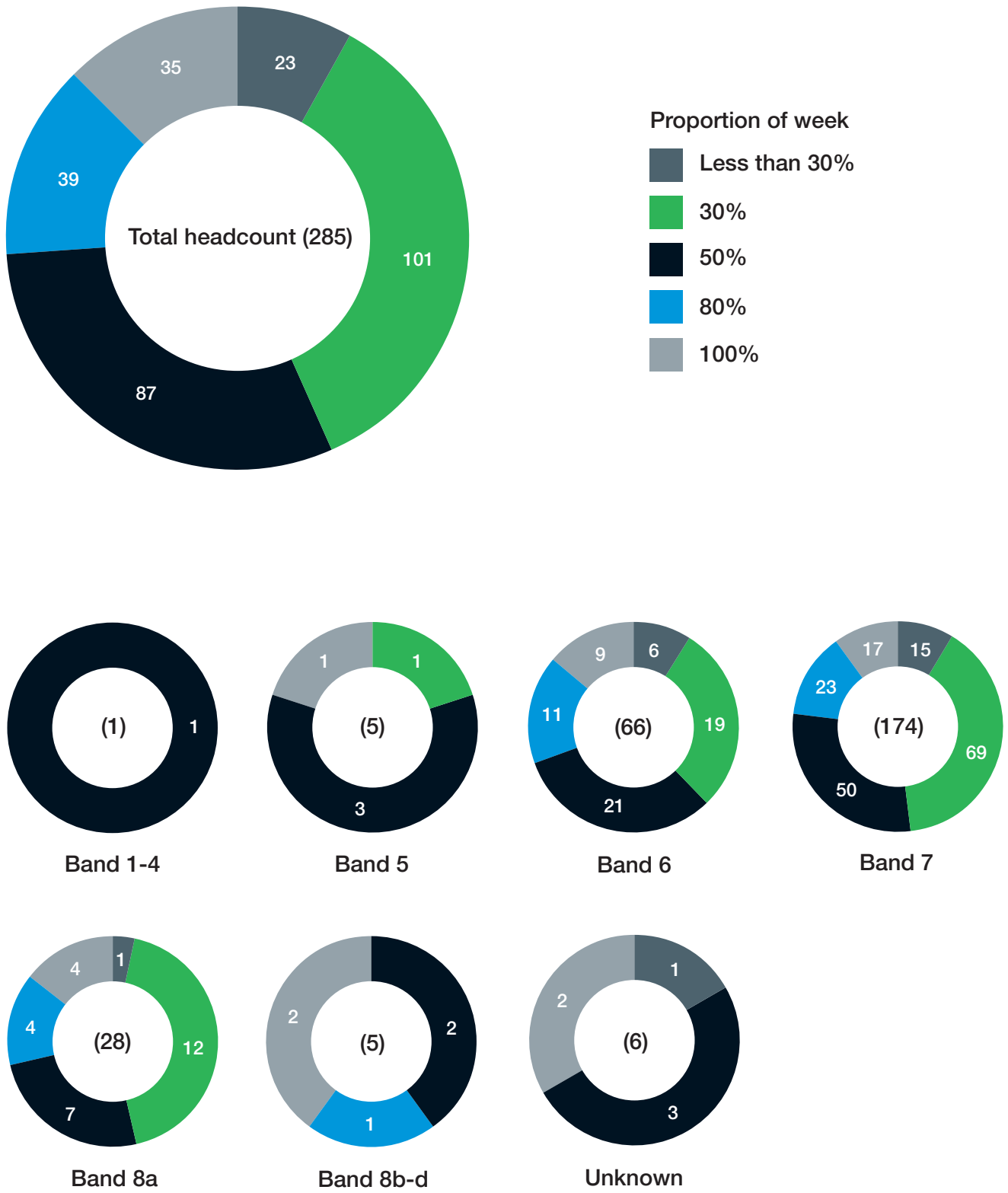
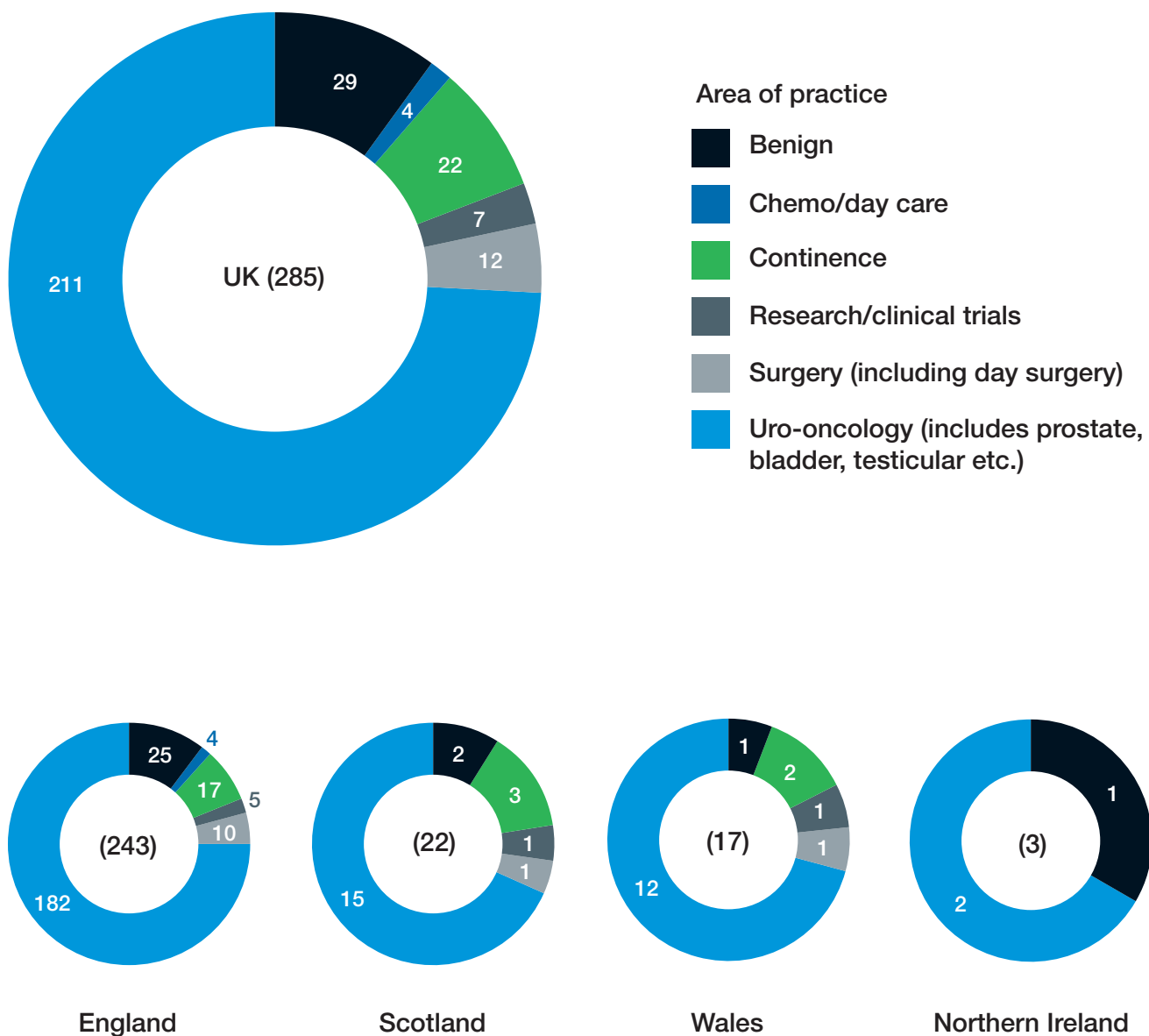


Figure 14: Whole Time Equivalent (WTE) by geographical distribution

	<i>Network</i>	<i>Benign</i>	<i>Chemo/day care</i>	<i>Continence</i>	<i>Research/clinical trials</i>	<i>Surgery (including day surgery)</i>	<i>Uro-oncology (includes prostate, bladder, testicular etc.)</i>	<i>Total</i>
ENGLAND	Cheshire and Merseyside	0.8	0.0	0.0	0.0	0.5	1.2	2.5
	East Midlands	0.0	0.3	0.0	0.0	0.8	3.0	4.0
	East of England	0.2	0.0	0.2	0.6	0.0	16.4	17.4
	Greater Manchester, Lancashire and South Cumbria	0.8	0.2	0.3	0.0	0.0	13.2	14.4
	London	1.4	0.0	1.2	0.0	0.0	16.3	18.9
	Northern England	0.0	0.0	0.3	0.3	0.4	4.0	5.0
	South East Coast	0.5	0.7	0.0	0.0	0.0	11.6	12.8
	South West Coast	1.1	0.1	0.7	0.4	1.0	13.2	16.6
	Thames Valley	0.0	0.0	0.0	0.0	0.0	2.1	2.1
	Wessex	0.7	0.0	0.8	0.0	0.5	7.3	9.3
	West Midlands	0.4	0.0	0.1	0.0	0.6	7.0	8.1
	Yorkshire and the Humber	0.9	0.0	1.0	1.5	0.0	6.7	10.0
WALES	North Wales	0.0	0.0	0.0	0.0	0.0	1.0	1.0
	South Wales	0.0	0.0	0.1	0.5	0.1	6.8	7.6
NI	Northern Ireland	0.3	0.0	0.0	0.0	0.0	2.0	2.3
SCOTLAND	NHS Grampian	0.0	0.0	0.0	0.3	0.8	2.3	3.4
	NHS Highland	0.0	0.0	0.0	0.0	0.0	0.8	0.8
	NHS Orkney	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	NHS Shetland	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	NHS Tayside	0.3	0.0	0.0	0.0	0.0	0.3	0.6
	NHS Western Isles	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	NHS Borders	0.0	0.0	0.0	0.0	0.0	0.8	0.8
	NHS Dumfries and Galloway	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	NHS Fife	0.0	0.0	0.0	0.0	0.0	2.2	2.2
	NHS Lothian	0.0	0.0	0.1	0.0	0.0	1.0	1.1
	NHS Ayrshire and Arran	0.8	0.0	0.0	0.0	0.0	0.5	1.3
	NHS Forth Valley	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	NHS Greater Glasgow and Clyde	0.0	0.0	0.1	0.0	0.0	1.3	1.4
NHS Lanarkshire	0.0	0.0	0.0	0.0	0.0	0.5	0.5	
Total	8.1	1.3	5.0	3.5	4.7	121.3	144.0	

Figure 15: Area of practice by country

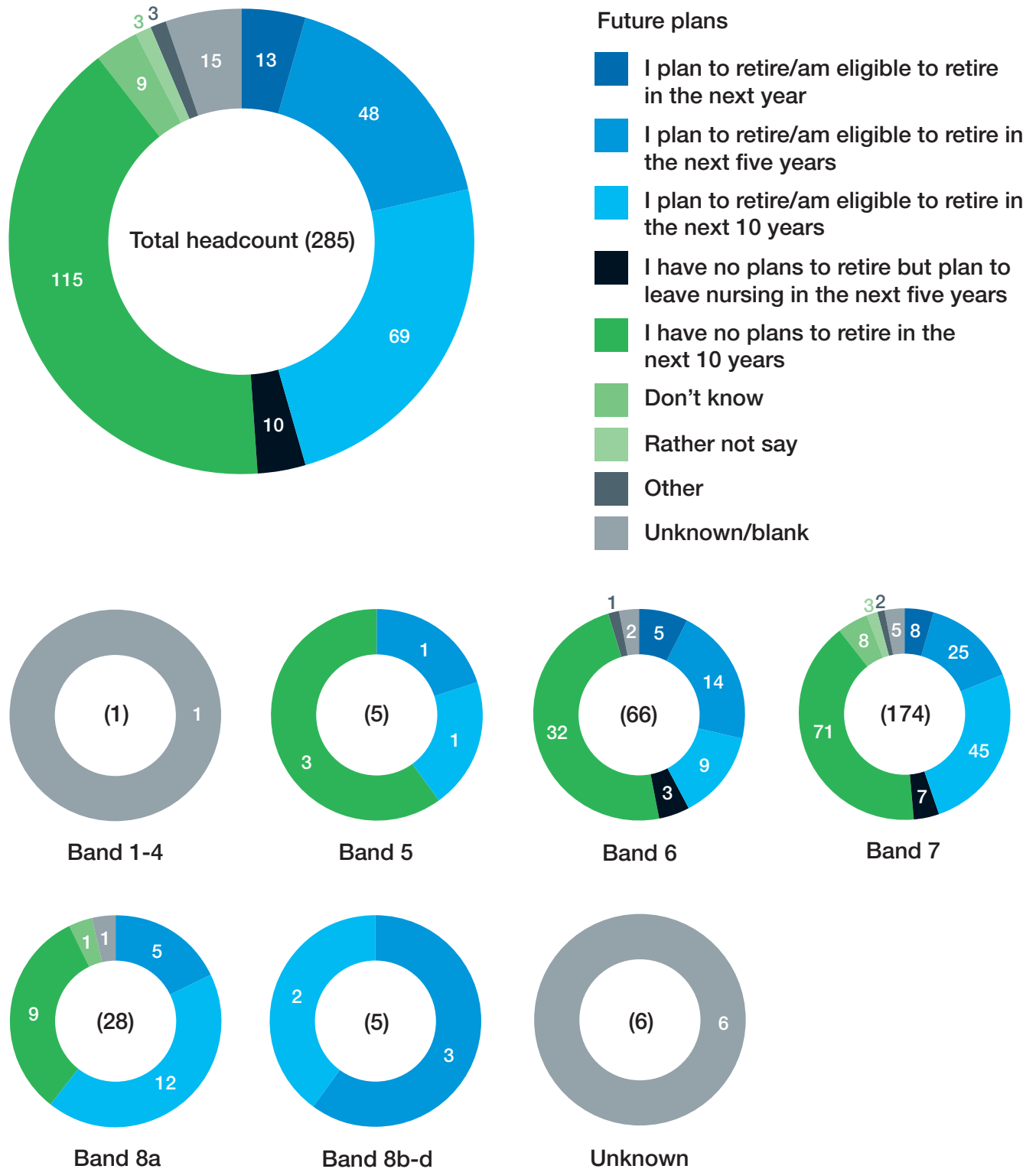


211 (74%) of UK respondents said they worked in uro-oncology.

The intention of the workforce

140 (49%) of the 285 respondents to this question declared an intention to retire or leave the profession within the next 10 years. Of this group 58 declared an intention to leave in the next five years and 13 within the next year (Figure 16). This will represent a substantial loss of expertise and talent if succession planning is not considered. This finding reflects the English national census which shows an ageing workforce in cancer nursing with 33% of the specialist nursing workforce now over the age of 50 (Macmillan Cancer Support 2014).

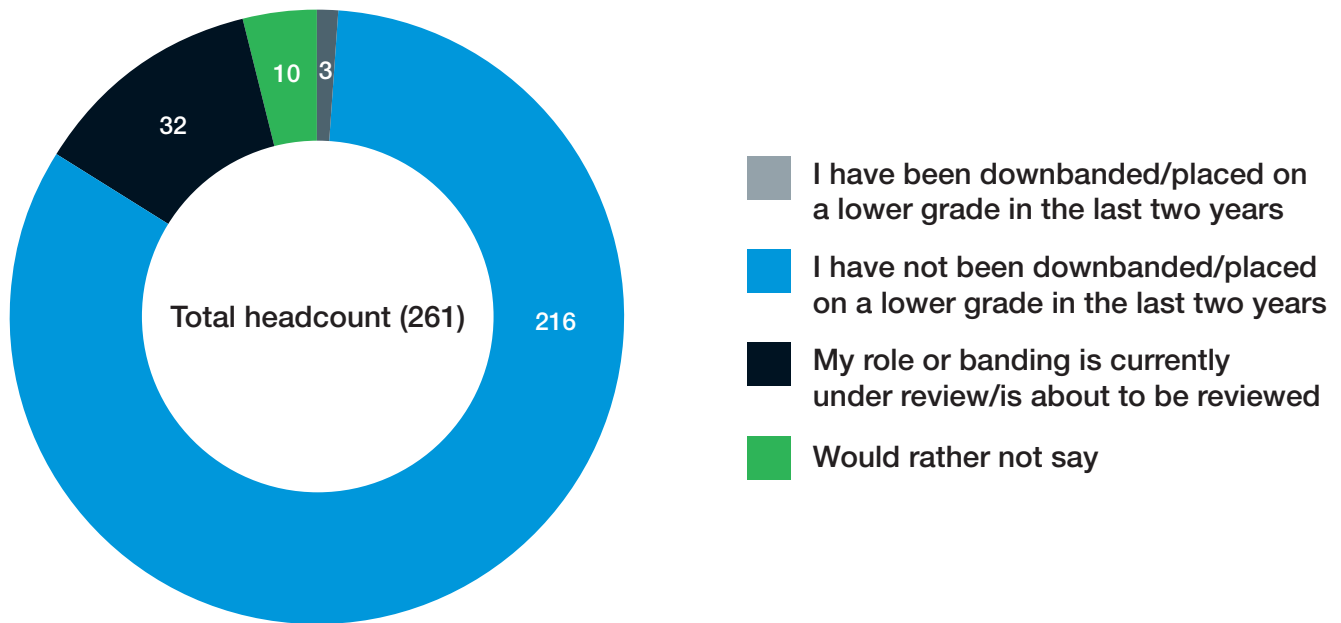
Figure 16: The stated future plans of the workforce by band



Current workforce issues

In response to asking about changes in pay band or current situation, 261 nurses responded. The workforce appears to have experienced little down banding (three people declared they had been down banded), however 32 nurses currently have their posts under review. 13 nurses were successful in obtaining a higher banding. 10 people chose to answer the question with “would rather not say” (Figure 17).

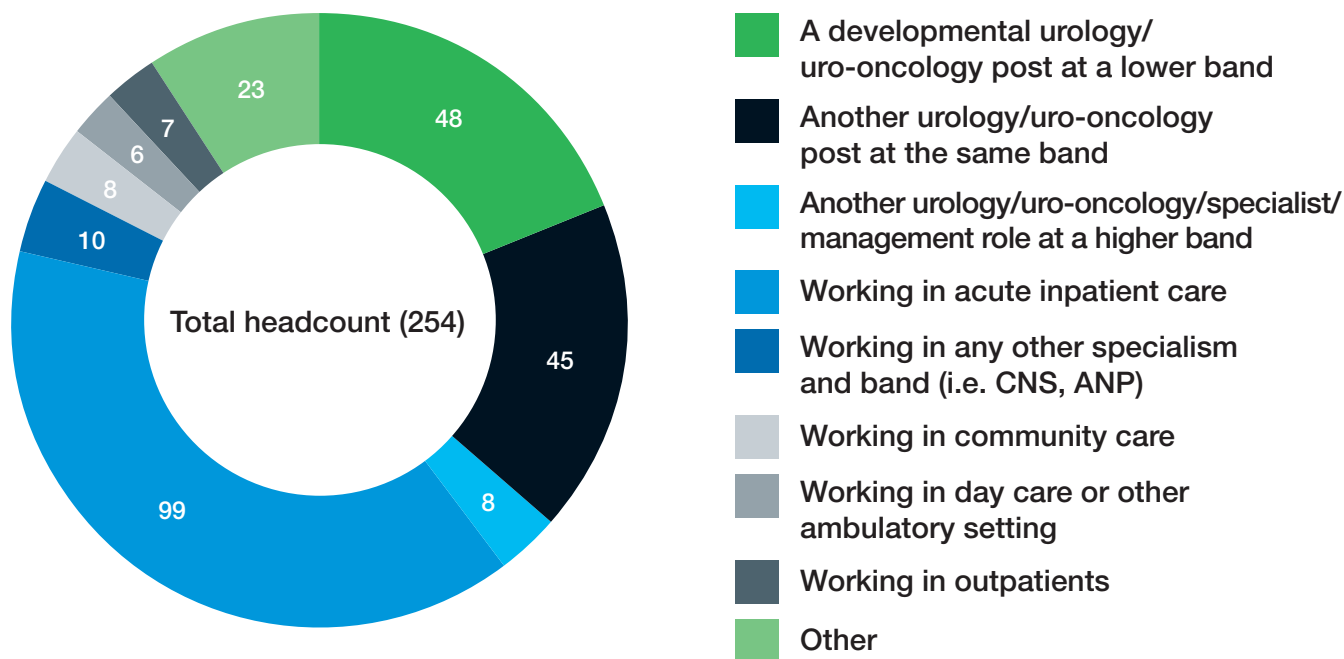
Figure 17: Experience of nurses with respect to banding and employer review



The respondents declared unfilled or frozen posts. This equated to 58.3 full time equivalents (FTE) across the UK. This does not reflect need for posts but only posts currently unfilled. One respondent cited 3.6 Whole Time Equivalent (WTE) posts unfilled.

254 nurses answered a question on the role they had immediately before the specialist role they have now (Figure 18). The largest group (99) had a previous role in acute inpatient care. Only 48 had come to a specialist role via a development post, 19% of those who responded (Figure 18), but there also appears to be horizontal (45) and downwards (8) movement. With only three consultant posts in this speciality (Macmillan Cancer Support 2014), lateral movement is not unsurprising.

Figure 18: Role immediately before current specialist role



The lack of a career structure for uro-oncology roles was a recurrent theme in the qualitative comments. One respondent noted that lack of specialism at ward level means recruitment to specialist uro-oncology posts is “a major problem... with no good candidates to take up the role of Urology Nurse Specialist”. There was also a sense of isolation for nurses working as the single-handed CNS for urology in a trust.

Workforce reconfiguration was clearly underway in some trusts with some respondents on a fixed-term contract, a secondment or a post funded by charity income with no sense of longevity for the role. Some identified that this was part of a wider review of CNS posts, with one respondent stating that:



For the second time in four years, we have been told posts will be lost or downgraded.

The shift towards more community-focused care provision was seen as a threat to hospital-based posts, rather than the post-holder having the opportunity to take on more community specialist care provision. The move towards more integrated primary and secondary care trusts in some parts of the UK may be more encouraging for services such as uro-oncology.

The sense of threat to the role in some trusts was also evident. One respondent spoke of the need to “ensure I have evidence to demonstrate the benefits of our role and grading”. Several respondents identified areas of the service they would like to develop such as “services for African Caribbean men with prostate cancer”, or better “transition from hospital to home for men with prostate cancer”, but developing these ideas or applying for additional funding was not seen as feasible with the current workload.



6. Workload

The complex work of specialist nurses in caring for men with prostate cancer

The complexity of care is comparable to other specialist nurses across an entire disease trajectory. The survey asked the nurses what interventions they performed at different points of the patient pathway. The nurses were asked to state which interventions they provided most of the time (more than 70%) for prostate cancer patients across the prostate cancer journey. 258 nurses responded.

The response included a wide array of complex interventions. Some of these were almost universal for example meeting the information needs of patients and families which occurs at all parts of the patient pathway, as do psychological interventions, physical assessment, requesting imaging and laboratory tests, and the prescribing or recommendation of medicines. Some interventions were more focussed to a specific part of the pathway, for example 45 respondents declared that they performed procedures (e.g. biopsy) in order to diagnose prostate cancer. The distribution of this response can be seen in Figure 19.

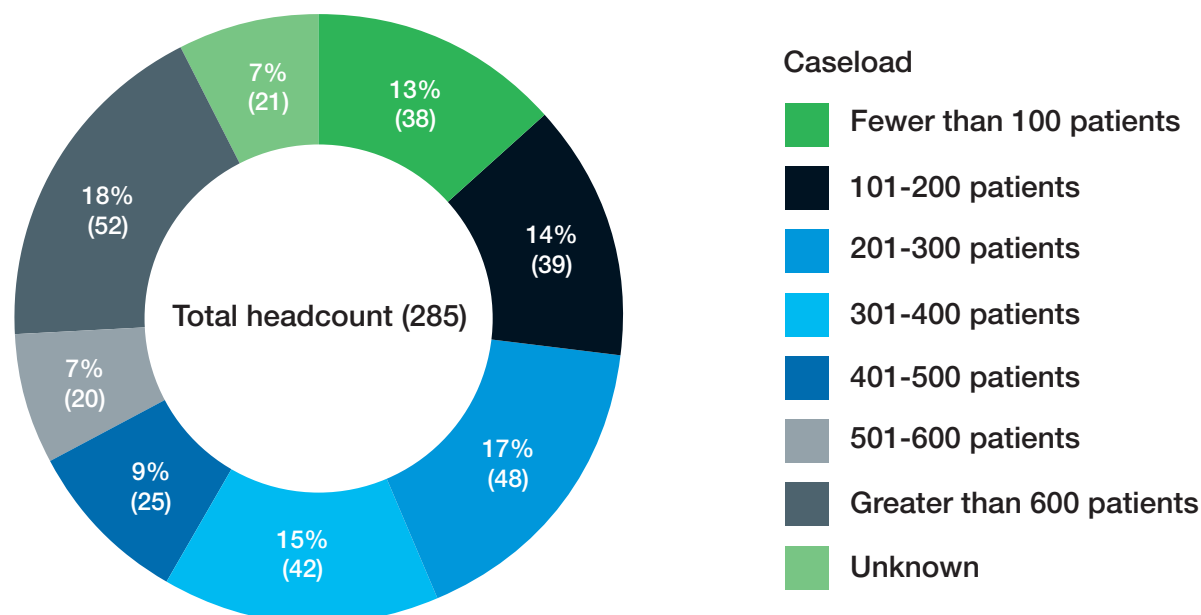
Figure 19: The scope of specialist nursing work

	<i>Triage referrals</i>	<i>Physical assessment</i>	<i>Symptom control</i>	<i>Recommending medication</i>	<i>Prescribing medication</i>	<i>Requesting labs/imaging</i>	<i>Performing procedures, e.g. biopsy</i>	<i>Meeting information needs of patients and family</i>	<i>Psychological interventions</i>	<i>Social interventions/benefits advice</i>	<i>Formal Holistic Needs Assessment</i>	<i>Referrals</i>	<i>I do not see patients routinely during this time</i>	<i>Total</i>
Before diagnosis	72	67	67	66	18	107	25	136	89	43	42	75	45	852
Diagnosis	48	52	110	106	26	114	11	180	155	128	99	109	18	1156
Post diagnosis	56	60	147	127	25	132	9	186	163	134	94	124	12	1269
Treatment	47	51	146	123	26	108	7	184	144	102	70	109	16	1133
End of treatment	33	36	111	87	19	94	4	148	123	94	78	99	21	947
Follow up/stable disease	60	77	147	136	29	137	9	174	146	108	81	122	16	1242
Continence	48	53	133	119	32	67	5	158	94	60	43	118	18	948
ED	50	45	96	119	32	67	5	158	94	60	43	118	18	905
Progressive disease	53	42	108	95	21	102	7	159	112	89	71	109	17	985
End of life care	27	19	46	38	6	38	3	97	66	51	29	77	53	550
N/A	79	61	13	20	134	42	134	6	15	32	41	26	66	669
Total	573	563	1124	1036	368	1008	219	1586	1201	901	691	1086	300	10656

Caseload and workload

There was a wide variation in the declared caseloads. Of 285 responses, 38 nurses (13%) declared a caseload of less than 100 whilst 52 (18%) had a caseload of greater than 600 (Figure 20). The most common response was those with a caseload of 600 plus. It is unlikely that a caseload of this size would allow for proactive case management.

Figure 20: Caseloads carried by the respondents



Workload carried by the individual uro-oncology nurses was variable, particularly in terms of the range of patient problems/diagnoses covered.

Work left undone

Over half of the respondents (163) declared that they were unable to provide best practice nursing interventions (less than 30% of the time) for patients at one or more points in the cancer journey (Figure 21).

The most frequent interventions not performed were formal Holistic Needs Assessments (HNA), prescribing or recommending medication, and meeting information needs. Both meeting information needs and assessing needs from a holistic perspective form part of national cancer policy in England (DH 2011), and are also considered best practice in cancer care across the rest of the UK.

Figure 21: The distribution of work left undone

	Triage referrals	Physical assessment	Symptom control	Recommending medication	Prescribing medication	Requesting labs/imaging	Performing procedures, e.g. biopsy	Meeting information needs of patients and family	Psychological interventions	Social interventions/benefits advice	Formal Holistic Needs Assessment	Referrals	I do not see patients routinely during this time	Total
Before diagnosis	21	17	11	5	16	14	19	15	10	13	20	7	13	181
Diagnosis	7	18	10	5	21	15	13	10	10	12	25	4	2	152
Post diagnosis	6	15	13	5	23	14	8	10	10	10	26	5	2	147
Treatment	4	15	9	4	25	14	8	9	9	11	28	4	2	142
End of treatment	4	14	11	4	21	8	7	13	12	12	30	4	5	145
Follow up/stable disease	4	14	11	7	25	14	5	10	11	11	24	7	3	146
Continence	2	10	11	5	22	7	5	10	9	7	17	6	3	114
ED	2	12	12	7	23	6	5	7	8	8	15	5	4	114
Progressive disease	3	16	17	7	24	11	6	13	13	13	24	7	2	156
End of life care	5	9	11	6	16	7	5	12	13	13	17	7	10	131
Total	58	140	116	55	216	110	81	109	105	110	226	56	46	1428

Qualitative data showed that workload was deemed to have an impact on patient care, in particular capacity to undertake formal Holistic Needs Assessment:



Holistic Needs Assessments are offered and patients have to ring/see us for them to be done. No capacity for us to initiate contact.

(CNS, band 6)



Capacity means I do not have opportunity/time to complete HNA.

(CNS, band 7)



HNA not done formally; assessment of needs done routinely.

(CNS, band 8b)



Unfortunately I do not have time to carry out a HNA due to workload pressures.

(Specialist nurse, band 7)



We have a full clinical programme all week and will need to stop doing ‘something’ to add a formal HNA clinic.

(CNS, band 7)

For some there was also a frustration at not being able to see patients at all stages of the pathway “mainly just at diagnosis, due to shortage of CNS time”. Other examples provided of the impact of capacity (lack of) on patients were: biopsies and scans in the relevant timeframe”, “overbooked clinics, with patients not having enough time” and the need for “another band 7 so that the metastatic patients are better supported and survivorship needs of patients are better covered”.

Administrative support, or lack of, was a recurring theme but there was also a sense expressed by some of a devaluing or misunderstanding of the CNS role:



The CEO feels we are expensive ‘hand holders’. At the moment we are fighting having to do a clinical shift a month on the ward to help with the nursing budget!

(CNS, band 7)

Some respondents did consider they had sufficient resources (time and people) to fulfil their role; however, the sense that this was unusual is captured in the following quote:

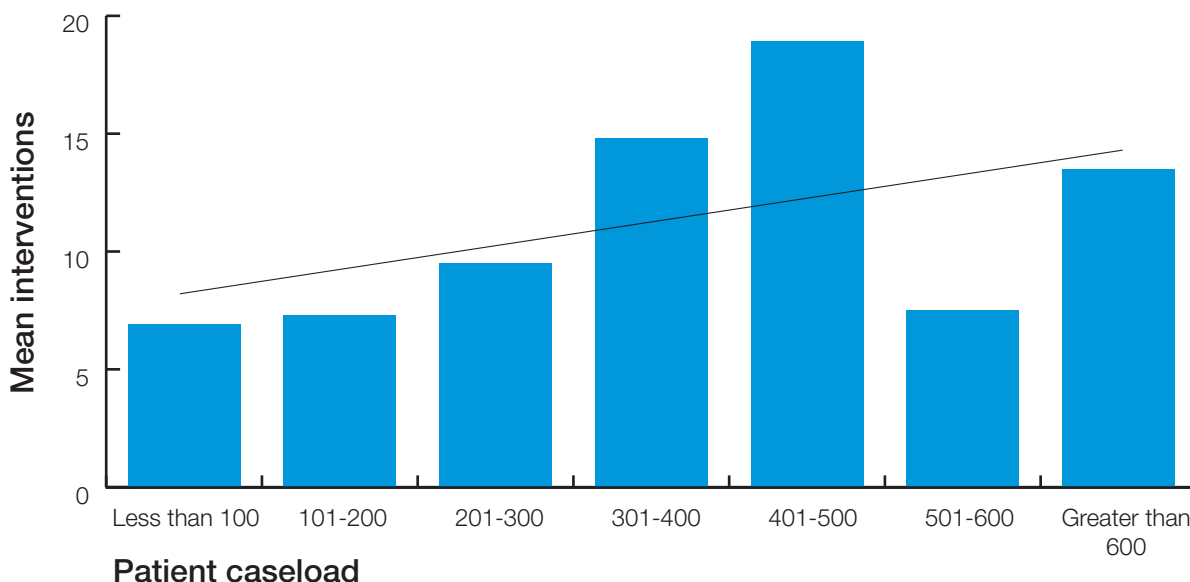


I feel I am lucky enough to be able to provide excellent standards of care.

(CNS, band 7)

Higher caseloads were associated with a higher mean declared necessary interventions left undone (Figure 22).

Figure 22: Mean interventions left undone per Whole Time Equivalent (WTE)

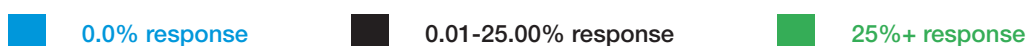


Who has access to administrative support?

The nurses were asked if they had any administrative support. 280 responded to this question. As can be seen from Figure 23, there is wide variation in access to administrative support. The focus of administrative support to services appears to be the typing of clinic letters (115). 72 (25%) of the nurses declared no support whatsoever.

Figure 23: Administrative support by pay band

Band	I have no admin support whatsoever	I have admin support only for clinic letters	I have 1-5 hours admin support to use as I wish	I have 6-12 hours admin support to use as I wish	I have 13-20 hours admin support to use as I wish	I have more than 20 hours admin support	Unknown	Total
Band 1-4	100% 1	0%	0%	0%	0%	0%	0%	100% 1
Band 5	60% 3	20% 1	20% 1	0%	0%	0%	0%	100% 5
Band 6	35% 23	32% 21	14% 9	5% 3	5% 3	11% 7	0%	100% 66
Band 7	23% 40	44% 77	13% 22	5% 8	7% 12	9% 15	0%	100% 174
Band 8a	7% 2	50% 14	7% 2	4% 1	11% 3	21% 6	0%	100% 28
Band 8b-d	40% 2	40% 2	20% 1	0%	0%	0%	0%	100% 5
Unknown	17% 1	0%	0%	0%	0%	0%	83% 5	100% 6
Total	72	115	35	12	18	28	5	285

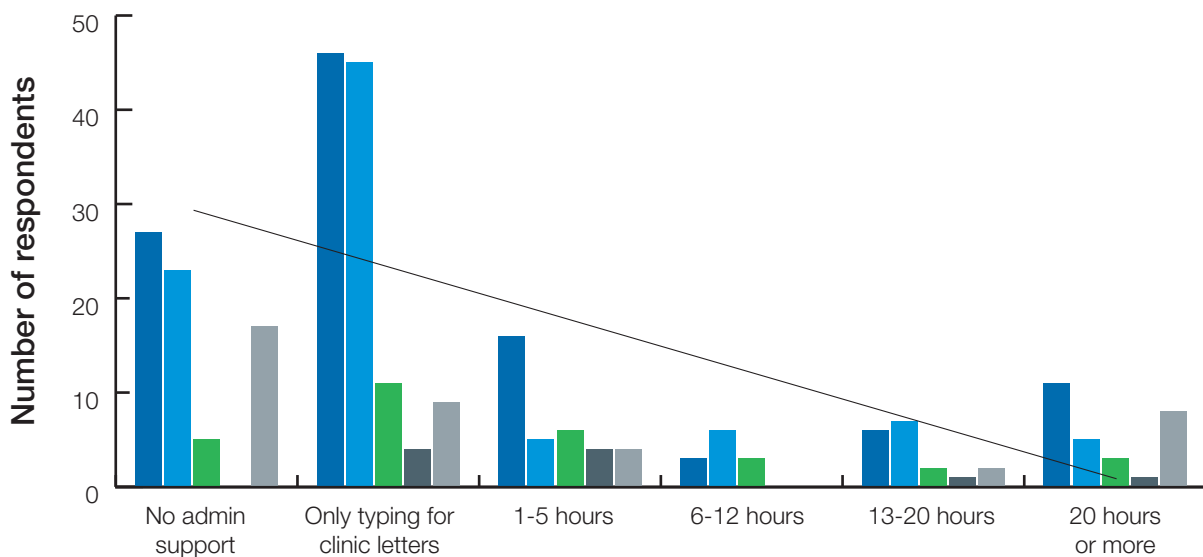


The burden of administration

The data shows that about 68% of the respondents who have more than 20 hours of administrative support per week work the lowest amount of overtime (sum 28/11+8=68%). About 65% of respondents said they had no administrative support per week or support for clinic letters only. Of these responses, about 86% declared that they work overtime with about 36% declaring that they work at least four hours overtime per week.

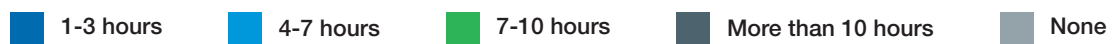
Having administrative support is associated with lower rates of unpaid overtime (Figure 24).

Figure 24: Unpaid overtime and access to administrative support



Unpaid overtime and administrative support

Unpaid overtime



7. Working in the multidisciplinary team

The multidisciplinary team (MDT) is a key component of cancer care delivery and is enshrined in English cancer policy (DH 2011), however increasing workload and cultural differences appear to present barriers for effective MDT working. The survey presented a number of consensus statements and the nurses were asked if they agreed with these statements. The respondents could choose more than one response.

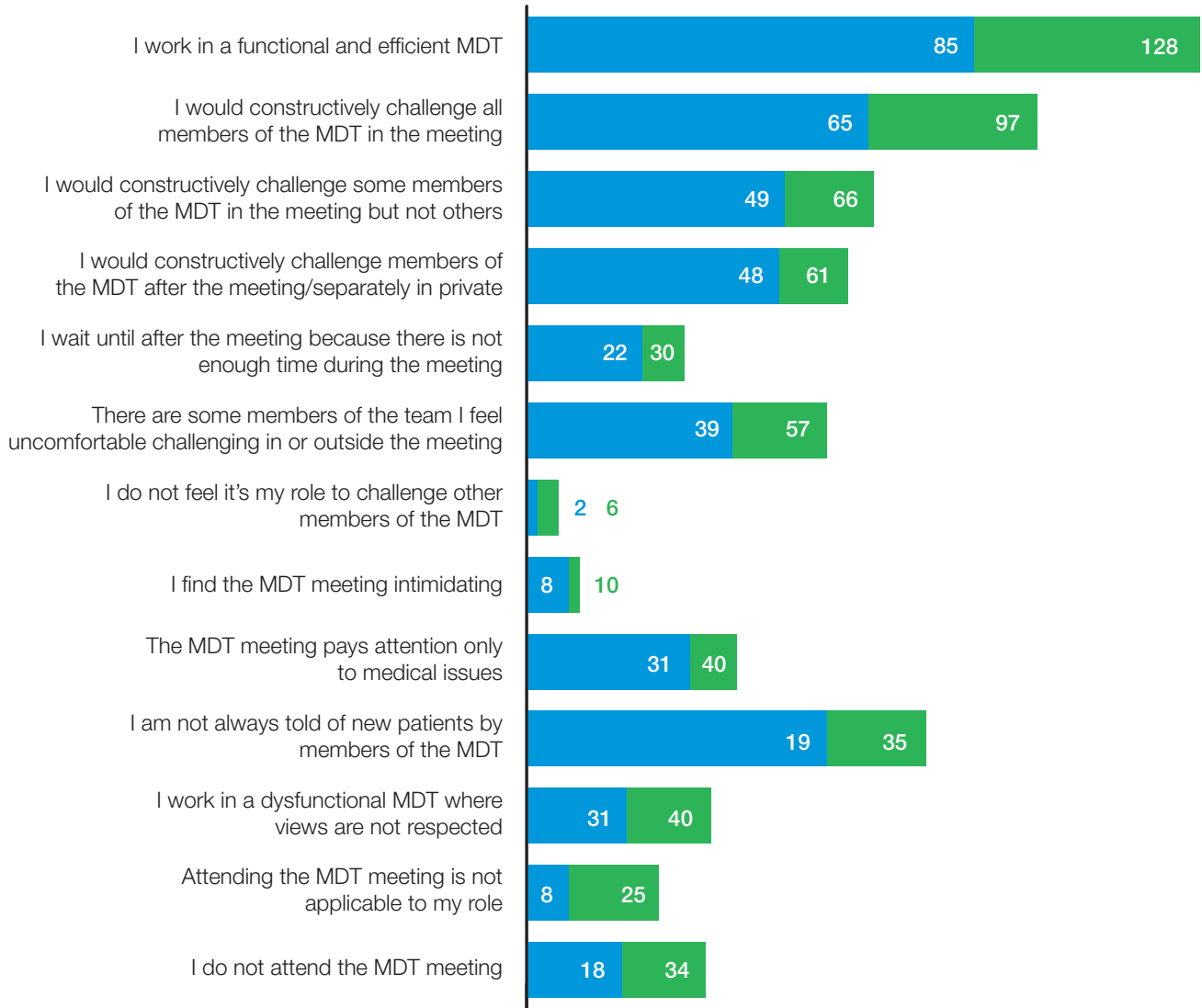
The statements were:

- I work in a functional and efficient MDT.
- I would constructively challenge all members of the MDT in the meeting.
- I would constructively challenge some members of the MDT in the meeting but not others.
- I would constructively challenge members of the MDT after the meeting/separately in private.
- I wait until after the meeting because there is not enough time during the meeting.
- There are some members of the team I feel uncomfortable challenging in or outside the meeting.
- I do not feel it's my role to challenge other members of the MDT.
- I find the MDT meeting intimidating.
- The MDT meeting pays attention only to medical issues.
- I am not always told of new patients by members of the MDT.
- I work in a dysfunctional MDT where views are not respected.
- Attending the MDT meeting is not applicable to my role.
- I do not attend the MDT meeting.

The responses were examined and compared with length of time in prostate cancer care, pay band, education, unpaid overtime, if administrative support was available and by caseload. Overall only 128 (45%) of the respondents felt they worked in a functional MDT. 35 felt they worked in a dysfunctional MDT where views were not respected and 10 found the MDT meeting intimidating. Only 97 (34%) of the nurses felt they could constructively challenge all members of the MDT in the MDT meeting. Six felt it was not their role to constructively challenge the other members of the team (four at band 6 and two at band 7). 76 (27%) nurses felt they were not regularly told of new patients by the MDT (Figure 25).

Band 7 was the most common pay band in England and the survey overall (174). This band is where most Clinical Nurse Specialists would be (Trevatt and Leary 2010, NCAT 2011, Macmillan Cancer Support 2014) however only 85 (49%) respondents felt they worked in a functional MDT with eight finding the meeting intimidating (Figure 25).

Figure 25: Response to statements about working in the MDT, including band 7

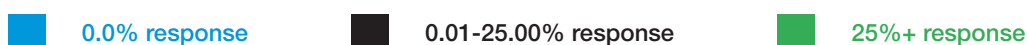


■ Total response to statements about working in the MDT

■ Band 7 response to statements about working in the MDT

Figure 26: Experience of working in the MDT by length of service

Agreed statements about MDT	Less than a year	1-3 years	4-6 years	7-10 years	Over 10 years	Unknown	Total
I work in a functional and efficient MDT	0.8% 1	9.4% 12	10.9% 14	19.5% 25	58.6% 75	0.8% 1	100% 128
I would constructively challenge all members of the MDT in the meeting	1% 1	5.2% 5	7.2% 7	18.6% 18	68% 66	0% 0	100% 97
I would constructively challenge some members of the MDT in the meeting but not others	1.5% 1	10.6% 7	19.7% 13	18.2% 12	47% 31	3% 2	100% 66
I would constructively challenge members of the MDT after the meeting/separately in private	3.3% 2	6.6% 4	11.5% 7	24.6% 15	54.1% 33	0% 0	100% 61
I wait until after the meeting because there is not enough time during the meeting	6.7% 2	13.3% 4	20% 6	20% 6	40% 12	0% 0	100% 30
There are some members of the team I feel uncomfortable challenging in or outside the meeting	5.3% 3	10.5% 6	17.5% 10	22.8% 13	42.1% 24	1.8% 1	100% 57
I do not feel it's my role to challenge other members of the MDT	16.7% 1	0% 0	33.3% 2	33.3% 2	16.7% 1	0% 0	100% 6
I find the MDT meeting intimidating	10% 1	0% 0	10% 1	20% 2	60% 6	0% 0	100% 10
The MDT meeting pays attention only to medical issues	7.5% 3	7.5% 3	12.5% 5	27.5% 11	45% 18	0% 0	100% 40
I am not always told of new patients by members of the MDT	5.3% 4	9.2% 7	15.8% 12	17.1% 13	51.3% 39	1.3% 1	100% 76
I work in a dysfunctional MDT where views are not respected	8.6% 3	5.7% 2	25.7% 9	14.3% 5	42.9% 15	2.9% 1	100% 35
Attending the MDT meeting is not applicable to my role	12% 3	8% 2	0% 0	16% 4	60% 15	4% 1	100% 25
I do not attend the MDT meeting	5.9% 2	5.9% 2	14.7% 5	17.6% 6	52.9% 18	2.9% 1	100% 34
Total	27	54	91	132	353	8	665



The quantitative data above show that only 49% (85) of band 7 and 53% (15) of band 8 nurses report that they work in a functional and efficient MDT. The free text comments were most extensive for this part of the survey, with most comments expressing concerns about conduct of the MDT. Common areas of concern relate to the lack of interest in non-medical concerns:



I don't feel my views are valued at the MDT; they certainly don't ask for a nursing opinion.

(CNS, band 7)



The MDT is driven by medical diagnosis, due to the number of patients we have to discuss.

(CNS, band 7)



I would challenge... but I don't always get heard... I feel ignored sometimes. I don't have access to all MDT members to challenge outside of the meeting.

(CNS, band 7)

The willingness of nurses to challenge is also a key finding in the quantitative data, with 23% (39) of band 7 and 14% (4) of band 8 nurses reporting that there are members of the MDT who they feel uncomfortable challenging either in or outside of the MDT meeting.

Other concerns about the effectiveness of the MDT relate to the lack of community input and little opportunity for the patient's views or wishes to be expressed; one respondent was particularly concerned that the needs of patients with metastatic disease may not be met by the MDT process. The most common reason expressed by the respondents for the above issues is a lack of time – large numbers of patients are commonly discussed, and problems such as “the consultant sometimes goes off-script” or “sometimes it can get quite heated” seen to contribute to the ineffective working of the MDT. The lack of buy-in at organisational level was reflected in one comment:



[The MDT is] often disorganised, poorly attended at consultant level. No team cohesion with clerical staff/management. Management do not respect the importance of MDT, often double book the consultants which forces poor attendance.

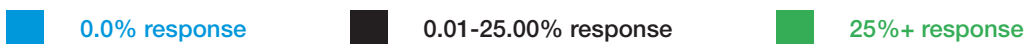
(CNS, band 6)

The views of the more senior nurses (bands 7 and 8) are of particular interest for this question. These nurses are more likely to have experienced a number of different MDT environments and are likely to know how they could/should function. In addition, nurses at this level should feel able to influence MDT processes.

Figures 27 and 28, overleaf, cover experience of working in the MDT by highest education qualification and by caseload.

Figure 27: Experience of working in the MDT by highest educational qualification

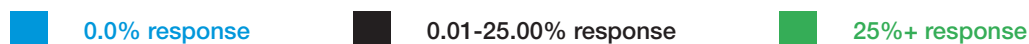
Agreed statements about MDT	PhD/Profdoc	Masters (nursing)	Masters (any other subject)
I work in a functional and efficient MDT	2% 2	11% 14	2% 3
I would constructively challenge all members of the MDT in the meeting	1.0% 1	20% 19	3% 3
I would constructively challenge some members of the MDT in the meeting but not others	2% 1	12% 8	8% 5
I would constructively challenge members of the MDT after the meeting/separately in private	0% 0	16% 10	0% 0
I wait until after the meeting because there is not enough time during the meeting	3% 1	13% 4	0% 0
There are some members of the team I feel uncomfortable challenging in or outside the meeting	2% 1	7% 4	5% 3
I do not feel it's my role to challenge other members of the MDT	0% 0	17% 1	0% 0
I find the MDT meeting intimidating	0% 0	20% 2	0% 0
The MDT meeting pays attention only to medical issues	3% 1	20% 8	5% 2
I am not always told of new patients by members of the MDT	0% 0	17% 13	5% 4
I work in a dysfunctional MDT where views are not respected	3% 1	15% 5	9% 3
Attending the MDT meeting is not applicable to my role	0% 0	4% 1	0% 0
I do not attend the MDT meeting	0% 0	12% 4	6% 2
Total	8	93	25



<i>Clinical teaching qualification (any)</i>	<i>Independent prescribing qualification (V300)</i>	<i>Post Grad cert/Dip in cancer/pall care/advanced practice</i>	<i>ENB or post registration course in cancer/palliative care</i>	<i>ENB or post registration course (other)</i>	<i>RN degree</i>	<i>Other first degree</i>	<i>RN diploma</i>	<i>RGN/RMN</i>	<i>Total</i>
24% 30	6% 7	7% 9	8% 10	6% 8	10% 12	6% 7	8% 10	11% 14	100% 126
26% 25	4% 4	7% 7	8% 8	8% 8	7% 7	4% 4	4% 4	5% 5	100% 95
27% 18	6% 4	2% 1	11% 7	6% 4	6% 4	3% 2	8% 5	11% 7	100% 66
34% 21	3% 2	2% 1	11% 7	5% 3	11% 7	2% 1	10% 6	5% 3	100% 61
27% 8	3% 1	3% 1	10% 3	7% 2	17% 5	0% 0	3% 1	13% 4	100% 30
34% 19	5% 3	2% 1	5% 3	7% 4	11% 6	4% 2	9% 5	9% 5	100% 56
33% 2	0% 0	0% 0	17% 1	0% 0	0% 0	0% 0	17% 1	17% 1	100% 6
30% 3	10% 1	0% 0	10% 1	0% 0	10% 1	10% 1	0% 0	10% 1	100% 10
33% 13	0% 0	3% 1	10% 4	5% 2	10% 4	3% 1	8% 3	3% 1	100% 40
28% 21	5% 4	1% 1	7% 5	8% 6	8% 6	5% 4	5% 4	11% 8	100% 76
29% 10	0% 0	3% 1	9% 3	9% 3	15% 5	0% 0	3% 1	6% 2	100% 34
16% 4	20% 5	4% 1	0% 0	12% 3	24% 6	4% 1	8% 2	8% 2	100% 25
21% 7	3% 1	3% 1	6% 2	26% 9	9% 3	0% 0	12% 4	3% 1	100% 34
181	32	25	54	52	66	23	46	54	659

Figure 28: Experience of working in the MDT by caseload

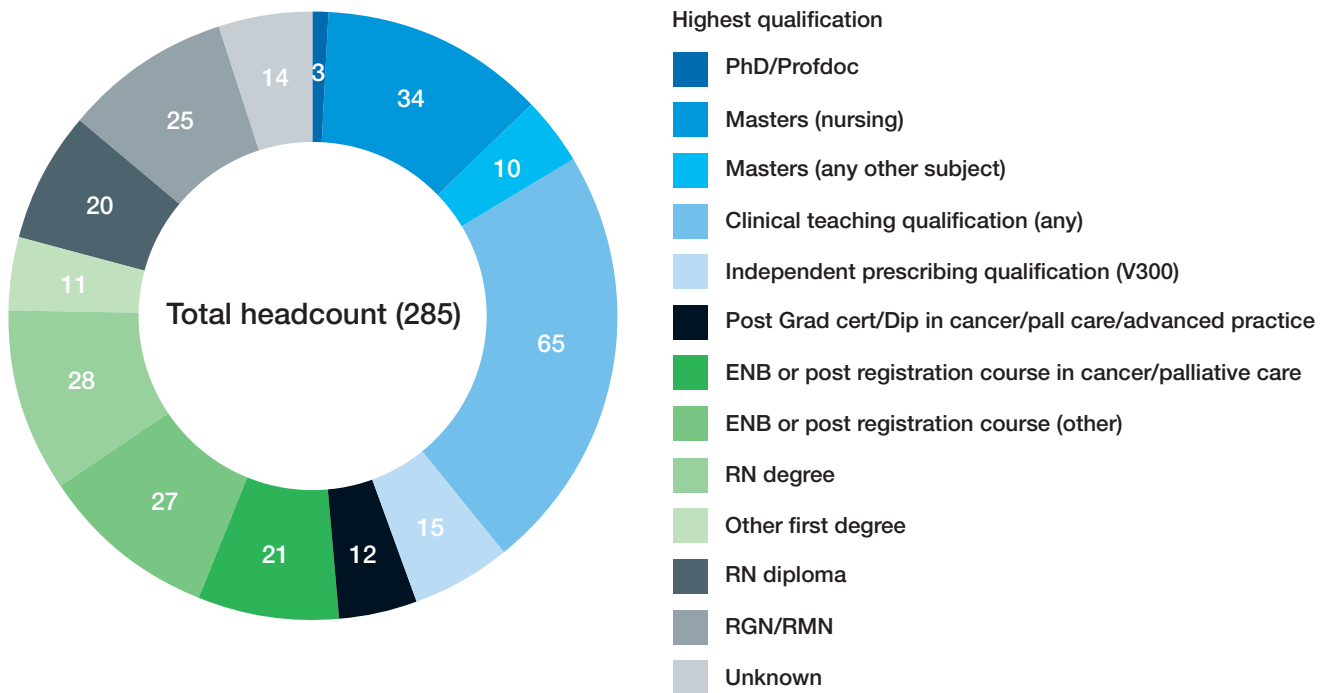
Agreed statements about MDT	Less than 100 patients	101-200 patients	201-300 patients	301-400 patients	401-500 patients	501-600 patients	Greater than 600 patients	Total
I work in a functional and efficient MDT	8% 10	14% 17	17% 21	20% 24	8% 10	7% 8	26% 32	100% 122
I would constructively challenge all members of the MDT in the meeting	8% 7	12% 11	21% 19	20% 18	5% 5	8% 7	27% 25	100% 92
I would constructively challenge some members of the MDT in the meeting but not others	6% 4	20% 13	17% 11	18% 12	12% 8	11% 7	17% 11	100% 66
I would constructively challenge members of the MDT after the meeting/separately in private	8% 5	8% 5	20% 12	17% 10	10% 6	8% 5	27% 16	100% 59
I wait until after the meeting because there is not enough time during the meeting	7% 2	21% 6	21% 6	18% 5	7% 2	7% 2	18% 5	100% 28
There are some members of the team I feel uncomfortable challenging in or outside the meeting	7% 4	18% 10	23% 13	16% 9	11% 6	11% 6	14% 8	100% 56
I do not feel it's my role to challenge other members of the MDT	0% 0	40% 2	0% 0	0% 0	40% 2	20% 1	0% 0	100% 5
I find the MDT meeting intimidating	0% 0	20% 2	20% 2	10% 1	20% 2	10% 1	20% 2	100% 10
The MDT meeting pays attention only to medical issues	8% 3	10% 4	28% 11	15% 6	13% 5	5% 2	23% 9	100% 40
I am not always told of new patients by members of the MDT	9% 7	11% 8	20% 15	17% 13	12% 9	11% 8	20% 15	100% 75
I work in a dysfunctional MDT where views are not respected	11% 4	14% 5	6% 2	17% 6	17% 6	11% 4	23% 8	100% 35
Attending the MDT meeting is not applicable to my role	24% 6	32% 8	12% 3	8% 2	4% 1	8% 2	12% 3	100% 25
I do not attend the MDT meeting	33% 11	3% 1	15% 5	18% 6	9% 3	12% 4	9% 3	100% 33
Total	63	92	120	112	65	57	137	646



8. Education and development

The current workforce is highly educated with many nurses holding post-registration qualifications. Figure 29 shows the highest level of qualification the nurses declared. 14 nurses did not answer this question. 34 respondents said they have a Masters qualification in nursing, the level recommended in most of the advanced practice frameworks as the standard of education required to fulfil a specialist role.

Figure 29: Highest level of qualification



Figures 30 and 31 describe highest qualifications declared by length of service and pay band.

Figure 30: Highest qualification by length of service (years) working in prostate cancer

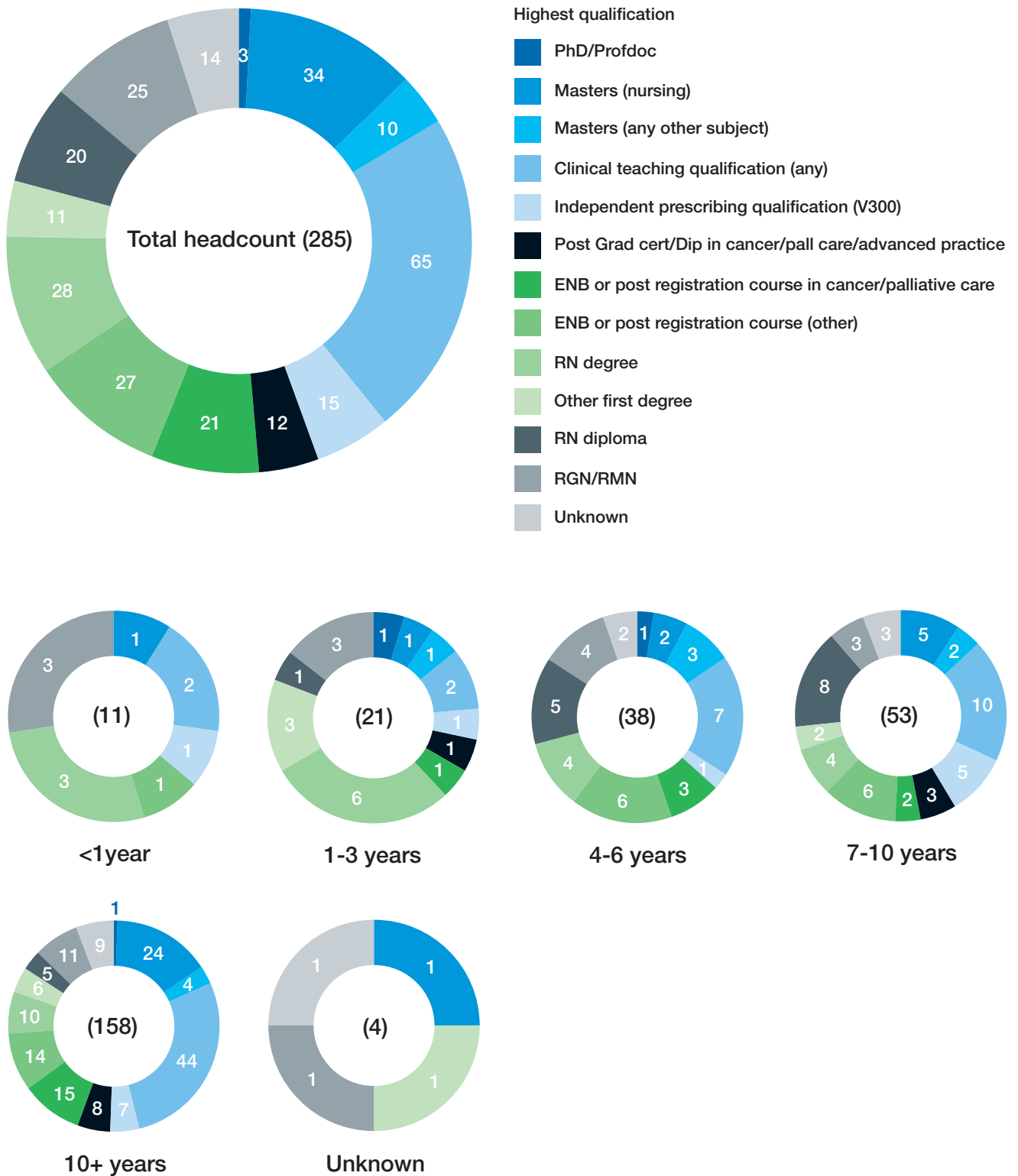
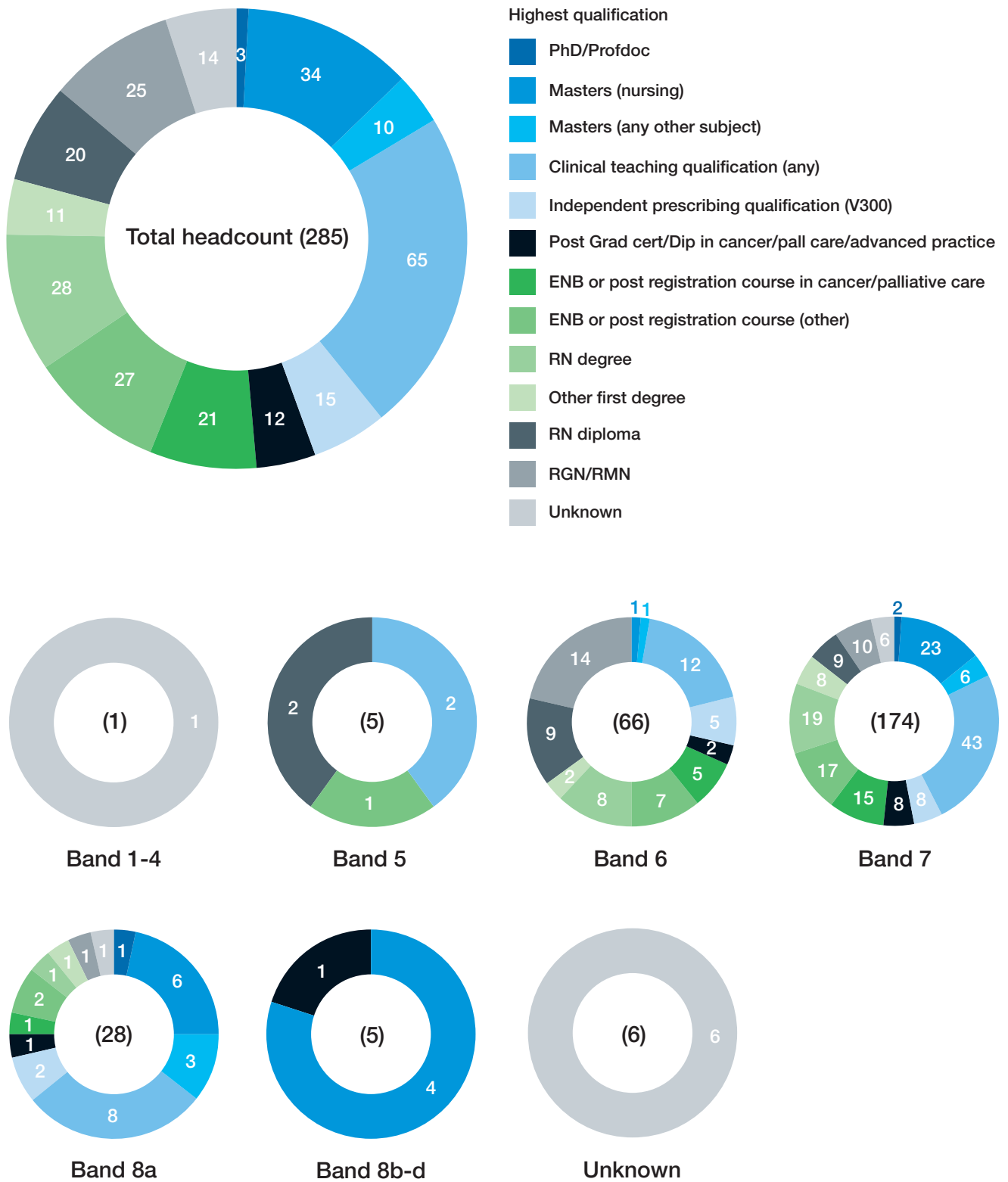


Figure 31: Highest qualification by pay band



Desire for education and development

There was a desire for further education and development activities across the population with 729 items chosen by respondents. The highest demand (179) was for specialist update study days, clinical skills study days (93), advanced practice courses (81) and clinical short courses (Figures 32 and 33).

Qualitative data indicated that a number of nurses use their own resources (time and money) for Continuing Professional Development (CPD), whilst others rely on charity funding (examples given: Macmillan Cancer Support and Prostate Cancer UK). For some nurses, lack of local CPD means that personal development has to be undertaken online.



All education is in my own time.

(CNS, band 7)



Workload precludes taking much time off for study.

(CNS, band 8a)



Current degree education is self-funded in own time.

(CNS, band 7)



I have applied three years running but management always finds an excuse; this year they didn't sign the paperwork in time.

(CNS, band 6)

Respondents indicated a range of education that they would wish to access if time and funding were available, from assistance with journal publication, conference attendance and counselling training, to undertaking a PhD.

Figure 32: Additional level of qualification desired by pay band
(the 285 respondents could choose more than one option)

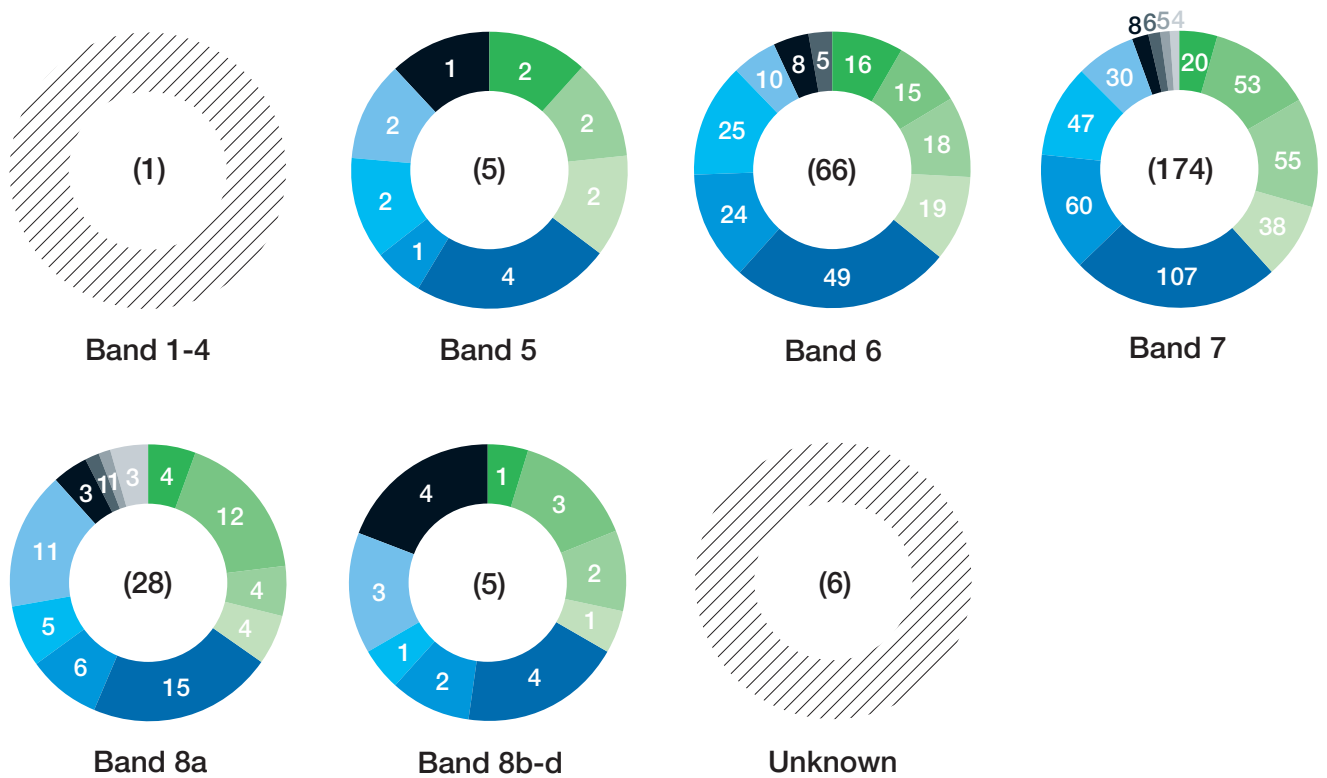
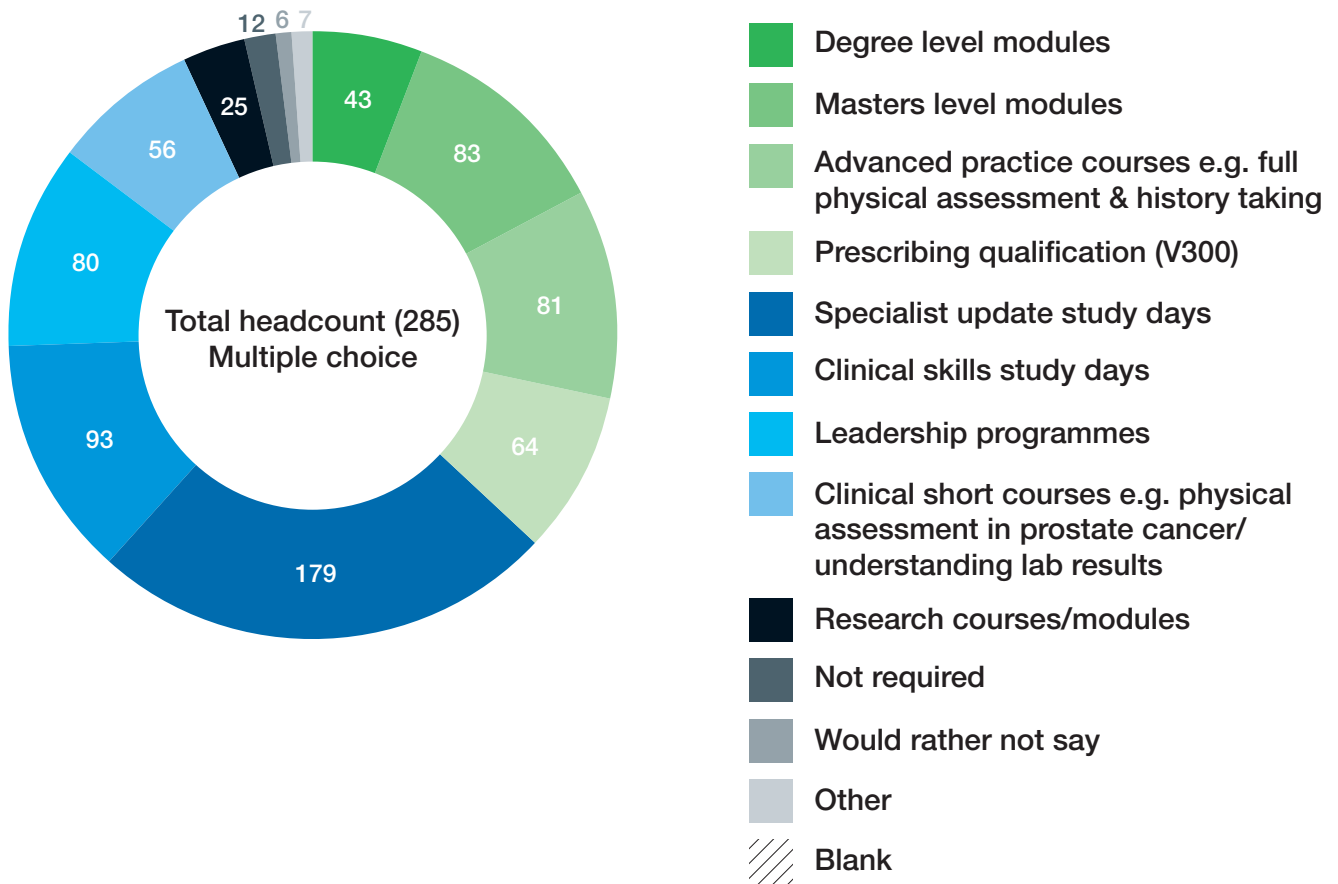
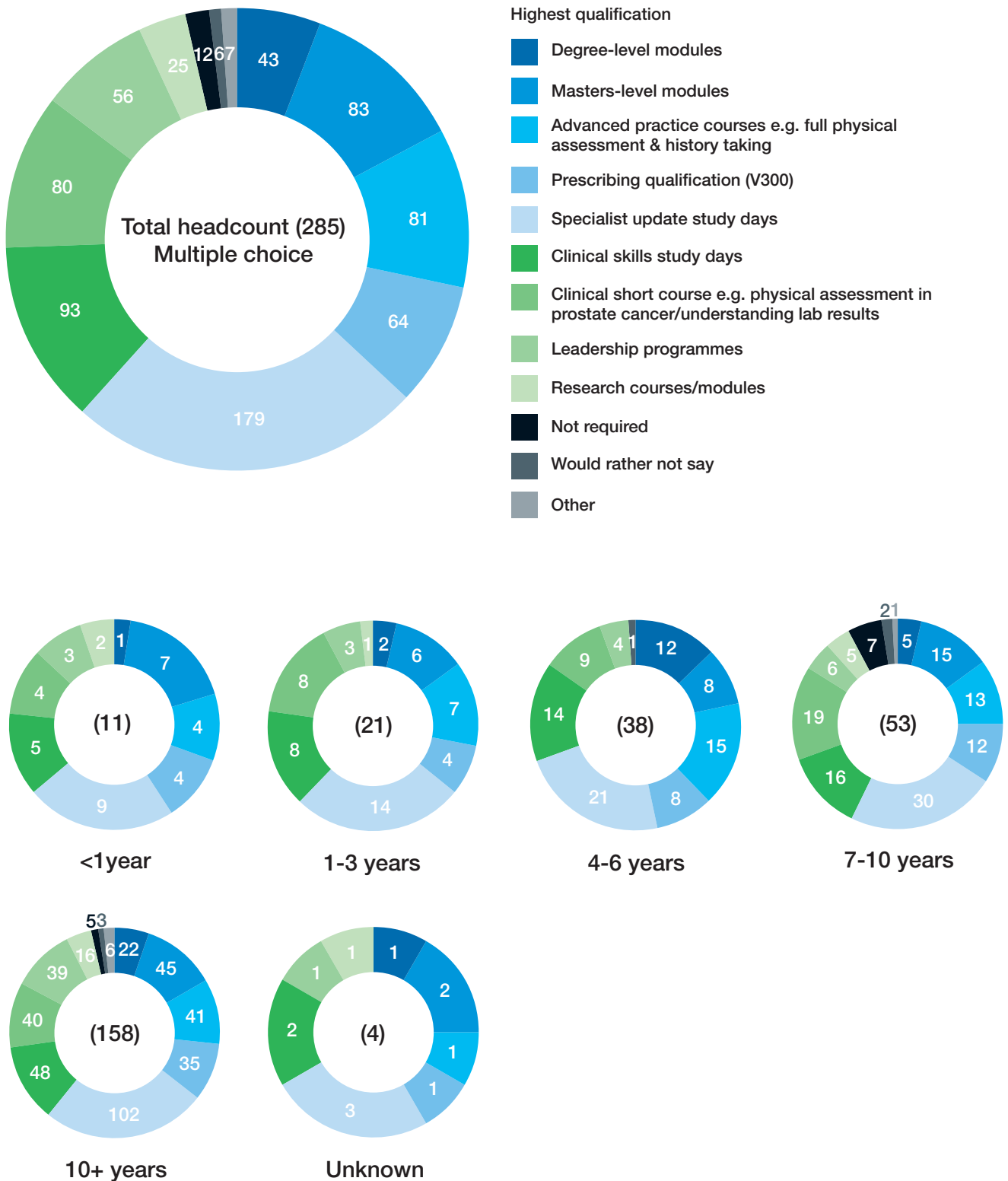


Figure 33: Additional level of qualification desired by years in prostate cancer practice (the 285 respondents could choose more than one option)





9. Recommendations

As prostate cancer is predicted to become the most common cancer overall by 2030, consideration of strategic planning should be given to patterns of care delivery and the future workforce. Capacity to provide cancer nursing care needs to be addressed nationally and locally.

The following recommendations are presented in response to the findings from the survey.

- Caseload size and work left undone reported in these findings indicate that there are areas where best practice cancer standards cannot be provided due to workloads. Administrative support should be provided to all specialist nurses to ensure that they can release more paid time for patient care. This should extend beyond support for clinic letters.
- Urgent attention needs to be given to strategic workforce planning to develop expertise and ensure that the workforce is a sustainable one. Succession planning is essential and development programmes should be established in order to provide cancer patients with cancer nursing care in the future. This should range from entry-level opportunities to systems leadership positions, such as consultant-level posts, to retain talent and develop services across care settings and different modes of local delivery.
- These findings show that there is an unequal distribution of specialist prostate cancer care across the geographical regions of the UK. This inequality needs to be addressed to ensure timely and effective provision of specialist cancer nursing to all men with prostate cancer who need it.
- Constant cycles of specialist nurse workforce reviews without tangible outcomes undermine the confidence of staff providing a frontline service and should be stopped.
- Provision of education is not equitable, and is heavily reliant on self-funding, or pharmaceutical and charitable support to advance knowledge and skills in prostate cancer nursing practice. Specialist nurses in long-term conditions are effective at the management of care but require specific advanced practice skills such as clinical reasoning, physical assessment and access to prescribing courses. In addition, frontline staff require ongoing support to professionally update. Investment in the development of the current and future workforce is necessary to retain talent and plan for the future. Development programmes in leadership that build resilience and address the cultural issues identified in this study should be provided. Strategic planning of education and development of the workforce is also needed.
- Cultural issues in the provision of multidisciplinary care need urgent attention. Only 128 of the respondents in this survey felt they worked in a functional multidisciplinary team. Workloads, reluctance or inability to address the holistic needs of patients were cited as reasons for suboptimal team working. The multidisciplinary team is the foundation of good cancer care, which means that cancer care is at risk of being suboptimal. Work needs to be done to improve multidisciplinary care delivery. The pivotal and complex contribution of the cancer nurse specialist to patient experience and safe, effective care as the key accessible professional should be acknowledged in policy and best practice guidance so that it is clear to colleagues, employers and commissioners of services. Access to leadership development and multidisciplinary team development might also be of benefit.

10. Areas for further work

This work has produced some questions about the sustainability of the workforce and the culture in which it operates. Enquiry into these issues is likely to better inform decision making around these roles. Optimum caseload calculations and workforce planning and development would help address workload issues, and exploration of cultural issues would contribute to the understanding of the findings around working in a multidisciplinary team.

This work should be repeated in two to three years to examine workforce trends and inform workforce planning.



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