Developing a Nurse-led MPN Clinic
A tool-kit to support NHS staff

UK/LO/CORP/12/0268 Prepared: June 2012
Toolkit initiated and funded by Shire Pharmaceuticals
Foreword

The Way Ahead...

Due to the demands to improve quality and increase capacity in the NHS, many hospitals are seeking alternative ways of running outpatient clinics. The development of a nurse led clinic service delivers high quality, patient centered care in a cost effective fashion and frees up capacity in consultant led clinics and therefore offers a timely and practical solution to the issues faced in many departments across the country.

Patients with Myeloproliferative Neoplasms (MPN's) are an appropriate group of patients for who nurse led clinics have been proven to work well.

We have both been involved in setting up and running nurse led clinics for many years and when approached by Shire Pharmaceuticals, to help develop a 'toolkit' for helping other nurses to set up similar clinics we felt that this was a great opportunity provide detailed guidance as to how to undertake such a project, from the embryonic stages right the way through to establishing and maintaining such a service provision. This toolkit provides 'best practice' based on the real world experience of the authors, to enable others to establish and manage their own clinics for patients with MPN's.

Once set up these clinics can allow nurses to develop their scope and enable specialist nurses to practice more autonomously, and to accomplish and practice advanced skills. In this ever-evolving NHS we very much hope that this document will be of use to nurses hoping to set up nurse led MPN clinics. We hope that every aspect of implementation has been touched upon, from obtaining a business case and funding to clinical governance and continuing professional development (CPD) in what we believe to be the first toolkit of its type for use by nurses in haematology who are committed to establish nurse led clinics.

Michelle Taylor and Louise Wallis
On behalf of the MPN Nurse Tool-kit Steering Group
June 2012
Introduction

In early 2012 two meetings were initiated and funded by Shire Pharmaceuticals with NHS Commissioners and Haematology Nurse Specialists to develop a practical tool-kit that will aid the development and commissioning of Myeloproliferative Neoplasm (MPN) Nurse-Led Clinics for appropriate haematology patients.

At the first meeting, the steering group defined the structure and content and at the second meeting they were invited to ratify and validate the content.

Triducive, a specialist communications consultancy facilitated both steering group meetings and ensured that the group approved copy and content of the final document.

Shire had no input into any of the content, their support being offered as a service to medicine.

This steering group reflected different geographies and NHS Trusts throughout the UK as below:

- Richard Ellis, NHS Cancer Services Commissioner
- Yvonne Francis, Clinical Nurse Specialist Haematology; Guys and St Thomas' NHS Foundation Trust, London
- Phyllis Paterson, Myelodysplastic/Myeloproliferative Diseases Clinical Nurse Specialist; Addenbrookes NHS Trust; Cambridge
- Adrian Pattinson, Haematology specialist nurse practitioner; Huddersfield Royal Infirmary, Huddersfield
- Theresa Peters, Macmillan Haematology Clinical Nurse Specialist; Royal United Hospital, Bath
- Paul Ryan, Haematology Commissioner, Herefordshire Primary Care Trust
- Michelle Taylor, Clinical Nurse Specialist in Haematology; The Great Western Hospital, Swindon;
- Ruth Thompson, Macmillan Haematology Clinical Nurse Specialist; Belfast City Hospital, Belfast
- Joanne Tonkin, Nurse Consultant Haematology; Colchester Hospital University NHS Foundation Trust, Colchester
- Louise Wallis, Haematology Specialist Nurse; Royal Bournemouth Hospital, Bournemouth

There is a growing appetite to develop and deliver nurse-led MPN clinics and in the emerging NHS environment, this trend is being increasingly received well by NHS budget holders and clinical directors.
**Myeloproliferative neoplasms (MPNs)**

Myeloproliferative neoplasms (MPNs) are chronic haematological disorders with a significant amount of patients requiring long-term follow-up. Nursing has an opportunity to take on more of this role. With the QIPP agenda driving health policy, nurse-led clinics can help deliver quality care and improve productivity gains in hospital clinics.

Studies have suggested that nurse-led clinics are acceptable to patients, carers, and staff. The role of nurses in patient care has evolved over time and nurses are increasingly involved in tasks and procedures previously performed by physicians.

**Who is this document for?**

This document aims to provide nursing leads, clinical colleagues and NHS business managers interested in developing nurse-led MPN clinics practical insight, action steps and templates based on the experience of the steering group.

**References**

**Format**

This material has been developed to provide a set of resources that meet the needs of NHS colleagues across the UK.

The content has been assembled based on direct feedback from a steering group of experts who have successfully set-up and run MPN clinics in their own trusts.

The content of this tool-kit is broken into three inter-linked phases:

- Setting up the nurse-led clinic
- Running the nurse-led clinic
- Maintaining the nurse-led clinic

Within these three phases there are sections covering more detail; the sections will provide best practice, the context to be considered and outline the required action steps to be taken. Each section includes an implementation plan.

References are included. Useful templates are available at the end of the document.

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**Phase**

**Setting up the nurse-led clinic**

<table>
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<th>Business case and funding</th>
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**Objective**
The purpose of a business case is to capture the reasoning for initiating a project or task. It is often presented in a formal, structured written document, but may also sometimes come in the form of a verbal presentation.

**Context**

Setting up any new service in the NHS requires the development of a business case.

The NHS must demonstrate that it is making the most effective use it can of public money to deliver quality healthcare. This requires clinicians to scrutinize regularly the way they deliver healthcare in order to deliver maximum quality within the available resources.

A significant financial burden faces the NHS, as it has to find savings of between £15 billion to £20 billion between 2011 and 2014.

Yet the vision for the NHS is bold and includes:

- Being genuinely centered on patients and carers
- Achieving quality and outcomes that are among the best in the world
- Refusing to tolerate unsafe and substandard care
- Eliminating discrimination and reducing inequalities in care
- Putting clinicians in the driving seat and setting hospitals and providers free to innovate, with stronger incentives to adopt best practice

NHS commissioning is the process by which the NHS ensures the health and care services provided most effectively meet the needs of the population.

It is a complex process with responsibilities ranging from assessing population needs and prioritising health outcomes, to procuring products and services, and measuring the performance of service providers.

It has been suggested that the greatest challenge in health care commissioning is defining the ‘product’ that is to be commissioned. In health, this product should be regarded as health gain, both at an individual and a population level.

The process of NHS commissioning is illustrated in the following diagram:
NHS Commissioners face issues including:
• NHS increases in funding above inflation have come to an end (including for MPN patients)
• Population living longer with greater burden of disease and higher expectations for good health (including in MPN)
• Public awareness means people seek diagnosis earlier when the presentations are more ambiguous

Compared to other therapeutic areas, MPN is relatively low on the agenda of commissioners and clinical commissioning groups, however the need to improve efficiencies in the NHS is a key focus of ALL commissioners. Costs need to be saved and productivity gains need to be achieved which can be aligned to QIPP (quality, innovation, productivity and prevention).

Nurse-led MPN clinics have advantages such as: 
• Improved continuity of care, leading to improved treatment compliance
• Longer time spent with a healthcare professional at each visit
• Fewer delays in clinics (Le; patients can be seen more quickly by a range of HCPs)
• A more holistic approach
• Less formal: some patients are more at ease speaking to a nurse
• Reduces Consultants' workload, allowing them more time to focus on complex clinical cases
• Draws on CNS expertise and experience of a high number of patient cases: often the CNS will have more relevant experience of the disease than the patients' GPs
• Improved access to support groups
• Facilitates easier identification of patients suitable for clinical trials

Telephone clinics have specific advantages which have been identified as: 
• Improved capacity of hospital day services
• Reduced burden on the ambulance service
• Reduced burden on patients/carers/relatives (e.g. not necessary to take time off work to attend/take patient to hospital appointment)
• Reduced cost to both the patients and health service
• Patient experience

In terms of NHS service redesign, commissioners and service development leads must model different service scenarios and identify the optimum service model that both improves outcomes and reduces inefficiencies.

The objective is to improve patient outcomes whilst reducing the overall cost of service per patient. This may be seen as optimising the patient journey by streamlining the treatment process and ensuring that all appropriate actions and interventions are taken at the right time and implemented effectively. Typically, commissioners see the costs of care as falling into three categories:

It is broadly accepted that the consumables budgets are the easiest to address (variable costs) as they are easier to quantify and do not have political impacts such as staffing reductions or the closure of hospital facilities.
The challenge therefore is to define the optimum patient pathway that ensures all of the appropriate steps are taken and implemented effectively, whilst reducing unnecessary staff costs or location costs objectively and defensibly.

A business case is required for this and will require collaboration between commissioners and clinical staff (including the lead consultant). Stakeholder engagement (e.g. Trust management, NHS commissioner, cancer network, patient group, clinical leads) is paramount. The shortfalls of the current service need to be understood and the reason for improvement clearly highlighted (and aligned to QIPP). The growing burden of disease at a local level should be considered with the cost impact shown and where (and when) the financial savings will be achieved.

Various NHS Trusts have their own business case template and it is worth familiarising yourself with that and seeing previous examples. (Your finance lead should be able to help with this).
### Implementation Plan: 1. Business case and funding

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<td>Identify all local stakeholders</td>
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<td>1.2</td>
<td>Gain clinical buy-in</td>
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<td>1.3</td>
<td>Gain commissioning buy-in</td>
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<td>1.4</td>
<td>Obtain business plan template (use other local examples)</td>
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<td>1.7</td>
<td>Map current service shortfall</td>
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<td>1.8</td>
<td>Map improvement gains – why do this?</td>
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<td>1.9</td>
<td>Evidence for nurse-led clinic – include patient benefits</td>
<td>Specify person</td>
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<td>1.10</td>
<td>Align outcomes to QIPP</td>
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<tr>
<td>1.11</td>
<td>Capture costs (e.g. drugs, tests, information collection, clinic costs, staff costs)</td>
<td>Specify person</td>
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<td>1.12</td>
<td>What is the cost saving and when will this be achieved?</td>
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### References

11. [Department of Health. Equity & Excellence: Liberating the NHS (pg. 8), 12 July 2010](http://www.dh.gov.uk/en/Managingyourorganisation/Commissioning)
15. [NHS Innovation Centre – Developing a Business Case](http://www.ic.nhs.uk/commissioning Accessed April 2012

Toolkit initiated and funded by Shire Pharmaceuticals

UK/LO/CORP/12/0268 – June 2012
### Section 2 Practical considerations

**Objective**  The section provides details about practical considerations experienced by nurse colleagues who have set up MPN clinics.

**Context**

Any clinic will require resourcing in the form of staff, technology, record keeping and space. There needs to be support provided for staff and appropriate conditions for delivering patient care. The clinic needs to be coded appropriately as either nurse-led or consultant-led and this will need to be agreed with the operations manager and clinical lead. Access to consultant support is important for a nurse-led MPN clinic.

Telephone follow-up can also form part of a nurse-led clinic including: urology/oncology; breast cancer; prostate cancer and haematological disorders.

Also, consideration for cover due to annual leave, sickness or study is required. Could other nurses or doctors provide this? How would a clinic be cancelled? Administration staff should be in place prior to any clinic starting and educated in the process and relevant templates.
### Implementation Plan: 2. Practical Considerations

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<td>Code the clinic appropriately (liaise with business manager)</td>
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<td>Identify clinic space with phone availability (consider waiting room and consulting room space)</td>
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### References


Section 3  Nurse education and CPD

Objective
The clinic needs to be led by a nurse who is appropriately qualified and experienced.

Context

According to the experience of the Steering Group, minimum attributes of suitable nurses include:

- Registered Nurse
- At least degree level
- Approximately 5 years in haematology (2/3 years at senior level (band 6))
- Haematology/oncology module completed
- Shadowing consultant at clinic until confidence and competence is achieved
- Advanced communication skills

Over time other attributes include:

- Advanced practitioner (university based)
  - Health Assessment (includes history taking and clinical examination)
  - Nurse Prescribing

Colleagues seeking experience of MPN could shadow consultant clinics, visit colleagues in other nurse-led MPN clinics, find a mentor (CNS) and attend educational events.

Key factors that help in establishing and running a nurse-led clinic include:

- Recognising need for consultant and nurse time for a period of training
- Easy access to medical advice
- Non-medical prescribing status of the CNS is not necessary for the initial set-up of a service but is invaluable for the running of the clinic.
- Physical assessment module completed by nurse

Structured and ongoing support should be discussed with your line manager and may include:

- MPNs resource file
- Experience with different consultants
- Move through phases of shadowing/supervising/independence

CPD should include the following elements:

- Competency framework (examples are available from Macmillan/NMC/RCN)
- Attendance at conference/study day
- Participation in MPN Forum
- Publications and sharing best practice
- Independent nurse prescribing
The challenge in clinical practice is balancing clinical judgment with best practice and guidelines within the confines of NHS policy. Best practice should be provided and guidance followed – see section 5.

**Implementation Plan: 3. Nurse Education and CPD**

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<td>3.1</td>
<td>Relevant qualifications</td>
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<td>3.2</td>
<td>Length of haematology experience (band 6 at least)</td>
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<td>3.3</td>
<td>Competency framework agreed with line manager</td>
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<td>3.4</td>
<td>CPD plan in place</td>
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<td>3.6</td>
<td>Clinical assessment module completed</td>
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<tr>
<td>3.7</td>
<td>Haematology module completed</td>
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<tr>
<td>3.8</td>
<td>Shadowing of different consultants at MPN clinic achieved</td>
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<tr>
<td>3.9</td>
<td>Independent role in clinic achieved</td>
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<td>3.10</td>
<td>Prescribing arrangements agreed</td>
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<td>Date</td>
<td>Date</td>
<td>Update</td>
</tr>
<tr>
<td>3.11</td>
<td>Independent prescriber status achieved</td>
<td>Specify person</td>
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</table>

**References**

23. Department of Health – Independent Nurse Prescribing
Phase Running a nurse-led clinic

Section 4 Building services for appropriate patient types

Objective

The services offered by a nurse-led MPN clinic will be defined at a local level and will form part of the business plan. The services may evolve over time in accordance with clinical ability and patient needs.

Context

Whilst the services offered by a nurse-led MPN clinic will be included in the business case, the services need to be clearly communicated to all stakeholders:

- Preparation of patients - verbal notification and patient information leaflets about the nurse-led clinic
- Preparation of GPs – letter to all practices

Patient selection would need to be a clinical decision and commissioners would not get involved. However, commissioners would want to know that Cancer Network were happy (nurses should have involvement with Cancer Network and the Cancer Networks would want to know that cross-trust sharing of results was being facilitated) - this needs to be dealt with at business case stage.

Complex patients include:
- Newly diagnosed
- Multiple co-morbidities – complications
- Unstable disease
- Clinical trial patients
- Patients requiring transplant
- If treatment change is needed
- High risk for thrombotic event – defined by consultant

Greater intervention required
Increasing nurse experience

New and complex patients seen by consultant

More complex patients may be managed as nurse competence and confidence increases

Nurses may assume care for MPN patients with stable disease who require regular review but have an established diagnosis and agreed treatment plan

Consultant advice as needed
Referral to nurse-led clinic

Telephone clinic
Face to face
The MPN nurse-led clinic would have typically started with ‘easier’ to manage patients e.g.

- Low risk MPN patients
- Stable patients (not low risk) (definition: reviewed every 3-4 months/ dose remains same/blood count is consistent)
- On treatment and complying
- Requiring regular monitoring
- Low risk thrombotic complications
- Limited co-morbidities

Through close working with the consultant, agreement needs to be reached as to how and when to hand the patient over to the consultant e.g.

- Changes in treatment protocols
- Anyone who has become myelofibrotic
- Change in MPN status
- Emergence of significant co-morbidities

A typical nurse consultation would last 10-20 minutes and include the following steps:

- Obtain results and review blood count [consider having blood test in advance of consultation (GP, hospital pre-clinic)]
- Symptom review
- Physical examination as necessary
- Review existing treatment options and offer advice accordingly
- Provide other advice (health education, written advice) and need for further tests
- Prescription
- Agree follow-up
- Letter to GP and patient following consultation
- Document in medical notes

A multi-disciplinary approach to patient care helps with patient management via the nurse-led clinic. ²⁰⁻²²
## Implementation Plan: 4. Building services for appropriate patient types

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<tr>
<td>4.1</td>
<td>Agree referral process and criteria with Consultant and MDT</td>
<td>Specify person</td>
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<tr>
<td>4.2</td>
<td>Inform commissioner as part of the business plan</td>
<td>Specify person</td>
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<tr>
<td>4.3</td>
<td>Engage with the Cancer Network</td>
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<td>4.4</td>
<td>Inform patients - verbal notification and patient information leaflets about the nurse-led clinic</td>
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<td>4.5</td>
<td>Inform GPs – letter to all practices</td>
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<tr>
<td>4.6</td>
<td>Ensure nurse-led clinic is part of MDT process</td>
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<tr>
<td>4.7</td>
<td>Agree when and how to refer patients back to consultant</td>
<td>Specify person</td>
<td>Date</td>
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<td>Update</td>
</tr>
<tr>
<td>4.8</td>
<td>Conduct face to face consultation with patient prior to telephone consultation</td>
<td>Specify person</td>
<td>Date</td>
<td>Date</td>
<td>Update</td>
</tr>
</tbody>
</table>
For setting up telephone clinics:

<p>| | | | |</p>
<table>
<thead>
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</thead>
<tbody>
<tr>
<td>4.9</td>
<td>Identify another point of contact (i.e. family/carer) for telephone clinic patients if required</td>
<td>Specify person</td>
<td>Date</td>
</tr>
<tr>
<td>4.10</td>
<td>Ensure facility for dispensing prescriptions for telephone clinic patients</td>
<td>Specify person</td>
<td>Date</td>
</tr>
<tr>
<td>4.11</td>
<td>Ensure communication with GP, district nurse and patient for telephone clinic</td>
<td>Specify person</td>
<td>Date</td>
</tr>
<tr>
<td>4.12</td>
<td>Understand which patient types (personalities or patient preference) may be unsuitable for telephone clinics</td>
<td>Specify person</td>
<td>Date</td>
</tr>
</tbody>
</table>

References


Phase  
Running a nurse-led clinic

Section 5  
Role of policy, guidelines and protocols

Objective  
This section outlines the guidelines that need to be considered when setting up a nurse-led MPN clinic.

Context

The challenge in clinical practice is balancing clinical judgment with best practice and guidelines according to local and national NHS policy. Best practice should be provided and guidance followed.

QIPP Alignment

Any new clinical service should align to NHS policy. QIPP is the umbrella term used to describe the approach the NHS is taking at local, regional and national levels to reform its operations and redesign services in light of the weak economic climate.

By assessing reforms against the four components – Quality, Innovation, Productivity and Prevention – the NHS is meant to provide better quality services in the most productive and cost effective way possible, making the best use of the potential of innovation and targeted investment in prevention. The four QIPP elements can be seen as both distinct and inter-related. There are initiatives which focus on particular elements or which bring some or all of the components together.

QIPP is working at a national, regional and local level to support clinical teams and NHS organisations to improve the quality of care they deliver while making efficiency savings that can be reinvested in the service to deliver year on year quality improvements. The business case for nurse-led MPN clinics should align to QIPP.

<table>
<thead>
<tr>
<th>Quality</th>
<th>• Improving outcomes, quality of life and experience of MPN patients through a single, dedicated point of care for the MPN patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Innovation</td>
<td>• Opportunity to transform follow-up and reduce avoidable attendance and reduce waiting times</td>
</tr>
<tr>
<td>Productivity</td>
<td>• See more patients and free up consultants time so they can manage more complex cases</td>
</tr>
<tr>
<td>Prevention</td>
<td>• Familiarity and relationship between nurses and patients meaning patients talk more about their condition which facilitates a more preventative role for nurses (e.g. smoking cessation advice)</td>
</tr>
</tbody>
</table>
Care Quality Commission (CQC) [England Only]

As the Health and Social Care regulator for England, the Care Quality Commission is the new health and social care regulator for England. It is oriented towards health and social care and aims to ensure better care for everyone in hospital, in a care home or at home.\(^2\) This has introduced a new set of essential standards of quality and safety that all care providers must meet.\(^2\)

- Patients can expect to be involved and told what’s happening at every stage of their care
- Patients can expect care, treatment and support that meets their needs
- Patients can expect to be safe
- Patients can expect to be cared for by qualified staff
- Patients can expect their care provider to constantly check the quality of its services

Trusts and localities registered with the CQC must meet defined standards in six key outcome areas, which are validated by assessment performed by CQC staff. These are:

<table>
<thead>
<tr>
<th>Information and involvement</th>
<th>the information that providers make available to people so they can make informed decisions about their care and support</th>
</tr>
</thead>
<tbody>
<tr>
<td>Personalised care, treatment and support</td>
<td>the way in which providers make sure that people get effective and safe care and treatment that supports their individual needs</td>
</tr>
<tr>
<td>Safeguarding and safety</td>
<td>the way in which providers assure people who use services that equipment and premises are safe and suitable, risks are managed and people’s human rights and dignity are safeguarded</td>
</tr>
<tr>
<td>Suitability of staffing</td>
<td>what providers do to make sure that they have suitably qualified, skilled and knowledgeable staff who can ably support people</td>
</tr>
<tr>
<td>Quality and management</td>
<td>what providers do to manage risk and ensure essential standards of safety and quality are maintained</td>
</tr>
<tr>
<td>Suitability of management</td>
<td>what providers and managers must do to show CQC that they are suitable to run the service and to notify CQC of any relevant changes</td>
</tr>
</tbody>
</table>

The running of nurse-led MPN clinics in the devolved nations need to be run in accordance with the relevant Health and Social Care regulators.
Clinical guidelines
Local guidelines for MPN patient management may be developed based upon BCSH guidelines, and supported by nurse-led protocols and treatment algorithms.

A range of clinical guidelines should be familiar to nurses running MPN nurse-led clinics. These include:

- British Committee for Standards in Haematology (BCSH) guidance on these conditions [http://www.bcsghguidelines.com/4_HAEMATOLOGY_GUIDELINES.html](http://www.bcsghguidelines.com/4_HAEMATOLOGY_GUIDELINES.html)
- British Committee for Standards in Haematology (BCSH) guidance on 'levels of care' for the provision of facilities for the treatment of adults with haematological conditions
- Guidance from the Department of Health on improving outcomes for cancer patients
- Cancer Network Guidelines
- Shared care protocols
- National Patient Safety Agency (oral chemotherapy) [http://www.nrls.npsa.nhs.uk/resources/?entryid45=59880](http://www.nrls.npsa.nhs.uk/resources/?entryid45=59880)
- Individual Trust guidelines – including record keeping guidelines

Shared care guidelines

Shared care guidelines may be required to define the roles and responsibilities of the nurse and GP in the MPN patient care (this could form part of the business plan).

Shared care guidelines are developed when sophisticated or complex treatments that were initiated in secondary care are then prescribed by a GP. The guidelines set out the process that needs to be followed for the GP to take on prescribing responsibility. The term 'Effective Shared Care Agreement' (ESCA) is now being used.
### Implementation Plan: 5. Role of Policy, guidelines and protocols

<table>
<thead>
<tr>
<th>Task</th>
<th>Action</th>
<th>Responsibility</th>
<th>Start</th>
<th>End</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>5.1</td>
<td>Understand how nurse-led MPN clinic align to local QIPP plan</td>
<td>Specify person</td>
<td>Date</td>
<td>Date</td>
<td>Update</td>
</tr>
<tr>
<td>5.2</td>
<td>Understand how nurse-led clinic can support CQC requirements of Trust</td>
<td>Specify person</td>
<td>Date</td>
<td>Date</td>
<td>Update</td>
</tr>
<tr>
<td>5.3</td>
<td>Review British Committee for Standards in Haematology Guidelines</td>
<td>Specify person</td>
<td>Date</td>
<td>Date</td>
<td>Update</td>
</tr>
<tr>
<td>5.4</td>
<td>Review NICE guidelines</td>
<td>Specify person</td>
<td>Date</td>
<td>Date</td>
<td>Update</td>
</tr>
<tr>
<td>5.5</td>
<td>Review Cancer Network Guidelines</td>
<td>Specify person</td>
<td>Date</td>
<td>Date</td>
<td>Update</td>
</tr>
<tr>
<td>5.6</td>
<td>Established 'Effective Shared Care Agreement' with GPs</td>
<td>Specify person</td>
<td>Date</td>
<td>Date</td>
<td>Update</td>
</tr>
<tr>
<td>5.7</td>
<td>Understand NPSA guidelines (oral chemotherapy)</td>
<td>Specify person</td>
<td>Date</td>
<td>Date</td>
<td>Update</td>
</tr>
<tr>
<td>5.8</td>
<td>Review Nursing &amp; Midwifery Council Advanced Practice guidelines</td>
<td>Specify person</td>
<td>Date</td>
<td>Date</td>
<td>Update</td>
</tr>
<tr>
<td>5.9</td>
<td>Review Record keeping guidelines</td>
<td>Specify person</td>
<td>Date</td>
<td>Date</td>
<td>Update</td>
</tr>
<tr>
<td>5.10</td>
<td>Agree local drug dosing algorithm as appropriate</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5.11</td>
<td>Comply with local trust guidelines</td>
<td>Specify person</td>
<td>Date</td>
<td>Date</td>
<td>Update</td>
</tr>
</tbody>
</table>

### References


Phase Maintaining a nurse-led clinic

Section 6 Audit and data needs

Objective This section outlines how the nurse-led MPN clinic can be audited to demonstrate success and identify where service improvements can be made.

Context

This section should link back to the business case and the reason for developing the nurse-led MPN clinic. The commissioner will want to see the outcomes of audits and potential benchmark against other similar services.

Clinical audit is a process that has been defined as "a quality improvement process that seeks to improve patient care and outcomes through systematic review of care against explicit criteria and the implementation of change". 26

The key component of clinical audit is that performance is reviewed (or audited) to ensure that what should be done is being done, and if not it provides a framework to enable improvements to be made. It had been formally incorporated in the healthcare systems of a number of countries, for instance in 1993 into the NHS, and within the NHS there is a clinical audit guidance group in the UK. 26

Audit usually take a five step process and will be useful to ascertain how the new service is meeting the needs set out in the original business plan (i.e. the reason for developing a nurse-led MPN clinic). All NHS Trusts will have an audit department and it is advisable to understand how they can help provide assistance with auditing nurse-led MPN clinics.

The five stages are:

**Stage 1:** Identify the problem or issue (as per business case)
**Stage 2:** Define criteria & standards (as agreed with stakeholders)
**Stage 3:** Data collection (Ethical issues must also be considered; the data collected must relate only to the objectives of the audit, and staff and patient confidentiality must be respected - identifiable information must not be used) – be aware of Data Protection Act
**Stage 4:** Compare performance with criteria and standards
**Stage 5:** Implementing change (best to be agreed with consultant and MDT)

After an agreed period, the audit should be repeated – it should be considered an ongoing process and seen as part of the everyday work. Professional journals, such as the BMJ and the Nursing Standard publish the findings of good quality audits, especially if the work or the methodology can be applied elsewhere.

Members of the steering group had conducted audits in the following areas:
- Patient satisfaction (waiting times, access to nurse, information provided)
- Safety (patient blood counts, side-effects and adverse events)
- Audit frequency of appointments
- Audit non attenders (DNA rates)
- Audit average waiting time for appointment
• Audit yearly consultant reviews
• Electronic patient records (checking patient blood counts and MPN control)

**Clinical Governance**

Clinical audit comes under the Clinical Governance umbrella and forms part of the system for improving the standard of clinical practice. Clinical Governance is a system through which NHS organisations are accountable for continuously improving the quality of services, and ensures that there are clear lines of accountability within NHS trusts and that there is a comprehensive programme of quality improvement systems. The six pillars of clinical governance include:

- Education and training
- Risk Management
- Clinical Audit
- Openness
- Clinical Effectiveness
- Research and development

Local clinical governance considerations need to be applied to nurse-led MPN clinics.
## Implementation Plan: 6. Audit and data needs

<table>
<thead>
<tr>
<th>Task</th>
<th>Action</th>
<th>Responsibility</th>
<th>Start</th>
<th>End</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>6.1</td>
<td>Agree what should be audited</td>
<td>Specify person</td>
<td>Date</td>
<td>Date</td>
<td>Update</td>
</tr>
<tr>
<td>6.2</td>
<td>Agree how it will be audited</td>
<td>Specify person</td>
<td>Date</td>
<td>Date</td>
<td>Update</td>
</tr>
<tr>
<td>6.3</td>
<td>Understand what the commissioner will want to see and when</td>
<td>Specify person</td>
<td>Date</td>
<td>Date</td>
<td>Update</td>
</tr>
<tr>
<td>6.4</td>
<td>Ensure you know members of the local audit department</td>
<td>Specify person</td>
<td>Date</td>
<td>Date</td>
<td>Update</td>
</tr>
<tr>
<td>6.5</td>
<td>Consider what will be done with the results</td>
<td>Specify person</td>
<td>Date</td>
<td>Date</td>
<td>Update</td>
</tr>
<tr>
<td>6.6</td>
<td>How should the results be communicated and to whom</td>
<td>Specify person</td>
<td>Date</td>
<td>Date</td>
<td>Update</td>
</tr>
<tr>
<td>6.7</td>
<td>Prepare a patient satisfaction survey</td>
<td>Specify person</td>
<td>Date</td>
<td>Date</td>
<td>Update</td>
</tr>
<tr>
<td>6.8</td>
<td>Engage clinical governance lead</td>
<td>Specify person</td>
<td>Date</td>
<td>Date</td>
<td>Update</td>
</tr>
<tr>
<td>6.9</td>
<td>Ensure CPD plan is up to date and is an ongoing process</td>
<td>Specify person</td>
<td>Date</td>
<td>Date</td>
<td>Update</td>
</tr>
<tr>
<td>6.10</td>
<td>Ensure that audit is an ongoing process</td>
<td>Specify person</td>
<td>Date</td>
<td>Date</td>
<td>Update</td>
</tr>
</tbody>
</table>

### References

Section 7  Templates

The following section contains templates used in the running of nurse-led MPN clinics.

They are aimed to stimulate best practice and facilitate the development of nurse-led MPN clinics and have come directly from members of the steering group.

<table>
<thead>
<tr>
<th>Section</th>
<th>Template</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Business case and funding</td>
<td>Template 1 Business case</td>
</tr>
<tr>
<td>2. Practical considerations</td>
<td>Template 2 Letter to GPs advising of service</td>
</tr>
<tr>
<td>3. Nurse education and CPD</td>
<td>Template 3 Local policy form</td>
</tr>
<tr>
<td>4. Building services for appropriate patients</td>
<td>Template 4 Competency framework</td>
</tr>
<tr>
<td>5. Role of policy, guidelines and protocols</td>
<td>Template 5 Patient information letter</td>
</tr>
<tr>
<td>6. Audit and data needs</td>
<td>Template 6 Clinical assessment</td>
</tr>
<tr>
<td>4. Building services for appropriate patients</td>
<td>Template 7 Annual cardiovascular risk</td>
</tr>
<tr>
<td>4. Building services for appropriate patients</td>
<td>Template 8 Local treatment algorithm</td>
</tr>
<tr>
<td>6. Audit and data needs</td>
<td>Template 9 Patient audit template</td>
</tr>
</tbody>
</table>

All these templates are currently used in the NHS but have been anonymised for obvious reasons.
The Purpose of this Business Case Document

The Business Case is an aggregation of specific information about the project and will be used by the appropriate Committee to assess whether the project is desirable, viable and achievable.

This document will ultimately provide the justification for the project and the proposed way forward, presenting the Committee with answers to the following key questions:

1. Does the project support delivery of the CCG commissioning objectives?
2. Does the project improve clinical quality and improved outcomes / experience for patients?
3. Is the outcome achievable – is there a realistic assessment of the ability to implement the scale of change envisaged?
4. Are you able to monitor and evidence delivery of the project / service?
5. Does the project demonstrate value for money – are the benefits and costs of realising them in the right balance?
6. Have options been considered – is this projecting the appropriate, or optimum, way of achieving the desired outcome(s)?

It is imperative that all of the necessary information is provided under each of the document headings. The guidance beneath each heading indicates the minimum information required. Additional information can be included if considered beneficial.

The Project Lead should work with their Clinical Commissioning Groups (CCGs), Clinical Leads and QIPP Account Delivery Teams to develop the Business Case. The Delivery Team approach is particularly important for the sections where specialist expertise is required i.e. finance and Business Intelligence.

Each member of the Delivery Team will be required to sign off the Business Case to demonstrate his or her endorsement prior to its submission to the relevant
1 - PROJECT OVERVIEW

1.1 Project Outline / Rationale

1.2 Strategic Fit

Provide a description of the business need for this project and its contribution to the organisation’s strategy.

1.3 Scope

Provide a description of the proposal; this should be concise but comprehensive.

- What is to be actioned e.g. increase, decrease, improve etc.?
- Scope of change e.g. geographical area, group of patients, practices involved, a particular CCG or cluster
- Detail the number of patients expected to benefit from delivery of the project
- What is the timeline for the proposal?
- Are there any other projects/accounts that are either dependent on the outcome or will be effected by it – i.e. what are the interdependencies?
- What health outcome/service improvement will a patient receive as a result of this project?
- Have you shared the proposals with existing providers (if applicable)?
- Are there any implications for Estates, Medicines Management or other?
- Are there any assumptions that would be needed to deliver success? E.g. behaviour change, 100% take-up, clinical engagement in primary care or secondary care

1.4 Options Analysis

Describe and evaluate the options that have been considered.

- Provide details of the options you have considered
- What criterion has been used to determine the best option?
- Has the balance of cost benefit and risk been considered?
- What would be the implications of not undertaking the project?

1.5 Preferred Option

Outline the reasons why the preferred option has been chosen (to include pathway development).

- What will the preferred option deliver in terms of improved quality of service?
- What other benefits will be derived from the preferred option?
- What will the pathway look like – attach as an appendix
What financial benefits will be delivered from the preferred option?
Will the revised pathway impact on current delivery of services/ e.g. fragmentation of current services, requirement of system wide sign-up and provider/stakeholder support?
Has the preferred option been shared with members of the Clinical Network / existing providers?

2 – PROJECT DETAILS / MEASURABLES

2.1 Benefits and Outcomes

Provide details of the expected outcomes and how these will be measured.

- How will the project contribute to reducing public health inequalities?
- Outline the strategic benefits.
- How will you know these outcomes have been achieved?
- What will the impact be against quality, safety and efficiency?
- What are the Critical Success Factors including the milestones and timelines related to these?
- How does this project contribute to the overall delivery of QIPP and how can you demonstrate delivery towards QIPP objectives?
- Outline the Key Performance Indicators which may be included within the contract – are they measurable, can the data be collected and reported (take into account cost reductions, demand reduction, productivity and quality)?
- What will the tangible outputs of the project be? E.g. technology, protocols, policies etc.

2.2 Outputs

What will be the real deliverables from the project?
E.g. technology / protocols / specifications / policies / training / processes

2.5 Service Specification

Will a service specification be required for this service?

NB: Service Specifications have to be signed off by all appropriate service areas, such as the Local Quality Assurance Group for all clinical / quality aspects of the specification. Please confirm the sign off arrangements with your Programme Management Office

2.3 Assumptions to Deliver Success

What are the critical success factors needed to deliver the project?
These should be both tangible factors as well as behaviour change
2.4 Critical Delivery Milestones

What are the estimated / proposed critical milestones to deliver the project?

<table>
<thead>
<tr>
<th>Key Milestone</th>
<th>Proposed Date / Deadline</th>
<th>Fixed / Flexible</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

3 - CLINICAL QUALITY / SAFETY / PATIENT EXPERIENCE / EQUALITY

3.1 Clinical Quality, Safety and Patient Experience

Provide details of all outcomes related to clinical quality, safety and patient experience.

Clinical Quality:
- What will be put in place and what will the impact be?
- How will you evidence clinical effectiveness? How will this be audited?
- Are there any training implications those delivering the service?
- What are key risks against clinical quality, safety and patient experience – develop a risk assessment?
- How will you measure the improvement in quality?
- What indicators would be needed to evidence delivery and are the indicators realistic?
- Have you taken into account the Mental Capacity Act and consent to treatment – will suitable arrangements be put in place to assess patients capacity to receive treatment?
- Prescribing – will the service be delivered in line with the legal regulations for medicines management? Does it meet QIPP and joint formulary processes?

Safety:
- How will clinical and patient safety be assured? Include the governance arrangements that will be put in place
- What will the impact on safety be and what would you be putting in place?
- What are the implications for Infection prevention?
• Have you taken into account a system for reporting incidents and complaints?

Patient Experience:
• Outline how the project will contribute towards improved patient experience
• How will you measure the patient experience / feedback?

3.2 Equality Impact

Please complete the embedded Equality Analysis Template and attach as an appendix to the Business Case (Guidance is embedded below to assist with completion of the template).

Under the Equality Act 2010, all policies, decisions, projects etc. should be assessed for their relevance to equality. The general equality duty requires that when exercising its functions that the NHS has due regard to the need to:
- Eliminate unlawful discrimination, harassment and victimisation;
- Advance equality of opportunity;
- Foster good relations between people who share a protected characteristic and those who do not.

You need to analyse the effect on equality for all protected characteristics – namely: Age, Disability, Sex, Race, Gender reassignment, Sexual orientation, Religion and Belief, Pregnancy and Maternity, Marriage and Civil Partnership and any other identified groups.

Is an Equality Analysis required? I.e. does the document you are considering contribute to the equality duties or impact on any of the protected characteristics?

If you consider that an equality analysis is not required, then you must complete the first page of the ‘Equality Analysis’ template embedded below, save as a new document and attach to the business case.

4 – FINANCE / ACTIVITY / WORKFORCE

4.1 Financial Impact

Detail the financial impact of the proposal, including initial (set up) costs, recurring cost/savings, timetable of investment/return, contract implications.

• Detail any existing costs
• Will there be any impact on prescribing costs?
• Outline timetable of investment/savings (part year and full year)
• Is there an expected transfer of activity from an existing contract?
• Proposed dual running?
• Detail cost benefit analysis including Value for Money.
• Outline the expected savings – when would they be realised (realistic timescales), are there any dependencies on delivering the savings?
• What is the proposed contract currency i.e. cost and volume?
- Will there be any financial incentives/penalties included within the contract and how will these be used to address health inequalities?

Please summarise in the table below the resource implication of the project. E.g. this will include equipment, management time, premises, impact on prescribing costs (primary and secondary care) etc.

<table>
<thead>
<tr>
<th>Resources Required</th>
<th>Recurrent or Non Recurrent</th>
<th>Timescale</th>
</tr>
</thead>
<tbody>
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</table>

All financial information needs to be confirmed and signed off by the nominated Finance Lead.

<table>
<thead>
<tr>
<th>Proposed / Estimated Start Date:</th>
<th>Current Financial Year £,000</th>
<th>Next Financial Year and Onwards £,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gross Savings (a)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Investment Required and Ongoing Recurrent Costs (b)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non Recurrent Costs (for set up or associated with decommissioning) (c)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Planned Net Savings (a+b+c)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Impact on Activity Levels

<table>
<thead>
<tr>
<th>Activity levels:</th>
<th>In Primary Care</th>
<th>In Secondary Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>1st year of operation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fully operational</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Please detail where the activity reduction / increase will be realised – e.g. outpatients, emergency admissions, A&E attendances, Community beds etc.*

*Number of patients projected to impact from the service proposal in a 12 month period – specify where there is a reduction and where there is an increase*
Projected activity profile / trajectory during first 2 years of operation:

<table>
<thead>
<tr>
<th>Primary Care</th>
<th></th>
<th></th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Yr</td>
<td>Apr</td>
<td>May</td>
<td>Jun</td>
<td>Jul</td>
<td>Aug</td>
<td>Sep</td>
<td>Oct</td>
<td>Nov</td>
<td>Dec</td>
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| Secondary Care | Activity Type (e.g. outpatients, A&E admissions, A&E attendances etc.): |           |           |           |           |           |           |           |           |           |           |           |           |           |
|               | Yr        | Apr       | May       | Jun       | Jul       | Aug       | Sep       | Oct       | Nov       | Dec       | Jan       | Feb       | Mar       | Total     |
|               |           |           |           |           |           |           |           |           |           |           |           |           |           |           |           |
|               | 1         |           |           |           |           |           |           |           |           |           |           |           |           |           |           |
|               | 2         |           |           |           |           |           |           |           |           |           |           |           |           |           |           |

<p>| Activity Type (e.g. outpatients, A&amp;E admissions, A&amp;E attendances etc.): |           |           |           |           |           |           |           |           |           |           |           |           |           |           |           |</p>
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<p>| Activity Type (e.g. outpatients, A&amp;E admissions, A&amp;E attendances etc.): |           |           |           |           |           |           |           |           |           |           |           |           |           |           |           |</p>
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</tbody>
</table>
4.2 **Workforce Impact**

- What will the workforce implications be when the service becomes fully operational?
- Will more or less staffing be required in primary and/or secondary care?
- Will there be significant workforce implications that could impact on service delivery?

<table>
<thead>
<tr>
<th>Impact on Workforce Levels</th>
<th>Primary Care (WTE)</th>
<th>Secondary Care (WTE)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical and Dental</td>
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<tr>
<td>Nursing</td>
<td></td>
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<tr>
<td>Managers</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Administrative</td>
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<td></td>
</tr>
<tr>
<td>All Other (<em>please specify</em>)</td>
<td></td>
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</tr>
</tbody>
</table>

5 – **OTHER**

5.1 **Stakeholder Engagement**

Describe your key stakeholders and how you will engage with them.

- Outline the project’s key stakeholders.
- What impact will the stakeholders have on the project?
- How will the various stakeholders influence the project?
- How will you keep the various stakeholders informed/included at key stages?
- Is there any evidence of patient support for this project, including consultation with patients and service users?

5.2 **Procurement and Contracting Aspects**

Has the appropriate sourcing work been undertaken to identify an initial procurement route?

- What will the impact be on the current provider - will you now be looking for them to provide the service in a different way?
- Will notice need to be given to the current provider and a new provider procured?
- Does this proposal impact on services provided / commissioned by other CCGs within the cluster?
- Provide an outline of the preferred procurement option
- What are the timescales involved in the identified procurement approach and will these be achievable?
- Is this an existing contract?
- Will this be a contract variation to an existing contract?
- What is the proposed length of the new contract?
5.3 Achievability

Describe any major risks identified and the likelihood of each risk occurring.

- Outline the significant risks for the project
- What possible actions can be taken to reduce/minimise the risks?
- Are there any contingency plans for any of the risks?
- What are the timescales for delivery and are these achievable?
- Have you considered the issues that may arise when mobilising/implementing the project?

5.4 Additional Information

Detail any additional information in support of this business case.

6 - BUSINESS CASE ENDORSEMENT

Members of the Project Delivery Team must sign below to indicate their contribution and agreement with the content of the Business Case.

<table>
<thead>
<tr>
<th>Clinical Commissioning Group (CCG)</th>
<th>Name</th>
<th>Signature</th>
<th>Date</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Project Sponsor</td>
<td></td>
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<tr>
<td>QIPP Account Director</td>
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<tr>
<td>Project Lead</td>
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</tr>
<tr>
<td>Clinical Lead</td>
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<tr>
<td>PMO Delivery Assurance Manager</td>
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<tr>
<td>Finance Lead</td>
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<tr>
<td>Contracts Lead</td>
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<tr>
<td>Business Intelligence Lead</td>
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<tr>
<td>Medicines Management</td>
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<tr>
<td>Quality &amp; Patient Experience</td>
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<tr>
<td>Equality &amp; Diversity</td>
<td></td>
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</tbody>
</table>

NB: When the Full Business Case is completed please complete the ‘ASSURANCE DECLARATION FORM’ enclosed at the end of this document (Appendix 1) – this should be completed in conjunction with the appropriate Locality Director. This needs to be completed prior to the business case being considered for approval by the CCG Board or Delivery Assurance Board. The declaration will summarise the FBC key points / issues, and records the sign off from the Local Quality Assurance Group.
7 – APPENDICES

Please clearly label all appendices attached to this Business Case and provide a list below.

APPENDIX 1

ASSURANCE DECLARATION

Please complete the Assurance Declaration in conjunction with the appropriate Locality Director. This needs to be completed prior to the business case being considered for approval by the CCG Board or Delivery Assurance Board, and will form part of the business case proposal for approval.

<table>
<thead>
<tr>
<th>PROJECT TITLE</th>
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<tbody>
<tr>
<td>PROJECT LEAD</td>
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<tr>
<td>CCG SPONSOR</td>
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<tr>
<td>LOCALITY DIRECTOR</td>
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GENERAL INFORMATION

| Brief Description of Proposal (as per page 1 of the FBC) |  |
| Are there any perceived or declared conflicts of interest? (See section 1.2) |  |
| Scale / Scope of Proposal (See section 1.3 - CCG or system wide?) |  |
| Contractual Implications (See section 1.3 & 1.5) |  |
| Impact on Pathways? (See section 1.5) |  |
| Estimated Project Start Date |  |

FINANCIALS (see section 4.1)

| Operational / Realisation of Savings Start Date |  |
| Level of Recurrent Investment Required £’000 (full year) | £ |
| Level of Gross Savings to be Achieved £’000 (full year) | £ |
| Net savings to be achieved (full year) £’000 | £ |
| Non Recurrent Costs £’000 | £ |
**PROVIDER ENGAGEMENT**
Please detail any provider engagement – this will include presentation to any contractual meetings such as JCCG / SDIP process. Please provide dates of any meetings, title of meeting and outcome etc.

<table>
<thead>
<tr>
<th>Date of Meeting</th>
<th>Title of Meeting</th>
<th>Outcome</th>
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**CLINICAL ENGAGEMENT**
Please detail any clinical engagement – this will include presentation to any of the Clinical Networks. Please provide dates of any meetings, title of meeting and outcome etc.

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<tr>
<th>Date of Meeting</th>
<th>Title of Meeting</th>
<th>Outcome</th>
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**CLINICAL QUALITY / SAFETY / PATIENT EXPERIENCE / EQUALITY**
(see section 3.1 & 3.2)
Summarise briefly the impact against the following:

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<tr>
<th>Quality/Experience</th>
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<tr>
<td>Clinical Quality</td>
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<tr>
<td>Safety</td>
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<td>Patient Experience</td>
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<td>Equality</td>
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**QUALITY SIGN OFF (Local Quality Assurance Group - LQAG)**
The Full Business Case has to be presented to one of the 3 LQAGs to ensure all quality aspects of the proposal are considered

<table>
<thead>
<tr>
<th>Date of LQAG Meeting</th>
<th>LQAG Meeting</th>
<th>Outcome</th>
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**DATE ASSURANCE DECLARATION**
COMPLETED
Dear Dr

Re: [INSERT REFERENCE TITLE]

We have developed a nurse-led MPN/telephone clinic for a specific group of Drs [INSERT NAME] and [INSERT NAME] follow up patients.

The aims of the service are as follows:
- To enable patients to receive appropriate healthcare without the burden of a hospital visit, improving the patient experience
- To free up consultant capacity, enabling them to increase capacity for new patients, ensuring that they get the appropriate treatment at the earliest opportunity.

This clinic is run by the Specialist Nurse practitioner in haematology, [INSERT NAME].

The patients we are offering this service to those on long-term follow-up who may or may not be on long-term treatment with oral drugs. These patients routinely require blood tests and it is hoped that this can be undertaken in the community or at the hospital. In order to further minimise trips to the Hospital we hope that, where required, repeat prescriptions can be managed by the GP with clear instructions from the Haematology team in a clinic letter.

Patients will be assessed over the telephone with the benefit of the recent blood results. Any change in disease status or current treatment will be relayed in a clinic letter to yourself as normal.

If at any time there is evidence that a patient requires formal review in outpatients an appointment will be made with the appropriate consultant haematologist.

We hope you agree that this is mutually beneficial to the patient and the service. If you have any questions or concerns please do not hesitate to contact us further.

Yours sincerely

[INSERT NAME] – Specialist Nurse Practitioner in Haematology
Haematology Specialist Nurse Led Clinic

Introduction
The purpose of this policy is to safely manage the care of stable haematology patients with asymptomatic disorders through a nurse led telephone follow-up clinic.

1. Definitions
Outpatient activity is increasing which is creating a serious capacity and demand concern. Many factors contribute to the increasing demand for haematology care. These include:

- Increasing local population
- Increasing age of the local population
- Prolonged survival of cancer patients
- Increasing incidence of haematological malignancies
- Increasing incidence of serious haematological malignancies in younger patients
- Increasing range of therapies including complex outpatient treatments
- Lack of physical space in the haematology department.

The nature of haematological disease means that some patients are followed up on a long-term basis as outpatients at varying degrees of frequency ranging from monthly to annually. These patients often attend hospital for a review of current blood parameters and are then advised that their disease is stable and a further follow-up appointment is scheduled.

Aims of the service
The Haematology Nurse Specialist will run the clinic. The aims of the service are as follows:

- To enable patients to receive appropriate healthcare without the burden of a hospital visit, improving the patient experience
- To free up consultant capacity, enabling them to increase capacity for new patients, ensuring that they get the appropriate treatment at the earliest opportunity

Benefits of the Telephone Follow-Up Clinic

- Potential reduction of DNA rates.
- Increased patient choice
- Reduced waiting times
- Convenience for patients
- Nurse led clinic offering the patients more time
- Enhanced patient satisfaction
- Manage capacity and demand more effectively
- Redirected Consultant time for other clinical priorities
- Reduce the burden on the hospital transport system
**Inclusion criteria**

Patients eligible for this method of follow-up are those who are deemed by their consultant to have stable disease, but require regular monitoring of their blood parameters every 3, 6 or 12 months. Occasionally patients will be reviewed more regularly when clinically indicated.

**Clinic schedule**

The clinics will take place weekly. The clinic will consist of 10 ten-minute slots.

**Referral protocol**

Patients will be referred by the Consultant Haematologist by letter or following discussion that specifies the patient’s management plan in terms of frequency of follow-up, blood parameters and drug regimen details.

**Cost Implications**

This service will be cost neutral, as it will not create additional activity only redesign the way current activity is managed.

**Evaluation**

The service will be constantly monitored in terms of activity through PAS. However service user satisfaction will be evaluated on a regular basis through patient satisfaction surveys.

2. **Roles and responsibilities**

**Medical staff**

It is the responsibility of the Consultant Haematologist to refer the individual patient to the Specialist nurse by letter or following discussion specifying the frequency of follow-up, blood parameters and drug regimen details where appropriate. The Consultant Haematologist remains clinically responsible for the patient’s care and will advise the Specialist Nurse in the event of complications occurring as a result of treatment or the underlying disease.

**Nursing staff**

It is the responsibility of the specialist nurse to accept referrals from the haematologists and manage the patient’s care according to the referral and this policy. It is the responsibility of the specialist nurse to refer the patient back to the consultant haematologist in the event of complications occurring as a result of treatment or the underlying disease. The specialist nurse is responsible for recording the care of the patient in the medical notes as per trust policy and communicating with the GP.
3. Main context of the document

Background
A significant percentage of patients with early CLL (stage A Bitnet’s classification) MPD, MGUS, mild anaemia, thrombocytopenia, thrombocythaemia and haemochromatosis with stable non-progressive asymptomatic disease are suitable conditions for the telephone follow-up clinic where only intermittent monitoring will be required. Some will progress over time and will then require formal review in outpatients for consideration of treatment. The consultant haematologists to the telephone clinic for active monitoring will refer selected patients. Many patients will require assessment through the telephone clinic on a 3 – 12 monthly basis.

Purpose of follow-up

Chronic Lymphocytic Leukaemia
To detect progression of lymphoproliferative disorder.
Progression is typically manifest by one or a combination of the following features:
• Rising white blood cell/lymphocyte count (rising by >50% in < 1 year).
• Anaemia
• Thrombocytopenia
• Neutropenia
• Development of new nodes/organomegaly.
• Development of B symptoms (sweats, fevers or weight loss)

Essential Thrombocythaemia and other myeloproliferative disorders
MPDs are a relatively common disease. Typically the condition is straightforward to manage however suitability of patients for inclusion in a telephone clinic should be assessed on a case by case basis.

The objectives of management may be summarized as:

• To ensure optimal control of the platelet count with cytoreductive therapy with a target platelet range of 200 – 400 x 10⁹/L.
• To monitor for adverse effects of therapy most notably myelosuppresion, anaemia and leg or mouth ulcers.
• To monitor for the late complications of the disease including myelofibrosis (usually manifest by falling haemoglobin and blood film changes) and leukaemic transformation.
• To monitor for complications of the disease for example arterial and venous thrombosis and haemorrhage.
**Patient Assessment**
At each telephone appointment the following must be assessed:

- Full blood count
- U&Es/LFTs/LDH
- Other blood tests in accordance with the diagnosis, (see flow chart)
- Patients should be asked specific questions relating to their condition. Such as in CLL patients should be asked about the development of B symptoms
- If they have become aware of new lymphadenopathy they will need formal review in the outpatient clinic for full physical examination.

**Action**
If there is laboratory or clinical suggestion of disease progression or transformation, then following discussion with the referring consultant, an appointment for formal review in outpatients will be arranged.

**4. Monitor compliance and audit**
Patient satisfaction surveys will be undertaken at least 2 yearly.

Lead Consultant signature

_________________________

Nurse specialist signature

_________________________

Lead nurse / Manager signature

_________________________
Template 4 – Patient Information Letter

Dear

We have developed a telephone clinic for doctors [INSERT NAME] follow up patients at [INSERT HOSPITAL TRUST]. This clinic is run by the Specialist Nurse practitioner in haematology, [INSERT NAME].

As you know we are monitoring your condition and this involves obtaining a blood test and discussing the results with a doctor at the hospital. With this new clinic, you can get your blood test done in the community at your local GP practice or at the hospital. You will have the opportunity to discuss your results with the nurse specialist over the phone. It would save you the time and frustration in travelling to the hospital, trying to park and paying car park fees.

I enclose your appointment letter for your information.

Please be by the telephone at this time or alternative arrangements can be made to discuss the outcome

This will replace the old method of monitoring your condition.

However, if you tell us you are having problems or your blood results are not normal, you may be given an appointment to be seen by myself or a doctor at the hospital. You may need an appointment to see the doctor at least annually. If you are unwell and concerned before the telephone appointment, please call us for advice.

Please read the enclosed sheet for further information.

The telephone number we have for you is:
[INSERT NUMBER]

What is a telephone-based follow up clinic?
Many patients only need to be seen every few months, some with a blood test to find out if they are experiencing any symptoms or problems. A telephone clinic will allow us to do exactly the same thing but save you having to visit the hospital personally.

What will happen when you telephone me?
The nurse specialist will discuss your condition with you and any problems you may be having. You will be told the results of your blood test. This is a 10-minute consultation. If you wish to discuss issues in more depth, an appointment can be made for you to attend the hospital.

What if I forget to tell you something?
You can always access the hospital team. This can either be through your GP, or via the specialist nursing team on [INSERT DETAILS]
What if I can’t make my appointment time?
It is important to remember that the telephone appointment is just the same as a normal clinic appointment. You should be available by the telephone at your appointment time. If you are not available then please contact the hospital on [INSERT NUMBER] and quote the clinic code [PROVIDE CLINIC CODE]. They will make you a new appointment.

What if I miss my appointment?
Please contact the hospital and they will arrange another appointment for you.

What if my contact details (as given on my appointment letter) are wrong?
Please contact the hospital with your correct details.

What happens if I don’t have a telephone?
Please write to the hospital at the address at the top of this letter. We will then give you an appointment to come to the hospital.

What happens after the telephone consultation?
If all is well, you will be sent a letter with the date and time of your next telephone appointment. The letter will also contain a request form for a blood test.
If there are any problems you may be asked to attend the hospital to be seen by a doctor. You will be contacted with a date and time for this appointment.
If you experience problems relating to your blood condition between your booked appointments, you can always access the hospital team. This can either be through your GP, or via the Specialist nurse [INSERT DETAILS]

If I need a blood test how do I get it done?
You should have a blood test form already from your last appointment. You should have your blood test taken 3 to 7 days before your next telephone consultation. You can have this done at your GPs surgery, or at the hospital. After each telephone consultation you will receive a new blood test form in the post.

If you are unsure about any of the information in this letter please contact the Nurse specialist on [INSERT DETAILS].

We will be monitoring the success of this clinic closely and you may be sent a questionnaire to fill in. We are very grateful for any feedback and the answers you give will in no way affect your care in this clinic.
Template 5 – Clinical Assessment

Patient assessment – ET Assessment and Management

Assessment

Bloods
- FBC each visit
- U&E’s, LFT’s & cholesterol yearly (thyroid if on Ifn)

General assessment
- Understanding of condition
- Co-morbidities – ensure under regular review
- Medicines review – general
- Smoking
- Alcohol
- Cardiovascular - ensure cholesterol reviewed by G.P

Symptoms / complications of E.T
- Headache
- Lethargy/Fatigue
- Visual disturbance
- Chest/abdominal pain
- Muscle weakness
- Thrombosis
- Paraesthesia
- Itching
- Erythromelagia
- Bleeding

Physical assessment if needed (spleen x2 year)
### RESULT

<table>
<thead>
<tr>
<th>RESULT</th>
<th>ACTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adverse effect of medication or disease complication</td>
<td>Discuss with Dr</td>
</tr>
<tr>
<td>hb/wbc/neuts normal</td>
<td>No change in meds</td>
</tr>
<tr>
<td>plt 200-400</td>
<td>Arrange next f/up (max 3/12 if on treatment)</td>
</tr>
<tr>
<td>No symptoms</td>
<td>Consider reactive cause of elevated plts.</td>
</tr>
<tr>
<td>plt &gt;400 but intercurrent problems (e.g infection/ trauma)</td>
<td>If suspected reactive- no change in dose, rpt FBC in 2-3/52</td>
</tr>
<tr>
<td>No compliance issues &amp; No symptoms</td>
<td></td>
</tr>
<tr>
<td>plt&gt;400, no intercurrent problems, wbc normal, not anaemia</td>
<td>Discuss with Dr</td>
</tr>
<tr>
<td>plt &lt; 200 but &gt;100. Or hb&lt;10</td>
<td>Discuss with Dr</td>
</tr>
<tr>
<td>plt&lt;100</td>
<td>Discuss with Dr</td>
</tr>
<tr>
<td>Falling Hb/anaemia</td>
<td>Assess for blood loss etc.</td>
</tr>
<tr>
<td>Normal wbc</td>
<td>Send b12/folate/ferritin/</td>
</tr>
<tr>
<td>Req blood film FOA consultant</td>
<td>Rpt Fbc 1/12</td>
</tr>
<tr>
<td>Falling wbc/neuts &lt;1.8 but &gt; 1.0</td>
<td>Discuss with Dr</td>
</tr>
<tr>
<td>Falling wbc/neuts &lt;1.0</td>
<td>Stop treatment, d/w Dr</td>
</tr>
<tr>
<td>Pt Pregnant</td>
<td>Discuss with Dr</td>
</tr>
<tr>
<td>Development of pancytopenia</td>
<td>Discuss with Dr</td>
</tr>
<tr>
<td>Rising wbc/blasts</td>
<td></td>
</tr>
<tr>
<td>Increasing symptoms, (weight loss etc.) or spleen size</td>
<td>Discuss with Dr</td>
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</tbody>
</table>
# Template 6 - Annual cardiovascular risk to be sent to GP

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>JAK2 status</th>
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<td>Year of diagnosis</td>
<td>?Exon 12 / mpl</td>
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<tr>
<td>Previous treatments</td>
<td>Symptoms at diagnosis</td>
</tr>
<tr>
<td>Thrombotic episodes pre diagnosis</td>
<td>Thrombotic episodes post diagnosis</td>
</tr>
<tr>
<td>Haemorrhagic symptoms pre diagnosis</td>
<td>Haemorrhagic symptoms post diagnosis</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Current treatment</th>
<th>Current FBC</th>
<th>Hb</th>
<th>WCC</th>
<th>Plat</th>
<th>neut</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recent BM biopsy Y/N Results:</td>
<td>Current symptoms</td>
<td></td>
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<tr>
<td><strong>Cardiovascular risks</strong></td>
<td>Yes / No</td>
<td>Date last tested &amp; result</td>
<td>Advice given</td>
<td></td>
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<tr>
<td>Hypertension</td>
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<td>Diabetes</td>
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<tr>
<td>Hypercholesterolaemia</td>
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<td>Smoking</td>
<td></td>
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<tr>
<td>Smoker Y / N</td>
<td>No. smoked per day</td>
<td></td>
<td></td>
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<tr>
<td>Non-smoker Y / N</td>
<td>------------------</td>
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<tr>
<td>Past smoker Y / N</td>
<td>Date stopped</td>
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INFORMATION FOR GPs
NURSE/PHARMACIST LED SERVICE FOR PATIENTS RECEIVING

[SPECIFY MEDICATION}

A new service is being introduced at the RUH for patients with certain myeloproliferative disorders (mainly essential thrombocythaemia & polycythaemia rubra vera) who are stable on therapy. At present these patients are seen in the Haematology clinic every 2/3/4 months by a Consultant Haematologist/Registrar, essentially to have their blood results reviewed and a prescription for anagrelide written. Many of them remain on the same dose for several years.

The Nurse/Pharmacist-led service will manage these patients instead of the clinicians, creating more clinic slots for new haematology referrals.

**How the service will work?**
The Consultant Haematologist will refer the patient to the Nurse/Pharmacist-led service. They will be given a 6-month supply of [SPECIFY] by pharmacy labelled “Take as directed” and a dosage card with the dose written on. They will also be given a blood form.

Every 2/3/4 months they will have a blood test at their GP surgery or [HOSPITAL], and the dosage card will be sent in to the RUH with the blood form. One of the Nurse/Pharmacist team will look up the result and decide whether the dose needs to be changed, based on blood test parameters provided by the Consultant.

The new dose will be written on their dosage card & sent back to the patient in the post, with another blood form. They will also be phoned with this information. When necessary a repeat prescription will be obtained for [SPECIFY] from the Consultant, to resupply the patient.

Patients will be seen annually by the Consultant in the Haematology clinic, or more frequently if necessary.

**Impact on GPs?**
We do not anticipate that this new way of working will have a major impact on GPs, as some patients have blood tests at their surgery & some at the [HOSPITAL].

If you have any queries on the service, or about your patient’s anagrelide treatment, please phone their Consultant’s secretary & they will contact one of the team.
Template 8 – Patient Audit Questionnaire

The Haematology Team at [INSERT] Hospital are conducting a questionnaire about the Nurse Led Myeloproliferative Clinic. The purpose is to develop a better understanding of what it has been like, and to use this information to decide if the introduction of this service has been worthwhile.

We would very much appreciate if you would take 10 to 15 minutes to answer the following questions and post your completed questionnaire in the stamp addressed envelope provided?

You are not asked to put your name on the questionnaire, so cannot be identified. All information will be treated as confidential.

Thank-you for your co-operation.

Questions

1. Approximately how many occasions have you been seen by the Specialist Nurse at the clinic? (please tick)

<table>
<thead>
<tr>
<th>Options</th>
<th>Ticks</th>
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</thead>
<tbody>
<tr>
<td>Less than 3 occasions</td>
<td></td>
</tr>
<tr>
<td>More than 3 occasions</td>
<td></td>
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</tbody>
</table>

2. Please indicate your opinions regarding the clinic (please tick)

<table>
<thead>
<tr>
<th>Options</th>
<th>Strongly agree</th>
<th>Agree</th>
<th>Neither agree or disagree</th>
<th>Disagree</th>
<th>Strongly disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) I am happy to be reviewed by the Specialist Nurse</td>
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<td>b) I can spend as much time as I need with the Specialist Nurse</td>
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<tr>
<td>c) I am confident that the Specialist Nurse manages my care well</td>
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<td>d) There are some things that I would prefer to talk about with a Doctor</td>
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<tr>
<td>e) I feel the service for myeloproliferative patients has improved since the Specialist Nurse came into post</td>
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</table>
3. Please tick as appropriate:
   I would prefer to see a doctor at every visit
   I am happy to see the Specialist Nurse most of the time and the doctor occasionally
   I would like to see a doctor most of the time and the Specialist Nurse occasionally

4. Try to think about the last time you were seen by the Specialist Nurse. In your opinion, which aspects of this experience were good?

   In your opinion, which aspects of this experience could have been improved?

5. Again, try to think about the last time you were seen by the Specialist Nurse. In your opinion, what aspects were better than your experiences before?

6. Do you have any thoughts about how we could improve the service provided?

7. Do you have any other comments that you would like to make?

   Thank-you for your cooperation – your opinion is of great importance to us.

   Please remember to return your completed questionnaire in the envelope provided.