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Review Article

Valuing urology clinical nurse specialists in the United Kingdom

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ABSTRACT

Urology Clinical Nurse Specialists (CNSs) in the United Kingdom play a central role in delivering holistic, patient-centered care across the cancer pathway, particularly in uro-oncology. They act as the primary source of information, support, and coordination for patients with urological cancers, including prostate, bladder, kidney, testicular, and penile malignancies. This discussion-based work evaluates the value, current challenges, and future potential of CNS roles within UK urology services.

Drawing on clinical expertise and existing literature, the paper highlights that CNSs contribute significantly to improved patient outcomes by managing treatment-related side effects, enhancing continuity of care, and supporting adherence to complex therapies such as immunotherapy and targeted treatments. Additionally, their involvement can reduce healthcare costs by preventing complications and optimizing treatment pathways.

However, the role faces several challenges, including workforce shortages, increasing patient demand, limited formalized training pathways, and variability in role recognition across healthcare settings. Recruitment difficulties and lack of standardized competencies further impact service delivery.

The study concludes that, with the growing complexity of urological cancer treatments and improved patient survival, the need for well-supported and adequately trained CNSs is critical. Strengthening education, workforce planning, and professional development initiatives is essential to maximize the value of urology clinical nurse specialists and ensure high-quality patient care across the UK.

Keywords: Urology, Clinical Nurse Specialists (CNS), Uro-oncology nursing, Advanced nursing practice, Patient-centered care

INTRODUCTION

There is a global need to reorganise the healthcare workforce to meet the greater health demands of an ageing population and improve health access to more people (World Health Organization, 2007). This concern is reflected in the WHO 2008 document, which has advocated for task shifting to optimise the workforce to improve efficiency and expand healthcare capacity by redistributing tasks that were previously performed solely by doctors to other trained professionals such as nurse practitioners and Clinical Nurse Specialists (CNS) (Falk et al., 2020). Since the publication of this document, the deployment CNS in cancer and surgical specialties has been prevalent in over 30 countries and is especially evident in the anglosphere or English speaking world (Federspiel et al., 2018; Maier et al., 2015).

Urology CNS are registered nurses who have usually been locally trained by the urology service and assessed by doctors and senior nurses before they can independently carry out specific clinics or procedures. They usually have several years of nursing experience and hold a level of at least Band 6, a grading scale used by the UK National Health Service (NHS) to describe skill level, experience, and responsibility. A newly qualified nurse in the UK would start at Band 5. Urology CNS duties may include undertaking clinics for non-admitted patients, assessing patients independently, counselling patients, undertaking procedures such as administering intravesical botox instillations and urodynamics, and performing low complexity procedures under local anaesthetic such as flexible cystoscopy or more challenging ones such as transperineal prostate biopsy and laser ablation of small recurrent bladder tumours *i.e.* Transurethral Laser Ablation (TULA). In this challenging healthcare environment of increasing unfilled

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positions, expected doctor shortfall, and ever growing waitlist for elective surgery, many urological departments have included CNS as part of workforce planning to help manage essential services. By utilising the skills of CNS in a multidisciplinary team with medical oversight and clinical governance, urology doctors are able to be redistributed to undertake surgical operations and clinics involving more complex care. A reflection of their growing presence in the country is reflected by the membership of 757 registered nurses of the British Association of Urological Nurses (BAUN) as of 2024, an organisation supporting and advancing the training for urology CNS. This equates to approximately one urology CNS for every two urologists on the specialist registry in the UK.

The acceptance and practicality of CNS by patients and other healthcare professionals to undertake these duties is reflected in the multiple qualitative research showing that they are able to deliver an efficient and safe service in urology (Henderson et al., 2004, Sapre et al., 2012; Drudge-Coates et al., 2019). However, it has been difficult to quantify this efficiency. There have been a few attempts in quantifying the worth of CNS either in time saving or cost savings but these analyses have been narrow in focus and on specific tasks (Drudge-Coates et al., 2019; Mishra et al., 2020). There has not been any studies reviewing the overall clinical activities performed by CNS in a whole urology department and the resultant time saving to a comprehensive urology service serving a defined population. This paper sets out to examine the overall picture of the value and breadth of practice by urology CNS at Barts Health urology department in North East London (NEL), UK between 2022 and 2023, which serves an approximate population of over 2 million people, and by doing so, demonstrate the value that a coordinated group of CNS can bring to the patients and the multidisciplinary team in a urology department.

LITERATURE REVIEW

The urology nurse lead has provided an activity review of the NEL urology service between 2022 and 2023. This review has documented the workload of the service run by the CNS, the type of clinics, and the number of patient encounters reviewed or managed by CNS in the NEL urology service in cancer clinics (Appendix 1) and benign urological clinics (Appendix 2). To assess the amount of time, the number of CNS is calculated in units of Whole Time Equivalent (WTE), which in the UK is 37.5 hours per week. The calculation of the equivalent number of doctors needed to cover these clinical activity is made by converting it doctors WTE which is 40 hours per week. The data collated does not include patients reviewed by doctor led clinics.

Some of the clinics are managed locally by each hospital site in the NEL urology service, whereas some clinics are centralised to a specific hospital. The number of patient encounters are provided by local urology CNS, however at the time of the data collection, the patient encounters in some benign urology clinics for Royal London hospital was not available and so was not recorded in the total number.

Oncology CNS activity is excluded from this review even though they are involved in the ongoing treatments of metastatic advanced urological malignancies and its chemotherapy care. There is a crossover of care between urology and oncology CNS but urology CNS do not participate in the delivery of intravenous chemotherapy in most urology departments.

Over the course of 1 year between 2022 and 2023, the urology CNS at Barts Health have led a number of clinics independently but with medical oversight and governance framework. They have had a total of 9781 patient encounters in 20 different cancer clinics, and 5482 patient encounters in 12 benign clinics. The variety of clinical activities are listed in Appendix 1 and 2. These activities have been performed by a team of 8.65 WTE CNS, where 6.65 WTE CNS is needed to manage the cancer clinics and 2 WTE CNS to undertake the benign clinics. On average each CNS can counsel, review, and manage 7 to 15 patients in a cancer clinic, and approximately 13 patients in a benign clinic. The breakdown of the number of CNS required in each subspeciality of urology. Each of these clinical activities are centralised to one hospital, or local to each hospital. In order to cover all the clinical tasks performed by a total of 8.65 WTE CNS, a theoretical value of 8.11 WTE urology doctors would be required if they worked only in clinics and had no other clinical duties. In the realistic setting that is reflective of current urological practice of 8 to 12 hours in clinics per week, a practical total of 27.0 to 40.5 WTE of urology doctors would be required.

The types of CNS-led clinic in both cancer and benign urology are shown. In cancer urology, 47% of clinics are conducted face to face with patients and 53% are either virtual reviews of results or telephone clinics with patients. In benign urology, the majority or 94% are conducted face to face with patients, with only 6% conducted virtually or by telephone.

DISCUSSION

It is evident that the utilisation of adequately trained CNS is necessary to manage the predicted increasing number of urological patients in the ageing population. Healthcare systems are under pressure to deliver high quality healthcare that is safe, efficient, and cost effective and as a result, updated models of service provision by task shifting and dismantling previous conventions have been promoted by the NHS, GIRFT (Get It Right First Time), and the British Association of Urological Surgeons (BAUS) in their strategic plan 2023-2036. The integration of highly trained CNS will augment the delivery of urological services and improve patient access.

Traditional tasks performed by doctors have been successfully transferred to the responsibility of CNS. The workload volume and demand of urological care in NEL in 2022-2023 is evident by the 15,263 patient encounters (9781 urology cancer and 5482 benign) that were managed by the CNS team in a single year. It is important to emphasise that a CNS led clinic is not lesser in the quality of medical care. Numerous articles have demonstrated that urology CNS can deliver equivalent or even better medical care to patients with significant cost savings and improved efficiency in reducing waiting times, whilst ensuring consistent satisfactory

patient feedback and competent technical abilities such as performing check cystoscopy and transperineal prostate biopsies (Bognini et al., 2023).

There is value in embedding CNS at every level of patient care as seen by the different roles that urology CNS play at Barts Health. They fulfill a crucial role in the multidisciplinary team and help bridge the gaps in the patient's healthcare journey, which can include initial assessments, diagnostics, treatment and subsequent follow up, and higher level discussions at cancer multidisciplinary team meetings. CNS are optimally positioned to advocate for patients, respond to patient needs and can support patients undergoing difficulty during their treatments as they are often close to the treatment process, and provide educational seminars before planned operations to help them better understand their conditions and treatments that may not have been addressed in clinic due to time constraints. Their integral part in patient care has been shown in literature to improve patient satisfaction and patient education, and also maintains a continuity of care and improves patient adherence to treatment plans. Furthermore, CNS have been identified to boost teamwork efficiency and team cohesion, and promote a patient safety culture. To further illustrate the integration of CNS in the urology service and in particular cancer pathways, where they can support the clinical team in cancer patients such as prostate and bladder cancer respectively. These pathways are predominantly doctor-led with CNS providing valuable supportive role in improving efficiency and patient experience.

The direct comparison between doctors and nurses WTE has been made to illustrate the amount of clinical work that CNS is able to take on, and also give an impression of the number of doctors needed to cover the same amount of work. A doctor's work is arranged slightly differently in the UK. 1 WTE for a doctor is the equivalent of 40 hours per week or 10 Programmed Activities (PA). Considering the same workload of 2022-2023, a theoretical total of 8.11 WTE of specialist doctors would be needed to cover the same number of clinics run by CNS per week. However, it is important to note that this comparison is speculative and somewhat specious as it does not reflect the reality of work of urology specialist doctors. A CNS can be employed to run clinics and undertake procedures only as the majority of his or her job plan however a specialist urology doctor in the UK does not only run clinics, but also performs on-call duties and operations; in a given week, a specialist doctor would usually dedicate only 8-12 hours (2-3 programmed activities) to seeing patients in clinics, which means approximately between 27.0 to 40.5 WTE doctors with this current job plan would be required to cover the equivalent clinical activities performed by CNS. Furthermore, one can argue that a specialist doctor may be more efficient in practice than a CNS and may be able to manage more patients within a given amount of time; however, the number of patients reviewed in clinic for both doctors and CNS are similar with a similar time allocation per patient, and so this point may not apply for clinic or telephone appointments for CNS. The salaries of CNS and urology doctors were deliberately not included and instead, a universal unit of time was used as for comparison in this review since each department may have differences negotiated in their salaries in the UK or internationally. However, given that the salary of a doctor is usually higher than that of a nurse, it can be inferred that a urology department would be more cost-efficient by deploying CNS in the clinics as detailed above. This is supported by the existing publication showing potential cost savings by CNS deployment especially in prostate cancer pathways and clinics.

It is important to stress that this not an argument to shift completely to only CNS-led clinics despite potential time and cost savings. Doctors in training need to have the exposure to areas that CNS are now performing e.g. flexible cystoscopy and prostate biopsy. Trainees need to be patient facing and learn to communicate with patients at different stages of their care and know how to initiate treatment and also monitor their progress. In the context of this report is not an argument to replace doctors but offers urology departments a specific arrangement in reducing workload and optimising workplace efficiency whilst ensuring adequate training of future urology doctors by utilising CNS in monitoring and reviewing the large numbers of patients. More training opportunities can be created for doctors by redistributing the clinical activities to properly trained CNS. In fact, experienced CNS can also share invaluable experience with trainee doctors, and provide a level of training for performing these procedures. This distribution of labour can increase a service efficiency and better cope the increasing pressures that urology services are set to face in the coming years. Furthermore, CNS serve as committed long term posts and ensure ongoing service provision to the department whereas trainee doctors can often rotate in their duties within the service, or even across specialities, which can sometimes lead patients to feel a lack of continuity in their care.

CONCLUSION

The utilisation of CNS in the NEL urology services is evident in ensuring the patient access and efficiency of the service especially with the expected increase in patient numbers. As part of the multidisciplinary team workforce, CNS can manage low complexity procedures and also support both patients and other healthcare colleagues, thus releasing doctors to manage more complex needs of patients and operations. Further potential areas to expand the use of CNS can include acute care, where they can support existing teams in managing common admissions such as urinary retention or acute stone episodes. This can help relieve the pressures on clinical teams, ensure patient access to prompt high quality of care, and importantly, protect training opportunities for trainee doctors. With adequate training and doctor oversight, CNS are a practical necessity in the UK to delivery exemplary care to an increasing number of ageing and morbid patients.

REFERENCES

World Health Organization (2007). Task Shifting to Tackle Health Worker Shortages.

Federspiel F, Mukhopadhyay S, Milsom PJ (2018). Global surgical, obstetric, and anesthetic task shifting: A systematic literature review. Surgery 164:553–558.

Falk R, Taylor R, Kornelsen J, Virk R (2020). Surgical task-

sharing to non-specialist physicians in low-resource settings globally: A systematic review of the literature. World J Surg. 44:1368–1386.

Maier CB, Aiken LH (2016). Task shifting from physicians to nurses in primary care in 39 countries: A cross-country comparative study. Eur J Public Health. 26:927-934.

Henderson A (2004). Outcome analysis and patient satisfaction following octant transrectal ultrasound-guided prostate biopsy: A prospective study comparing consultant urologist, specialist registrar and nurse practitioner in urology. Prostate Cancer Prostatic Dis. 7:122–125

Sapre N (2012). Nurse-led flexible cystoscopy in Australia: Initial experience and early results. BJU Int. 110:46–50.

Drudge-Coates L (2019). A nurse practitioner model for the assessment of suspected prostate cancer referrals is safe, cost and time efficient. Ecancermedicalscience. 13:994.

Mishra K (2020). Direct cost savings analysis of nurse practitioner for inpatient urology practice. Urol Pract. 7:467–473.

Bognini MS (2023). Assessing the impact of anaesthetic and surgical task-shifting globally: A systematic literature review. Health Policy Plan. 38:960–994.