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Developing a Cancer CNS Capabilities Framework in the North West

Research Briefing

AUGUST 2021

Background

The North West Cancer Alliance and Health Education England (HEE) commissioned Skills for Health to develop a Cancer Clinical Nurse Specialist (CNS) capability framework in the North West to inform the development of a national framework. The project is scheduled to run throughout 2021, leading to a launch of the framework in early 2022.

In order to do this, a research stage was included prior to the development of the framework with the aim of helping define the scope and review of current roles and responsibilities of the cancer CNS workforce in the North West. The research stage culminated with a workshop in which the Expert Group was invited to explore the emerging themes of the primary research.

Methodology

The introduction of the CNS role has been pivotal in cancer care and has rapidly proved its value (Kerr, Donovan, & McSorley, 2021). However, confusion still exists around the responsibilities of the role, as it has been utilised inconsistently across organisations. This study aimed to provide some clarity towards the successful design of a capabilities framework.

A mixed-method technique was adopted to carry out this research which, when combined, offers the ability to triangulate findings to provide richer, more robust data. The research methods undertaken were desk research; an online survey (N=359); semi-structured depth interviews (N=42); and a world café workshop.

Summary of findings

Cancer CNS are a key contact for patients to support them during their treatment. They are the main person in charge of patients' care and are able to address important questions about their diagnosis, treatment, and support.

For CNSs to thrive in their roles, and organisations and patients to fully benefit from their knowledge and experience, it is important that managers and workforce departments understand the scope of the role. In 2017, UKONS with the Royal College of Nursing (RCN) developed the *Careers and Education Framework for Cancer Nursing,* which aimed to provide some clarification of the CNS role; at the time of writing of this report (June 2021), it is being updated[1]. Additionally, Macmillan Cancer Support has also developed the *Macmillan Competency Framework for Nurses Supporting People Living With Cancer and Affected by Cancer*[2]. Despite this, inconsistencies remain.

Seven themes emerged from the research, summary of each themes may be found in the following tables.

Experience and entry pathways

Before becoming CNSs at Band 7, most participants gained experience as Band 6s in wards which provided them with knowledge of the tumour group. A few of them came from chemotherapy, palliative care, or research roles, which introduced them to cancer care prior to becoming a clinical specialist.

Key takeaways – training and entry routes

- Most CNSs gain experience as Band 6s (e.g., secondment) which provided them with knowledge of the tumour group.
- Cancer CNSs learn about the role "on the job".
- Patient contact and continuous learning are the main reasons participants were motivated to become CNSs.
- Backgrounds are varied, but most have experience in cancer care and/or site-specific speciality experience. This exposure helped them in their specialist pathway.
- Limited training is provided at the beginning of their journey as CNSs.
- Cancer CNSs use their own initiative to seek learning opportunities and learn in the job as no specific career/learning pathway is available. This is particularly important during the first year after becoming a CNS.

Roles and capabilities

Participants were asked to provide a brief description of their current role and responsibilities and four main themes emerged from their responses: patient centred care, collaborative working, specialist clinical skills, and general skills. These are consistent with the qualitative findings during the interviews, although in the interviews there was a greater emphasis on leadership.

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[1] Framework is available to download from the RCN website: https://www.rcn.org.uk/professional-development/publications/pub-005718

[2] Framework available following this link: https://www.macmillan.org.uk/_images/competency-framework-for-nurses_tcm9-297835.pdf

In addition, were asked to rate how important a range of capabilities would be in order for Cancer CNSs to carry out their job effectively in the future. A summary of these is provided in the table below.

Most important capabilities	**Less important capabilities**
• Communication skills	• Independent prescribing
• Patient Advocacy	• Active involvement in research
• Person-centred care	• Audit skills
• Teamworking	• Prevention
• Specialist Cancer Care	• Diagnosis

Key takeaways – Roles and capabilities

- CNS staff have **various roles, capabilities and responsibilities**. These include patient-centred care, patient-advocates, coordination of investigations, prescription, pre and post operational services.
- In addition, they **work alongside MDTs**, conducting such activities as team management, education and teaching, mentoring, project management and stakeholder engagement.
- **Specialist CNS skills and capabilities** also include advanced care planning, diagnostics and practice skills, complex symptom management, clinical assessments, nurse-led clinical reviews, research & evaluation. and end of life care.
- The main **barrier** impacting on their roles is **time constraints** followed by **staff shortages** and **lack of resources**.
- Patient care, clinical skills and leadership are the main capabilities emerging from the research.
- Patient care involves excellent communication skills, person-centred care, holistic practice, psychological and wellbeing support, patient advocacy, and teamworking.
- Clinical skills include a great knowledge of the cancer pathway, clinical assessment and therapeutic procedures, referrals, and symptom management. Non-medical prescribing was highly regarded by many, but not all CNSs, as enabling skills to improve their care and gain greater efficiency.
- Leadership involves high levels of autonomy, managing teams and managing complexity.
- Other relevant capabilities include education and mentoring, service development, research, additional patient support, and prevention.

Key takeaways – Team

- Flexible and part-time working was common in all teams.
- Most of the CNSs interviewed worked in small teams, of about 3-7 CNSs.
- Teams tend to have a majority of Band 7 CNSs with a few Band 6s; in addition, some teams also integrate Band 4 Cancer Care Coordinator or support worker.
- Band 6s CNSs mostly provide nursing support.
- Band 4s undertake administrative tasks, clinical examination support, and in some instances, they complete the Holistic Needs Assessments (HNA). This provides relief in CNSs' workload, increasing efficiency and quality of care for many of the teams.
- Managerial support to CNSs is highly dependent on their understanding of the CNS role.

Key takeaways – the evolution of the role

- Potential increase in medicalisation of the role.
- Increased levels of complexity. Knowledge to evolve to better support patients and how different elements of their life interact and impact health outcomes.
- More responsibility and higher level of autonomy - with increasing nurse-led clinics.
- Involvement in service development.
- More strategic responsibilities as they collaborate with other roles (e.g., associate practitioners), and other areas of cancer care (e.g., palliative care) which may create overlap between CNS across pathways.
- New ways of working might be needed as demand increases but staffing remains stable.

Key takeaways – professional identity

- The role of the Cancer CNS has evolved and continues to evolve, although the descriptor of "key worker" for the patient remains.
- Colleagues misunderstanding the role have a negative impact on CNSs and increases feelings of isolation and self-doubt.
- There are fears around the risks of becoming "mini-doctors", the erosion of the role linked to the progressive gain of independence, and the furthering of nursing identity.
- Confusion about the differences between CNSs and ANPs exist for many participants. Although two main views are prevalent: 1) ANP as a progression step for CNS, 2) ANP as an alternative pathway to specialist nursing.

Key takeaways – clinical supervision

- The role is very emotionally demanding and presents challenging and complex situations which might require support.
- Those who use clinical supervision find it useful to receive reassurance, care, and support.
- Groups that are smaller, with regular attendees, and run with a regular schedule are considered the most suitable.
- The skills of the facilitator greatly influence the experience.
- COVID-19 has had a great impact on access and availability for clinical supervision.
- People who do not attend clinical supervision tend to be: 1) new recruits who have never attended and do not see the benefit, 2) experienced nurses who find the support elsewhere (e.g., other CNSs) and feel they only needed it at the beginning of their career, and 3) people who wish to attend but time pressures or other external factors have impeded it.

Key takeaways – COVID-19 impact

- Telephone/video conferencing introduced - likely to remain for many consultations.
- Some clinics were halted during the first months of the pandemic.
- Building rapport was difficult when face-to-face consultations were not taking place. These were quickly resumed.
- Level of work declined in some cases as they were not receiving referrals from GPs. Workload is starting to be at similar levels as before the pandemic now, and it is expected to increase in the following months.
- Levels of responsibility and autonomy increase as colleagues/ supervisors redeployed
- Flexible and homeworking was introduced successfully.

Recommendations

New approaches to care delivery and organisational design are emerging in response to demographic changes, more complex patients, shift in policy as well as a range of financial pressures. Technological advances are also playing a central role in supporting the development of these new models such as facilitating collaboration and integration across multiple care providers and settings, improving communication between patients and professionals, increasing efficiency and empowering patients to manage their health and wellbeing more effectively, thus there is the need for a workforce that can meet these demands.

Confusion still exists around the responsibilities of the role, as it has been utilised inconsistently across organisations. This study aimed to provide some clarity towards the successful design of a capabilities framework. Many reasons exist that explain this confusion. Results of this research are consistent with previous findings in the diversity of titles, and these not necessarily being indicative of seniority. Despite a push from Lead Cancer Nurses and other workforce professionals to establish the CNS role as Band 7, this is not consistent in all organisations that have participated in the study. Band 7 CNSs and Band 6 CNSs often share the same title, yet do not share the same level of responsibility. Titles such as “Junior CNS”, or “Senior CNS” are used in some organisations to differentiate them, but this is not consistent.

Additionally, there is a body of literature describing the lack of awareness of healthcare professionals of the differences between Advanced Nurse Practitioners (ANP) and CNSs (Cooper, McDowell, & Raeside, 2019). This has increased feelings of isolation within the profession which have been exacerbated by inconsistent learning and development support in the transition to the role. Establishing a strong professional identity is important for nurses, and many struggle in new roles (Scholes, 2008).

Nursing is changing with cancer care, and inevitably the role of CNSs is constantly evolving. Findings indicate that the role is becoming more autonomous and independent, with a higher need of specialised clinical knowledge. Additionally, there is also a growing need for certain CNSs to remain generalists within cancer care. This need is highly linked to the policy motivation of bringing care closer to home. Managing this balance of the highly specialised CNS and the generalist within the specialism will be a challenge for service and workforce planners to face. However, a Cancer CNS capabilities framework should consider this in their design in order to provide guidance.

Threats to professional identity can also be addressed in the framework, as further clarification is needed regarding the space CNSs occupy within the Skills for Health Careers Framework, and lessons can be learned from the publication of the Advanced Practice Framework (Health Education England, 2017). A recent evaluation reached similar conclusions, in which the ANP role was perceived as either an advanced level of practice – career progression – or as a new generic role in the medical model. As a result, many CNSs believe they need to become ANPs in order to progress. There is a lack of clarity on the possible career pathways and space for growth for CNSs and how seniority and experience is recognised. Local solutions have spurred across the North West; for example, Salford Royal Foundation Trust in Greater Manchester have introduced Development Posts by which nurses with an interest in becoming CNSs but who are not yet ready to take on the responsibility are working as Band 6s whilst training to ultimately graduate as Band 7s. An evaluation of these initiatives would provide further insight into the possibility of standardisation and national rollout. These initiatives and subsequent evaluation would also formalise the need to establish the CNS role as Band 7. Similar programmes have also been running in the north, east and central London, through Health Education North Central London with success (see evaluation by Whittaker, Hill and Leary (2017) for further details). Solutions such as these, accompanied by a recognised capabilities framework have the potential to

address workforce challenges faced by CNSs, including recruiting and retention, by providing structured entry and progression pathways.

Results highlight the importance of the four pillars of nursing in defining the core capabilities of the role, regardless of pathway and location. However, it should also be recognised the importance of some advanced practice capabilities as they become increasingly relevant in the future. This evolution could be captured in a tier system, for example.

In summary, there are several areas where a Cancer CNS Capabilities Framework can provide guidance and address many of the concerns raised in the report to enable the sustainability of the role whilst raising its profile and aligning with existing frameworks and roles, for example by providing:

- consistency and clarity in role definitions
- clarification on entry routes to this area of practice
- pathways for career development and progression
- minimum standards for commissioners of cancer services
- support for workforce planning for CNS roles
- recognised learning outcomes for CNS education and training programmes.

The development of a Cancer CNS Capabilities Framework must be taken forward in close collaboration with other complementary programmes of work. This includes the update of the Careers and Education Framework for Cancer Nursing by the Royal College of Nursing, as well as Macmillan's Competency Framework for Nurses. This last document is unique in its provision of a toolkit that may aid in the operationalisation of the framework. Therefore, any further work needs to align with existing documents to reduce the persistent inconsistencies that have traditionally surrounded the CNS role, and collaboration is recommended to ensure the effective and widespread implementation of the framework.

Other recommendations:

Responding to these challenges and recommendations should support the expansion of the Cancer CNS workforce and the development of a Cancer CNS Capabilities Framework able to meet the needs of the workforce.

Training and development support

- Although it is no surprise that the main **barriers** impacting on staff roles are **time constraints**, **staff shortages** and **lack of resources**, it is important to be seen to respond to these issues. It would be advisable to set up some form of working group to understand how these challenges could be approached, what risks are involved and how those risks can be mitigated.

- **Designated study days would be helpful** – in particular, participants would welcome a sectoral Professional Development Plan (including a workbook and study time), which would be helpful for newly qualified CNSs, perhaps.

- With one in eight staff having **no access to Continuous Professional Development (CPD),** funding channels / opportunities need to be made available **more consistently** and these channels / opportunities should be **better communicated** to staff.

- **Induction is currently not meeting the needs** of new CNSs, therefore there is a need to provide appropriate support particularly at induction.

- Staff state that **'Limited training is provided at the beginning of their journey as CNSs.'** Allied to the

negative comments on induction, this reflects a need to address with some urgency the experience of new recruits (or experienced staff transferring from other roles).

Clinical supervision

- Although **most staff have access** to clinical supervision, this varies in terms of regularity and formality. It would be advisable, in the **interests of consistency and equality**, to set **minimum standards** in terms of the **timings** and **frequency** of formal supervision.
- Further investigation should be considered into the **issue of supervision** as it relates to *Urology*, where around a quarter of staff working in this pathway were **dissatisfied** with their supervision.

Roles and responsibilities

- **Inconsistency** and a lack of understanding appear to characterise the expected **career trajectory** of CNS staff. Staff talk of having to use their own initiative in seeking learning opportunities and of there being no specific learning/career pathway available. There needs to be consistency and clarity in terms of objectives, direction, opportunities, support and expectations (particularly important in those early years).
- There needs to be a **focused assessment** of where CNS roles are heading, what might **influence** this and what **action** needs to be taken (when and by whom) in order to **plan** and **prepare**. This needs to consider and set out **responses to issues** such as the potential increase in medicalisation of the role; increased levels of complexity; diagnostic and prescribing responsibilities, prescribing, changes in levels of autonomy, strategic input and involvement in service development.
- **Effective communication** of the role of Cancer CNS to non-CNS colleagues will be increasingly important alongside maintenance of the descriptor "key worker" in the eyes of the patient. This will ensue that misunderstandings do not negatively impact on, and exacerbate feelings of isolation and self-doubt amongst, CNS staff.
- There appears to be a **lack of diversity** in terms of the demographic profiles and protected characteristics of CNS staff. Being representative of communities and patients is important and it would be beneficial to investigate ways in which equality, diversity and inclusion and more representative staffing could be promoted.
- **Quantifying** the CNS workforce and their workloads remains a challenge. Alternative routes to self-reporting methods would provide a closer approximation to the numbers and their impact. Further engagement of data controllers and a review of workforce coding systems would aid to understand the size of the cancer nursing workforce and its diversity in terms of roles and bands.

COVID-19 recovery

- The **pandemic** has exerted a **considerable impact** on all staff, disrupting normal working, prompting redeployment and putting additional strain on an already strained workforce. In responding to COVID-19, many employers (across and beyond the health sector) have used the unprecedented situation as an opportunity to instigate activity focused on the development of **resilience protocols and support structures** for their staff. It would be advisable that those employers covered by this research adopt similar, **positive practises**, to address and plan for issues such as collaboration, improved communication skills, efficiency, integration of services, increased hygiene, infection control awareness and the impact on mental and physical health.

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