Developing a Cancer CNS Capabilities Framework in the North West - DRAFT

Research findings

July 2021

Contents

Report authors: Adela Sobrepera, Jon Parry, and Brenda González-Ginocchio. Skills for Health, 2021

Acknowledgements

The authors of this report would like to thank the participants of the interviews and the survey for sharing their insight and experiences of such an invaluable role. We would also like to thank the members of the Expert Group who have volunteered their time to provide guidance and advice in the undertaking of this research.

We would also like to acknowledge the role of Cancer Workforce Leads from the three North West Cancer Alliances for their mobilisation efforts by which engagement of wider stakeholders would not have been possible. Equally important has been the role of the Lead Cancer Nurses who have been incredibly helpful in the recruitment and engagement of Cancer CNSs in this research. They all have provided a great deal of insight and candour to the findings.

Finally, to Suzanne Lilley and the Greater Manchester Cancer Alliance for their vision, patience, and support to ensure the research speaks true to those who will use it.

Executive Summary

The North West Cancer Alliances 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. This report presents findings from extensive research aimed at helping to shape the framework through defining the scope and review of current roles and responsibilities of the cancer CNS workforce in the North West.

Cancer CNS staff are crucial in terms of supporting patients during their treatment. They are the key person in charge of patients' care and can address important questions about their diagnosis, treatment, and support. For CNSs to thrive in their roles, and for organisations and patients to fully benefit from their knowledge and experience, it is important that managers and workforce departments fully understand the scope of the role. Seven key themes emerged from the research regarding this role; the following provides a summary of each theme:

Experience and entry pathways

Although there appears to be no consensus on the career pathway for CNSs, before assuming the role at Band 7, most participants gained experience as Band 6s in wards which provided them with knowledge of the tumour group. Some CNS staff came from chemotherapy, palliative care, or research roles, which introduced them to cancer care prior to becoming a clinical specialist. Backgrounds are varied, but most have experience in cancer care and/or site-specific speciality experience and this helped them progress in their specialist pathway.

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 were consistent with the discussions arising through the research interviews, although in these, a greater emphasis was placed on leadership. Participants were also asked to rate how important a range of capabilities might be in order for Cancer CNSs to carry out their job effectively in the future. The most important capabilities included communication skills; patient advocacy; person-centred care; teamworking; and specialist cancer care. The least important included independent prescribing; active involvement in research; audit skills; prevention; and diagnosis.

CNS Teams

Most of the CNS staff interviewed, worked in small teams, of about 3-7 staff and tended to consist of 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 4s tend to 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.

Clinical Supervision

The CNS role is very emotionally demanding and presents challenging and complex situations which might require support. Those CNS staff who use clinical supervision find it useful to receive reassurance, care, and support. Groups tend to be small, with regular attendees, and those that are run with a regular schedule are considered the most suitable. COVID-19 has had a great impact on access to and availability of clinical supervision. Staff 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.

Professional identity

The role of the Cancer CNS has evolved and continues to evolve, although the descriptor of *key worker* for the patient remains. However, colleagues misunderstanding the role does have a negative impact on CNS staff and this contributes to their feelings of isolation and self-doubt. There are fears around the risks to the ongoing view of the role, related to the concerns of CNS staff being seen as "mini-doctors"; the erosion of the role linked to the progressive gain of independence; and the furthering of nursing identity. Additionally, confusion about the differences between CNS and ANP roles exist although two main views arose from the research - ANP is seen as a progression step for CNS; and as an alternative pathway to specialist nursing.

Evolution of the role

There are increased levels of complexity required for the CNS role, for example, the need for knowledge to evolve in order to better support patients; and the potential increase in medicalisation of the role. CNS staff will increasingly have to take on more responsibility and higher levels of autonomy. They also will assume 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. Finally, new ways of working might be needed as demand increases but staffing remains stable.

Impact of COVID-19

The impact of Covid-19 has affected all sectors of society but none as much as the health sector. In terms of the CNS workforce, many staff have been deployed to support other departments such as emergency care. Some CNS workloads have declined due to a reduction in referrals from GPs and, in addition, some clinics were halted during the first months of the pandemic. The lack of face-to-face consultations resulted in the emergence of different relationship with patients, for example a switch to remote methods impacted on the development of patient / nurse rapport. In terms of *ways of working*, flexible and homeworking was introduced successfully and this, along with the redeployment of colleagues / supervisors, led to an increase in levels of responsibility and autonomy.

These key themes are addressed in greater details throughout this report and help to build a comprehensive picture of the case for the development of a Cancer CNS Capabilities Framework. This framework should be taken forward in close collaboration with other complementary programmes of work which 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. Any further work needs to align with existing documents to reduce the persistent inconsistencies that have traditionally surrounded the CNS role. In addition, collaboration is recommended to ensure the effective and widespread implementation of the framework.

Background

The North West Cancer Alliances (Greater Manchester Cancer, Cheshire and Merseyside, and Lancashire and South Cumbria) and Health Education England (HEE) have 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. Spearheaded by the Greater Manchester Cancer Alliance and Skills for Health, 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.

At the same time, the Royal College of Nursing is currently updating their *Career and Education Framework for Cancer Nursing* [1] originally published in 2017. Transparency during this process has led the different organisations in this project to collaborate with the RCN and share learnings. The option to align the North West and RCN frameworks is therefore also being explored and became an additional objective of this research.

---

[1] Available to download at: https://www.rcn.org.uk/professional-development/publications/pub-005718

Methodology

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. All participants in this research were provided with guarantees regarding confidentiality and anonymity. At all times, the research was carried out in a manner which strictly complies with the European Union's General Data Protection Regulation (GDPR) and the UK Data Protection Act (DPA) 2018.

The research methods undertaken were as follows:

- Desk research to fully understand and contextualise the research and to guide the formulation of questions and themes for the primary research activities. A summary of the findings and bibliography can be found in the introduction and reference sections of this report.
- Online survey of a sample of Cancer Clinical Nurse Specialist and Lead Cancer Nurses. The survey was designed to extract information regarding the role and responsibilities of the role, their entry pathways and support available to them, whilst also enabling individuals to contribute their views and experiences.

  The online survey was designed using SurveyMonkey software. A weblink to participate was distributed by the Lead Cancer Nurses, Cancer Workforce Leads and Chief Nurse / Directors of Nursing representatives to their respective teams across the three North West Cancer Alliances.
- Semi-structured depth interviews. Due to COVID-19 restrictions and the wide geographical spread, these were conducted online and via telephone. Findings from the online survey provided the opportunity to conduct multivariate analysis, creating emerging themes for further discussion during interviews. The purpose of the interviews was to:
  - Review and refine the findings from the online survey.
  - Develop and deepen the emerging themes.
  - Create, understand, and develop opportunities for best practise.
  - Develop new lines of enquiry.
- A workshop was conducted in July 2021 to help confirm insights derived from the survey and the interviews. This helped to validate findings and provide evidence of wider, shared experiences and provide suggestions for additional data collection.

Introduction

Cancer prevalence

Cancer affects over 2 million people in England, and numbers are projected to grow every year[2]. This indicates the need for a cancer care workforce prepared to manage a rising demand, an aging population, and increased levels of complexity (e.g., comorbidity). In the North West, there were a total of 266,715 people living with a cancer diagnosis in 2018[3].

- 99,749 in Cheshire & Merseyside,
- 98,863 in Greater Manchester, and
- 68,103 Lancashire & South Cumbria.

Similar numbers are obtained by the Quality and Outcomes Framework (QOF) which gets regularly updated by GP Practices. This indicates that 3.22% of the population registered in a GP in the North West live with a diagnosis of Cancer, compared to 3.13% of the national average.

Cancer prevalence has been increasing every year and it is estimated to continue to increase 30.3% by 2040 for all cancers in people aged 15 and over in the UK (fig. 1) according to the Global Cancer Observatory (GCO) [4]. The GCO also suggests that the prevalence of prostate and trachea, bronchus and lung cancers will have a sharp increase by 2040, making them the most prevalent cancers in adults. Prostate cancer is particularly interesting as the 5-year survival rate is one of the highest in the UK from all Cancers (88%)[5], which indicates the need of care for long-term complex needs. Lung cancer on the other hand, has a lower 5-year survival rate (17.6%), which suggests a need for end-of-life care.

---

[2] https://www.cancerdata.nhs.uk/prevalence

[3] https://www.cancerdata.nhs.uk/prevalence

[4] https://gco.iarc.fr/tomorrow/

[5] https://www.nuffieldtrust.org.uk/resource/cancer-survival-rates

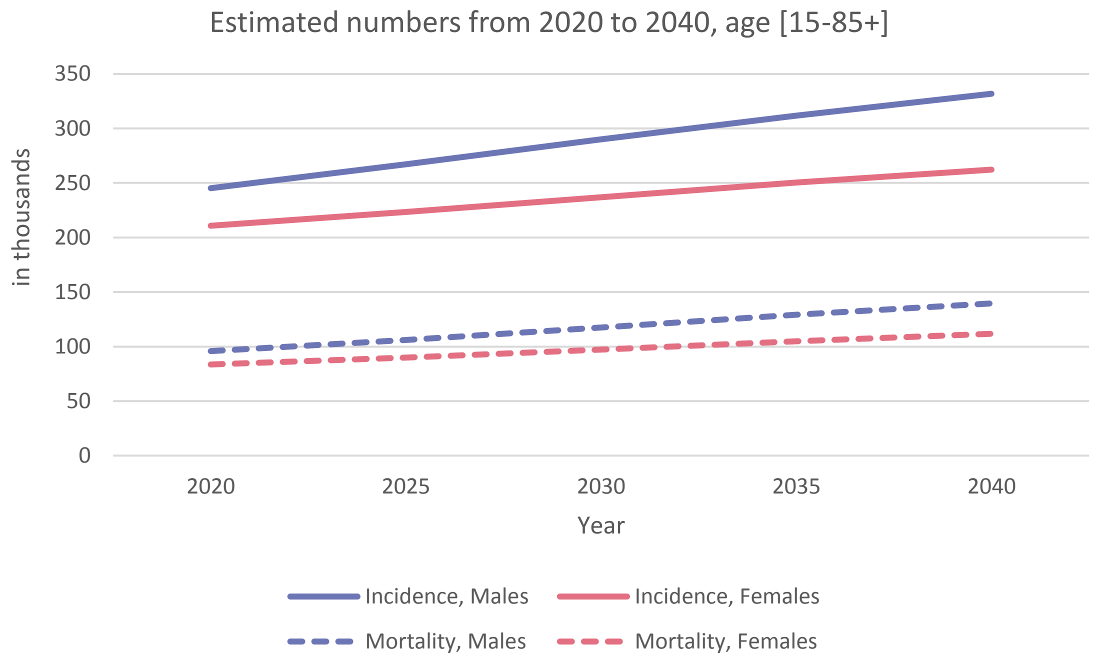

Figure 1. Projections of incidence and mortality numbers of all cancers in the UK of males and females aged 15 and above. Source: Global Cancer Observatory

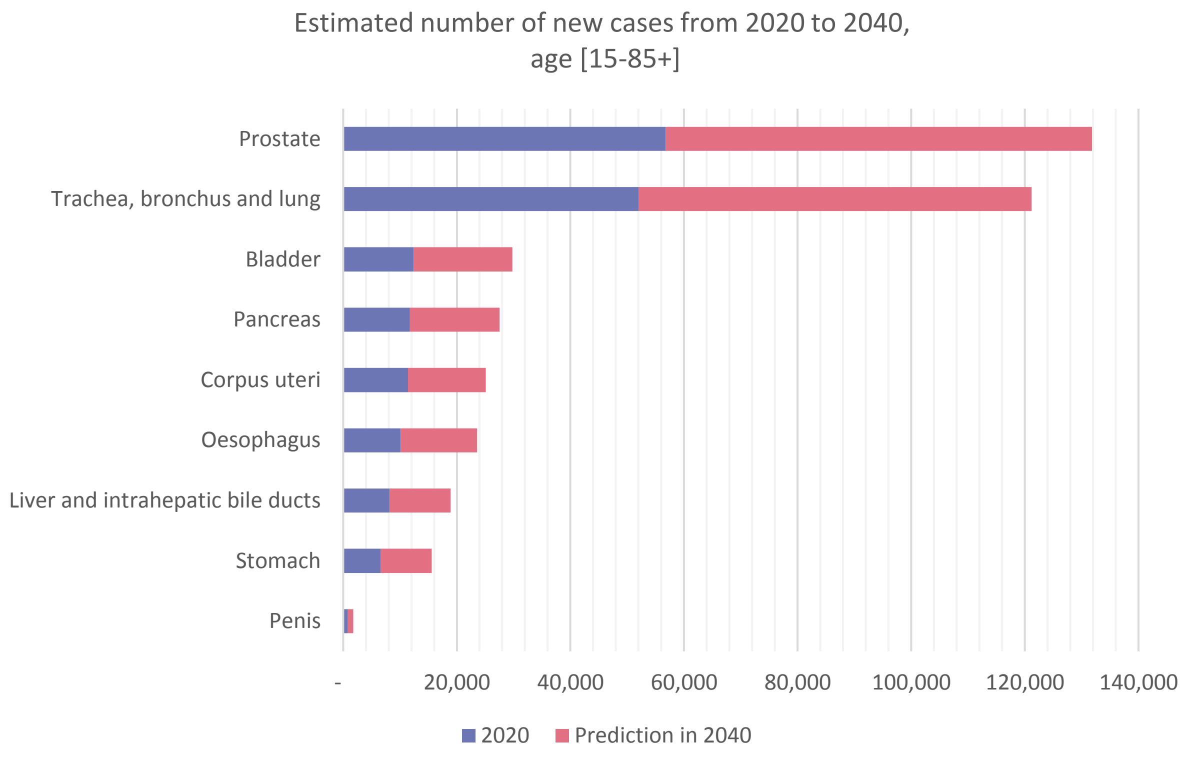

Figure 2. Estimated number of new cases in addition to current incidence numbers for the cancer types of interest of this study in the UK. Source: Global Cancer Observatory.

The Cancer Clinical Nurse Specialist

The Clinical Nurse Specialist (CNS) role exists in many countries with fundamentally different healthcare systems than the UK. Whilst unanimously considering the role in high regard, the difficulties in defining the roles and responsibilities of CNSs are common. See for example, Donald, et al. (2010) in Canada, or the report by the National Council of State Boards of Nursing (2007) in the USA. These studies highlight the difficulties of defining the role and identify that the uniqueness of CNSs lay in their core competencies.

Confusion over the CNS role may be related with the diversity in job titles nurses have after registration. This can have implications for the utilisation of the role and its perception by employers, colleagues, and service users. A recent study sought to better understand the variation of nursing titles in the UK by analysing the job titles of 17,960 nurses (Leary, Maclaine, Trevatt, Radford, & Punshon, 2017). The four most used titles were CNS (*n*=6721, 37%), specialist nurse/nurse specialist (*n*=2334, 13%), Advanced Nurse Practitioner (*n*=2214, 12%), and Nurse Practitioner (*n*=1977, 11%). There were even some (*n*=323, 2%) who appeared not to be registered nurses.

Additionally, different titles may adhere to different levels of the Skills for Health Career Framework (2010) and consequently be in different pay bands. This framework places specialist practice one level above initial registration and one below advanced practice, in which nurse practitioners would gain a wider scope of practice.

Interestingly, the Macmillan Census (2017) includes a wide variety of titles in their quantification of the cancer nursing workforce, with the majority being Clinical Nurse Specialist (59%), but also Cancer Nurse Specialist (20%), and a few Advanced Nurse Practitioners (4%). The inclusion of Advanced Nurse Practitioners is particularly interesting as it may imply both roles are equivalent or interchangeable, and its differences may just be semantical. However, much of the literature has tried to understand its distinctness. More recently, multiple documents defining the role and capabilities of ANPs have been published[6].

Clinical Nurse Specialists and Advanced Nurse Practitioners

Much of the confusion of the CNS role is created by the differences and commonalities with ANPs as both roles are clinically based with components of leadership, research, and training (or education). However, a recent literature review indicates that CNSs have, as the name indicates, a more specialist role, and ANP are generalists (Cooper, McDowell, & Raeside, 2019). The authors represent visually the significant overlap between the roles whilst still requiring unique knowledge (fig. 3).

---

[6] See for example *the Advanced Clinical Practice (Nurses) Working in General Practice / Primary Care in England* (Skills for Health, 2020)*, Advanced Nursing Practice Framework* (Northern Ireland Practice & Education Council, 2018) in Northern Ireland.

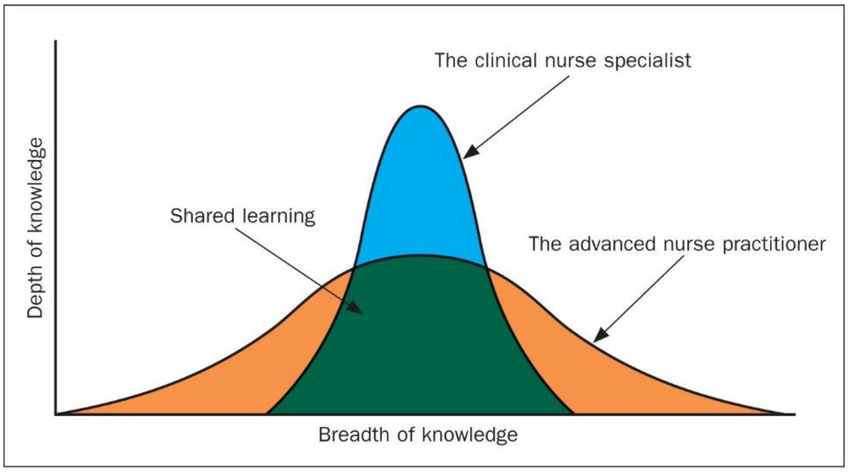

Figure 3. Graphical representation of the difference between ANP and CNS, from (Cooper, McDowell, & Raeside, 2019)

However, what level of education (e.g., master's) is required to achieve specific knowledge for CNSs is widely disputed and clarification on a career pathway for CNSs is missing from the literature. Further work has been carried out in order to define the role of ANP with the implementation of the "*Multi-professional framework for advanced clinical practice in England*" (Health Education England, 2017), yet an evaluation study indicated that the framework was not utilised nor perceived consistently by healthcare providers and employers. The evaluation indicated that ACPs were either perceived as an advanced level of practice – career progression – or as a new generic role in the medical model (Lawler, Maclaine, & Leary, 2020).

Workforce numbers

Little data exists on the numbers of Cancer CNS in England. Therefore, it is difficult to monitor their evolution within the organisation and within which pay band they are working. This poses one of the main challenges for this study but also a main contributor on the confusion on the role, as it is expected that higher the band, higher the level of autonomy. Despite this, the Macmillan Census (2017) provides a close approximation to the numbers and indicates that there are over 4,000 specialist nurses working in England, almost 800 of which are based in the North West.

Table 1. (Macmillan Cancer Support, 2017)

Cancer Alliance	Headcount	%
Cheshire & Merseyside	256	6%
Greater Manchester	391	9%
Lancashire & South Cumbria	136	3%
North West	783	17%
England	4,518	100%

In terms of pay banding, the latest Macmillan Census reports that 61% of specialist cancer nurses are Band 7, 27% Band 6, and 9% Band 8a.

This project also aimed to quantify the CNS workforce through data returns provided by Lead Cancer Nurses, yet completion was inconsistent with a participation rate of 43%. Inconsistencies were also identified when recording bands, as some included Advanced Nurse Practitioners and Nurse Consultants. Further breakdown of responses by Cancer Alliance and pathways can be found in Annex 3.

The value of the Cancer CNS

Cancer CNS are a key contact for patients to support them during their treatment. The Cancer Patient Experience Survey 2019[7] indicated the high value Cancer CNS have by patients thanks to the role they perform as the main person in charge of their care and being able to ask them important questions about their diagnosis, treatment, and support.

A recent literature review evaluating the value of CNSs in cancer care identified six main areas of impact (Kerr, Donovan, & McSorley, 2021):

1. Psychological outcomes: this refers to the emotional support Cancer CNS provide to patients throughout their cancer journey, with evidence suggesting the role they play in alleviating patients' fears and concerns, providing reassurance, and providing a holistic and supportive approach.
2. Information outcomes: the CNS role includes educating and providing clear information to patients to improve their knowledge and understanding.
3. Clinical outcomes: studies suggest that the role of the CNS leads to improvement of clinical outcomes, particularly on symptom management whether related to cancer or the cancer treatment (e.g., pain, fatigue, anxiety).
4. Service delivery outcomes: positive outcomes on service delivery were obtained in relation to the CNS providing continuity of care and acting as a patient advocate. CNSs are also found to be well-regarded by healthcare colleagues indicating that they are "the glue of the team" (Cook, McIntyre, Recoche, & Lee, 2019).
5. Satisfaction outcomes: this refers to people living with cancer and their carers being satisfied with the level of care provided by CNSs, with one study suggesting significant improvement when a CNS was involved in follow-up consultations, rather than the traditional care which involved medical consultations. The relationship between carers and CNSs is also an important factor in the high levels of satisfaction, as bereaved families regarded it as vital to their well-being.
6. Cost-effective outcomes: there are economic benefits related to the role of the CNS, as nurse-led clinics for example reported a significant cost decrease from previously doctor-led settings.

Another study looking into the cost-effectiveness of interventions led by Cancer CNSs in the NHS runs into well-known challenges, the difficulty of quantifying the workforce and the nebulous understanding of their duties. Despite these challenges, the authors conclude that Cancer CNS are a valuable resource in reducing hospital admissions, length of stay, and overall health care

---

[7] CPES 2019 is the latest iteration at the writing of this report (June 2021). CPES 2020 is expected at the autumn of 2021. More information available at https://www.ncpes.co.uk/

costs (Salamanca-Belen, Seymour, Caswell, Whynes, & Tod, 2018).

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. Evidence from 2011 suggested that some CNSs are not utilised to their full potential across the country and invited the UK Oncology Nursing Society (UKONS) to develop a competency framework and national standards for Cancer CNS to address inconsistencies (Vidall, Barlow, Crowe, Harrison, & Young, 2011). 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[8]. Additionally, Macmillan Cancer Support has also developed the *Macmillan Competency Framework for Nurses Supporting People Living With Cancer and Affected by Cancer*[9]*.* Interestingly, Kerr and colleagues (2021) emphasise the versatility of CNSs and advocate for the role to remain flexible to adapt to contextual variations.

---

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

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

Findings from the survey

This section provides a profile of the respondents from the online survey and an analysis of their attitudes to, and opinions on, some of the key topics including capabilities, supervision, development plans and COVID-19. The survey took place between March and April 2021 and remained open for 6 weeks. The survey link was shared with Lead Cancer Nurses who then cascaded it down to CNSs teams across the three North West Cancer Alliances. A comprehensive data analysis of all the aggregated 'closed' question[10] responses can be found at the annex for reference. This include demographic / protected characteristics information relating to all respondents. In addition, a range of responses to the 'open' questions[11] can be found throughout the report which provide context and add depth to the findings. Both types of question responses were analysed in shaping the key themes of this research and in scoping themes for the interviews and the workshop.

Respondent profiles

The survey targeted 24 NHS Trusts across the North West Cancer Alliances (Cheshire and Merseyside, Greater Manchester, and Lancashire & South Cumbria), in order to canvas a broad range of views from staff. The following provides a breakdown of respondent profiles (starting with demographic data) and illustrates the breadth of coverage in terms of roles, pathways, and locations.

Demographics

- **359** staff responded to the survey, representing **23** NHS Trusts from North West Cancer Alliances.
- **46.4%** of respondents were below 45 years of age, **36.9%** were aged 45-54 with the remainder **(16.7%)** aged 55 or above.
- An overwhelming share of responses came from females **(96.4%)**, with **3.2%** from males and **0.4%** of participants stating, 'prefer not to say.'
- **97.6%** of respondents indicated that they were *white* with the remainder (**2.4%**) stating they were from *black and minority ethnicities*.

---

[10] 'Closed' questions are generally answered in response to a set of multiple-choice options.

[11] 'Open' questions generally cannot be answered a yes / no or response to multiple choice options and requires a developed (more personal) answer.

Respondents by NHS Trust

Nearly all 24 NHS Trusts from the North West Cancer Alliances (NWCA) were represented in the 359 survey responses. The region with the most responses was Cheshire and Merseyside (44.4%), followed by Greater Manchester (34.8%) and Lancashire and South Cumbria (20.7%).

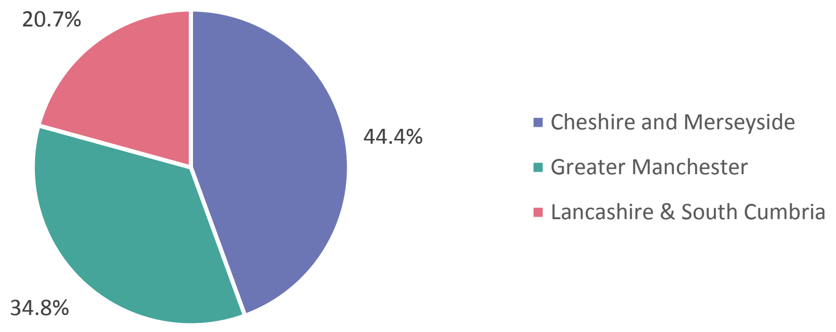

Figure 4. North West Cancer Alliance Respondents (%)

The most represented trusts by area were:

- *Cheshire and Merseyside*: More than 60% of responses in this region derived from 4 organisations, Wirral University NHS Trust (20.3%), Liverpool University Hospital NHS FT (18.9%), St Helens and Knowsley Teaching Hospitals NHS Trust (12.1%) and Mid Cheshire Hospitals (11.4%).
- *Greater Manchester*: Manchester University NHS Foundation Trust (FT) (35.3%), The Christie NHS FT (25.0%) and Pennine Acute and Salford Royal (Northern Care Alliance) (17.2%) account for nearly 80% of responses in this region.
- *Lancashire and South Cumbria*: East Lancashire Hospitals NHS Trust (31.9%) and University Hospitals Morecambe Bay NHS FT (26.1%) represent for nearly 60% of responses in the region.

Further breakdown of responses by Trust can be found in Annex 1.

Cancer Pathways

Nearly 40% of participants worked in the Breast (12.9%), Urology (12.6%) and Lung (11.4%) pathways. There was representation from all 21 named pathways in survey responses and in addition, participants also cited other pathways including nonspecific symptoms, Retroperitoneal Sarcoma, Neuroendocrine and thyroid, Hepato-Pancreato-Biliary (HPB) Sarcoma, and Palliative care.

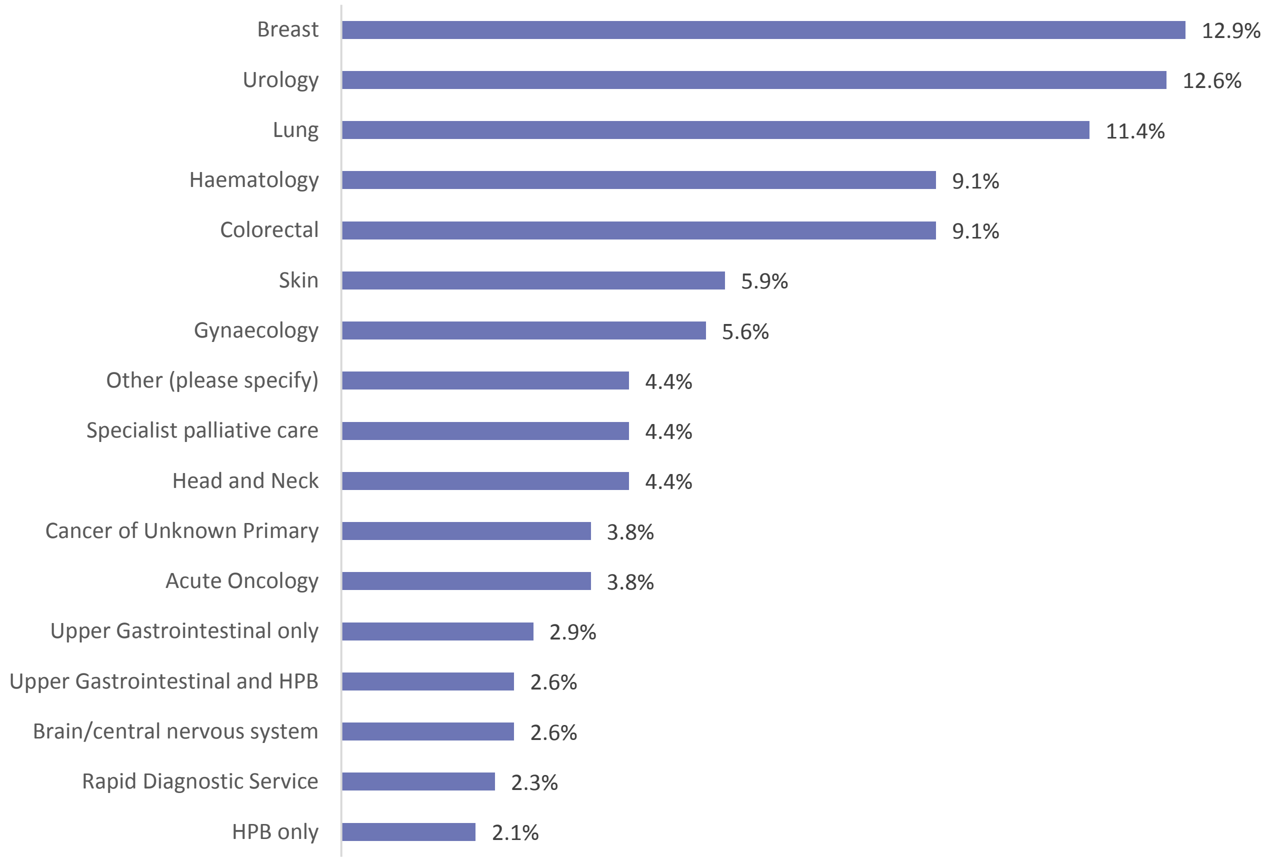

Figure 5. Respondents by pathway

Experience and entry pathways

Nearly half of respondents have been working in their current role for over 5 years, including 31.5% working in their current role for more than 10 years.

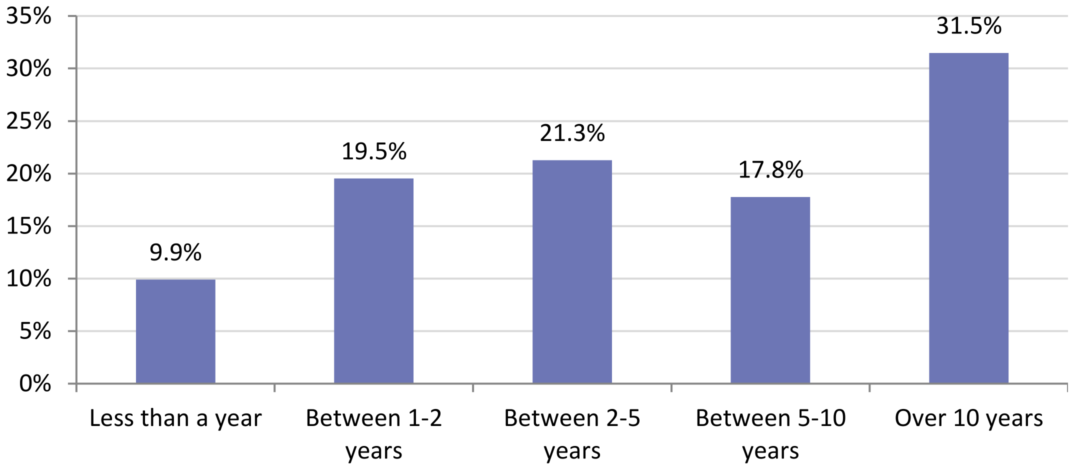

Figure 6. Length of time in current role

Over half of respondents have been working in cancer care for over 10 years (55.7%), with a quarter between 5 and 10 years (24.5%), and 13.1% for over 2-5 years, with only 6.7% having less than 2 years of experience.

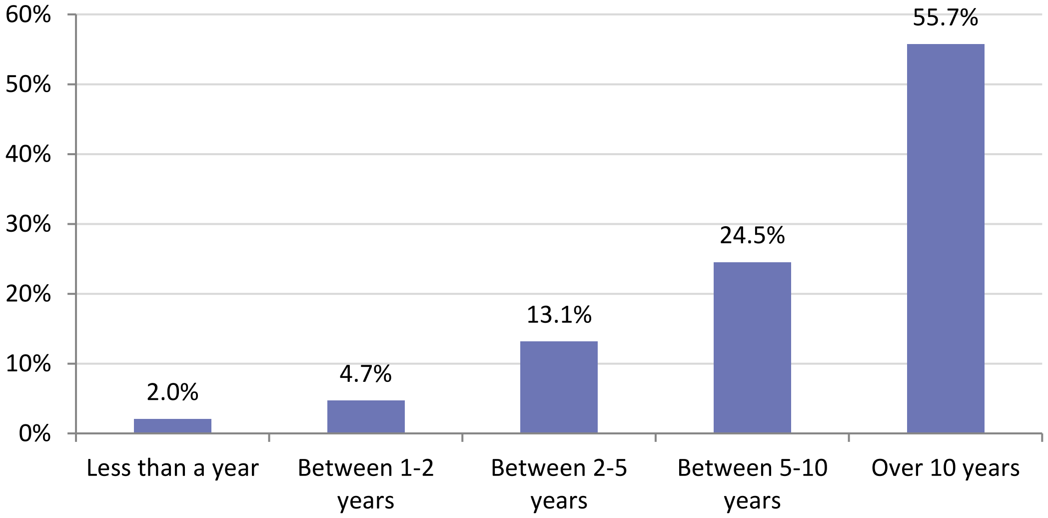

Figure 7. Years of experience in cancer care

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. 17.5% of respondents were in development post as Band 6s to develop into the role; however, this rarely impacted their job title.

Working in collaboration

CNS teams normally integrate more than one CNS, with only 10.4% of respondents stating they were the only CNS within their teams.

Almost all CNSs work with Medical Consultants (95.6%), Allied Health Professionals (78.6%), Ward-based staff (77.4%), Junior Doctors (74.2%) and out of hospital services[12] (70.7%) on a regular basis. Other professionals mentioned were Consultant Surgeons, Surgical Consultants, Palliative Care, Outpatient services, Radiologists, Pharmacists, Laboratory staff, Genetics Centre, Multidisciplinary teams (MDTs), Secretarial/Support staff, Macmillan (Community Navigators, Cancer support, Information centre), Therapists (complementary, physiotherapists, occupational), charities and voluntary sector staff, as well as Benefits advisors.

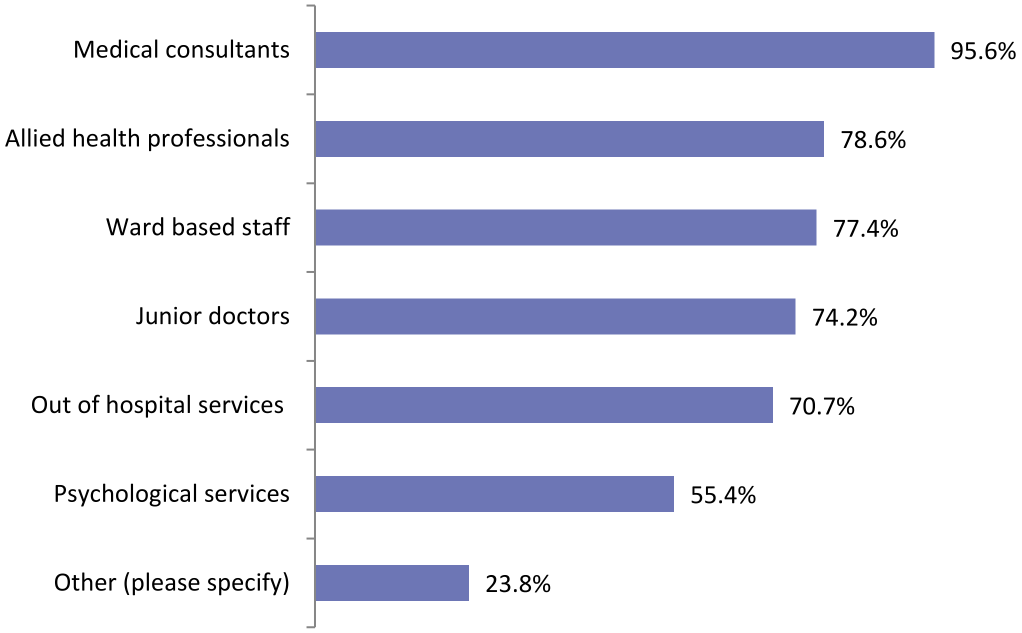

Figure 8. Professionals CNSs work with on a regular basis.

---

[12] Out of hospital services mostly include community teams and primary care, but also any other professional they might need to refer to provide holistic care (e.g., citizens advice)

Qualifications and training

Nearly 90% of respondents were either Registered Nurses/Midwifes or Health and Care Professions Council (HCPC) registered, with 40% having acquired a post registration qualification. Almost three quarters (70.5%) of participants have a university degree with 16.1% having a Master's degree (plus several currently undertaking Masters' modules: 7% - within "other" in fig. 9) and nearly 50% having a diploma.

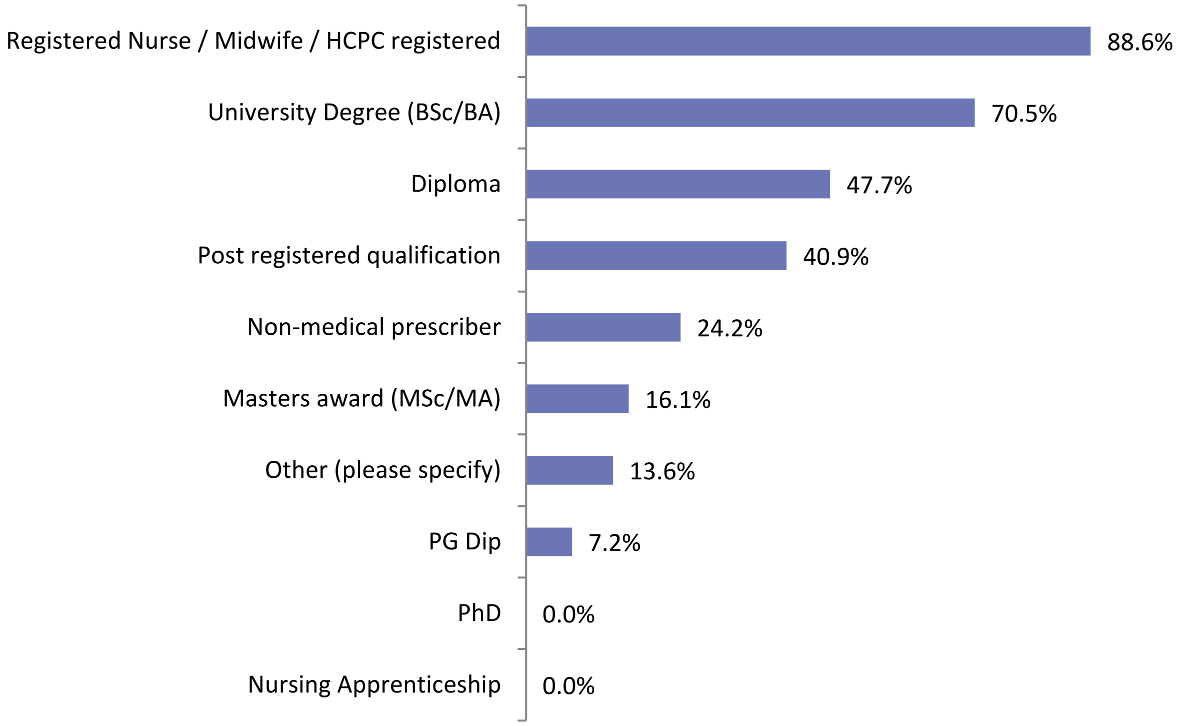

Figure 9. Qualifications

After completing their nursing degree, participants have undertaken further training. This includes the Level 2 Communication Training (92.8%), Specialist Cancer training (59.9%), Teaching and assessing qualification (57.2%) and Psychological support training (53%) (fig.10).

However, CNSs face several challenges to continuous learning, including limited funding (with some having to self-fund, particularly for academic pathways), lack of appropriately trained practitioners, limited teams' capacity, and no allocation of study time. Suggestions on ways to address these challenges included introducing a trust grant system and allocation of study leave and teaching time.

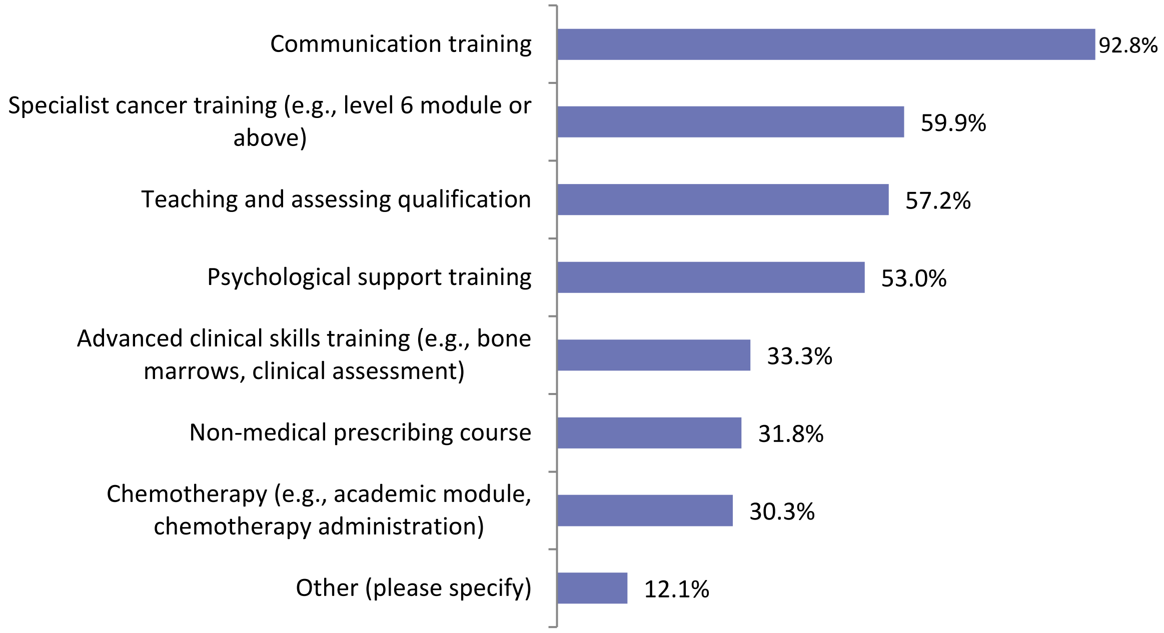

Figure 10. Training undertaken (over and above nursing training).

Funding for Continuous Professional Development (CPD) is mostly available via the Trust (63.6%), Macmillan Grants (40.9%) and the Cancer Alliance (9.1%). However, COVID-19 has halted the regular funding routes. Other funding routes have included the Rapid Diagnostic Clinics project funding, Liverpool Head and Neck Centre, the Department for Education (DfE), other charities (e.g., Breast Cancer Fund) or apprenticeships. Nevertheless, 12.5% of participants have not accessed CPD funding.

To guide training options and identify skills gaps, job plans, and Professional Development Plans are useful tools. Whilst three quarters of respondents had a job plan (74.6%), 15.9% did not, and surprisingly, 9.5% did not know if they did (fig. 11). Similarly, 70.5% had a Professional Development Plan, and 9.1% did not know if they did (fig. 12).

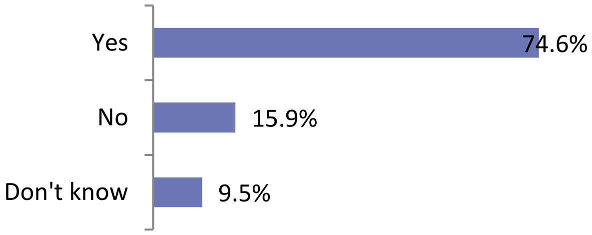

Figure 11. Respondents were asked "To the best of your knowledge, do you have a job plan?"

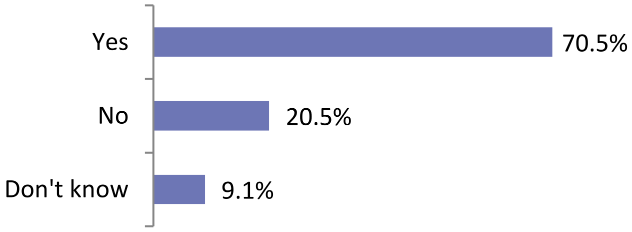

Figure 12. Respondents were asked "To the best of your knowledge, do you follow a Professional Development Plan?"

Key takeaways – Respondent Profile

- Half of respondents **previously worked** as **band 6 nurses** in various settings: community, district, hospice, surgical, trainee, ward, etc.
- Staff are **experienced** - nearly half of respondents had been working in their current role for over 5 years, including 31.5% working in their current role for more than 10 years, with 60% working in cancer care for over 10 years.
- CNSs tend to **work together** - teams normally integrate more than one CNS, with only one in ten stating they were the only CNS within their teams.
- Most staff were either **Registered Nurses/Midwifes** or Registered Health and Care Professionals, yet 11% were not.
- One in four CNSs do not have a **job plan**, or do not know if they do.
- Almost three in ten CNSs do not have a **Professional Development Plan**, or do not know if they do.
- A significant number of CNSs undertake Continuous Professional Development CPD), which includes communication skills, specialist cancer training, teaching and assessing qualification and psychological support training.
- Funding for Continuous Professional Development (CPD) is available in some instances via individual trusts, Macmillan grants and the Cancer Alliance.
- About one in eight of all CNSs had **no access to CPD fundin**g.

Roles and responsibilities

Participants held a diverse range of job titles. However, some patterns have been identified: 69.2% were "(Cancer Pathway) Clinical Nurse Specialist", 14.6% were (Cancer Pathway) Nurse Specialist, 3.7% were Clinical Nurse Specialists without specifying which pathway or cancer type. The rest were a variation of junior or senior CNS (e.g., Associate CNS).

Participants were also 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.

Patient-centred

- Accessibility – "being there when needed".
- Advanced communication skills (Effective person-centred communication)
- Case management
- Being a patient advocate, communicating with cancer patients and their families, providing information, and ensuring their understanding of their diagnosis and treatment options, assisting patients in their decision-making regarding their treatment and care.
- Coordination of investigations, tests, appointments, and patient care, enabling diagnosis and treatment as planned and on a timely manner.
- Liaison between patient and other healthcare professionals and services (e.g., referrals to GPs, rapid response, palliative care services, community services, financial, etc.)
- Ensure personalised and holistic care supported by evidence-based initiatives.
- Timely organisation of diagnostic tests pre and post diagnosis
- Prescribing (medical and non-medical)
- Pre and post operational services (disclosing cancer and post-operation results)
- Streamlining the patient pathway
- Managing side effects of treatment

Collaborative working

- Multidisciplinary team collaboration
- Team management
- Education, teaching, and support for team members and wider MDTs, ward and community staff, acting a specialist resource.
- Mentoring students
- Consultants' support in decision making (e.g., actioning their plans and helping patients understand)
- Manage projects to increase quality and reach of patient care.
- Influence local and national agenda relating to specialist area.
- Engage internal and external stakeholders to manage change and increase levels of funding.
- Raising the profile and representing the Trust in the wider community (e.g. Pathway Board representative, engaging

	with subgroups, GM Cancer initiatives) • Working with cancer data team to meet targets

Specialist clinical capabilities	
• Ability to recognise and manage difficulties and patient queries. • Advanced care planning and coordination • Advanced clinical examination skills and specific to specialty area • Advanced diagnostics • Advanced practice skills • Complex symptom management • Data collection • Ensuring regional pathway/guidelines are followed. • Facilitating support group • Holistic and clinical assessments • Monitor and maintain health, safety and security of self and others in own work area.	• Multi-tasking and prioritisation • Physical, emotional, mental, and spiritual well-being • Providing nurse-led clinical reviews and services • Psychological support and counselling • Research, evaluation and service audit • Scan results • Service development to continually improve patient experience • Specialist knowledge (tumour specific) • Tests and procedures administration • Treatment and end of life care • Triage

General Skills
• Initiative to work independently. • Leadership • Organisational skills • Problem-solving skills • Time management

Caseload is also a factor to consider when extracting roles and responsibilities of CNSs. It is widely assumed that CNSs manage a high number of patients, yet number of newly diagnosed patients varied greatly in self-reported numbers. Many CNSs share to have hundreds of patients a year, a few others, a couple of thousand, whilst others reported less than ten. It is difficult to determine whether such high numbers were attributed to their teams or Trusts rather than themselves as individuals. Additionally, several respondents were also unsure of the actual figures. Considering these caveats, the average number of cases reported in the survey is 265, with the most frequently mentioned number being between 200 and 350 new patients per year.

The Cancer CNS role in the future

Participants also shared how the Cancer CNS role is expected to evolve to become more autonomous to be able to increase the number of nurse-led clinics. This is expected to provide some relief to understaffed medical staff. Additionally, they are expected to increase the number of clinical tasks carried out independently; this includes prescription, diagnostic, investigation, and therapeutic procedures. Thus, increasing the number of advanced clinical skills in their repertoire.

A duality also emerges from the responses between the need for further sub-specialisation, and the need to provide services in the community. This is presented in the expected need for some CNSs to become experts in and deepen their knowledge and skills of one element of the pathway rather than working across it. Simultaneously, there is the strategic push to bring care closer to home and increase the provision of cancer care in the community. Therefore, these nurses would have to remain somewhat generalists within the pathway or cancer care.

Additionally, strategic, and managerial responsibilities are also included. CNSs will be expected to be increasingly involved in service development, evaluation, and leadership.

Finally, CNSs will need to manage their own care and wellbeing as increased levels of complexity and responsibility would require Cancer CNSs to be resilient.

Respondents 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**. Figure 13 clearly shows how all capabilities listed are considered very important by a significant proportion of respondents. But those capabilities related to high-quality patient care (e.g., communications, holistic practice) and coordination of services (e.g., teamworking, signposting) are those considered most important by a larger majority of respondents. However, those capabilities more closely related to advanced practice are more contentious. Table 2 provides a summary of the results.

Table 2. Summary of most and least important capabilities (weighted results).

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

Participants also were asked about any other capabilities not included in the list of fig.13 that they deemed important. However, most of these could be included as sub-domains. The following were mentioned:

- Ability to influence commissioning.
- Advanced Clinical Practitioner skills (Masters) and Advanced Nurse Practitioner (ANP) training.
- Clinical assessment and diagnostic skills.
- Conflict resolution
- Delivering and implementing change
- Empathy and honesty
- Ethics and confidentiality
- Independent assessments
- Independent working (autonomous practice)
- Mentoring
- Organisational skills and time management
- Radiology assessments
- Remote clinics (telephone/virtual)
- Resilience
- Workload prioritisation

Interestingly, participants highlighted the overlap between Digital Skills and Communication Skills which have been increasingly important in the past year as many consultations and meetings moved online. Thus, expressing the need for being able to build and manage relationships remotely with both patients and colleagues.

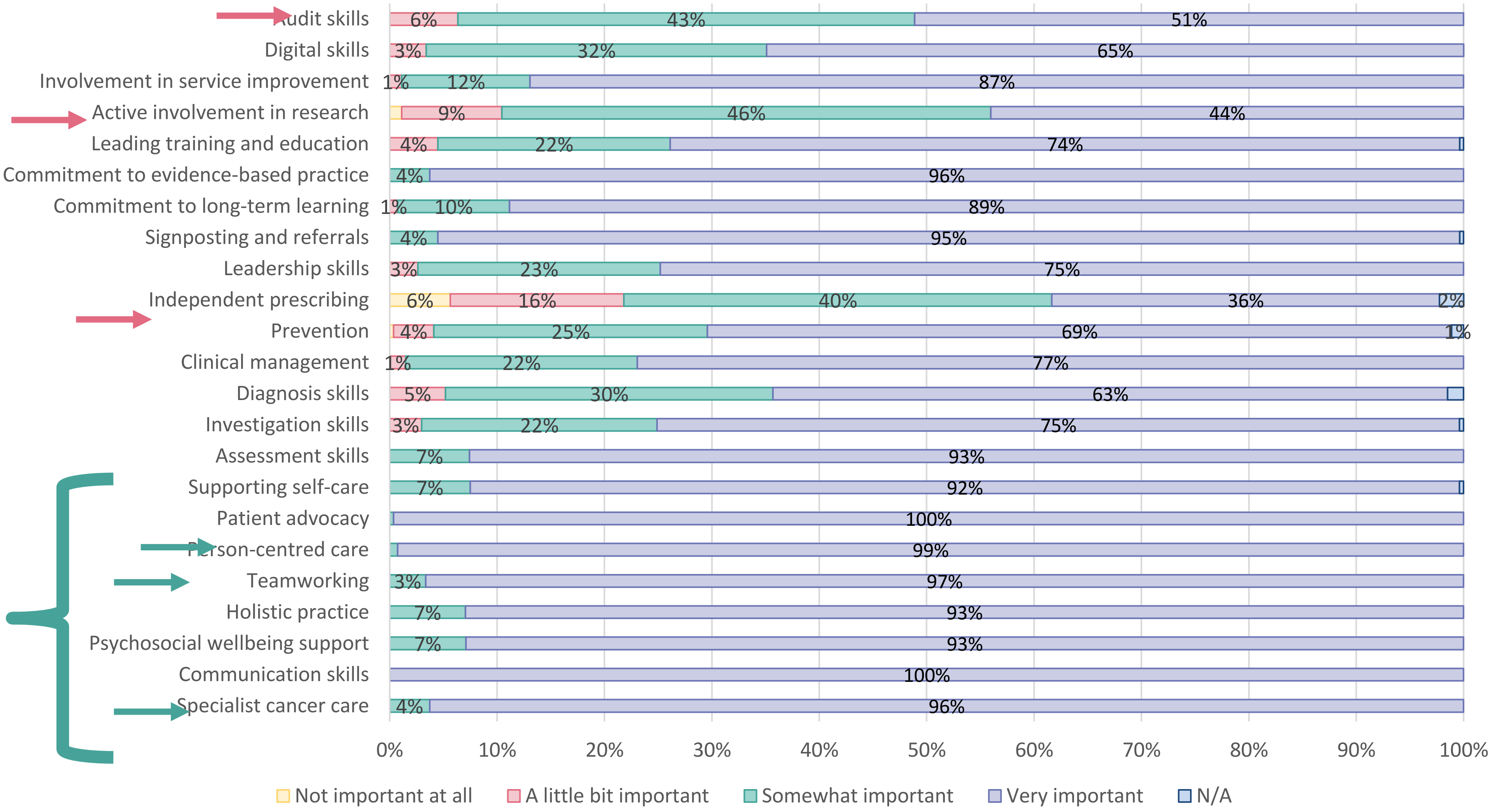

Figure 13. Capabilities perceived level of Importance. In green arrows the most important capabilities, in red arrows those less important.

Barriers for CNS to thrive

Time constraints is the main factor (80.5%) affecting CNS roles and responsibilities, as well as staff shortages (49.8%) and lack of resources (35.6%). Lack of understanding of the role, absence of support from other teams (medical, administrative) and limited funding for education and training as well as study leave, were also considered key factors affecting CNS ability to undertake their roles and responsibilities.

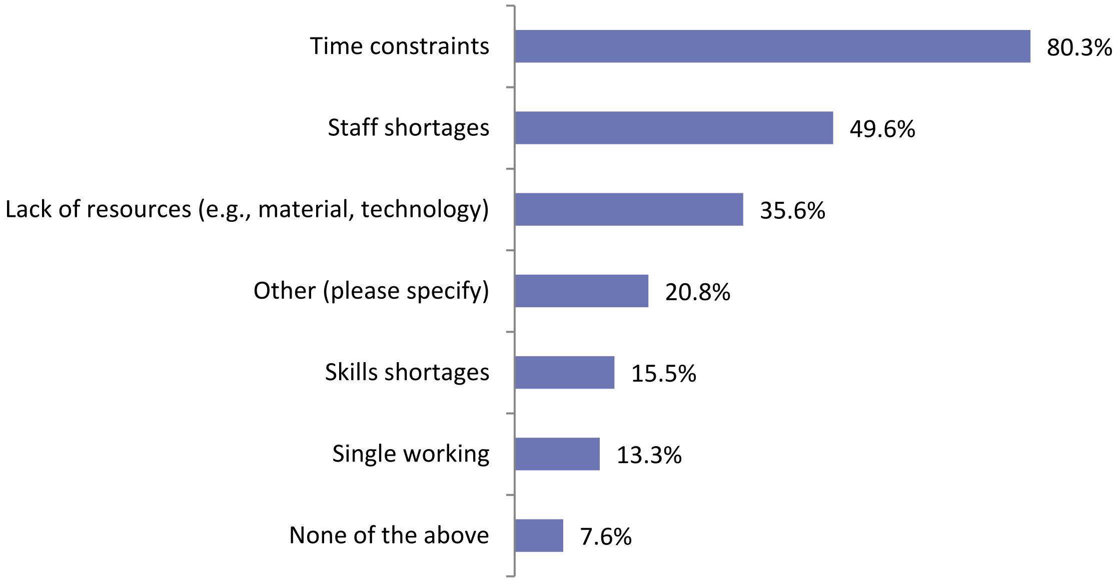

Figure 14. Factors impacting adversely on role / responsibilities.

These factors have a detrimental impact on the ability for CNSs to thrive in a myriad of areas, including community engagment, prevention activities, less time for support of families and carers, research and audits, learning and teaching opportunites, and service improvement.

Additionally, with the changes expected of the role, respondents share two main concerns which may hinder their opportunities to flourish in the role:

1. Risks around the medicalisation of the role. Confusion exists on the overlap between CNSs and ANPs as some are concerned that the increased medicalisation of the CNS role would turn them into ANPs.

> *"The role will become more of an ANP role due to less medical staff in certain specialities".*

2. Risks on decreased quality of care. This is perceived to be due to a reduced focus on psychosocial support, communication skills, and traditional nursing support, as there is an increase demand in advanced clinical skills and managerial responsibilities that reduce the time for direct patient care.

> *"I am concerned that roles may change by cancer CNSs being trained up to perform procedures that are currently performed by doctors which then erodes the time they have to offer nursing support."*

It is important to note that these risks are perceived by CNSs themselves and not managers.

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**.
- The **most important capabilities** for CNS staff are communication skills, patient advocacy, person-centred care, collaborative working and specialist cancer care.

Support and clinical supervision

Matrons are the line managers for more than a third (36.7%) of respondents, followed by Lead Cancer Nurses (20.4%) or a more Senior CNS (19.5%). Participants highlighted the accessibility of some of these managers to have one-to-one discussions whenever they feel they need to. It is also prevalent in the comments that CNSs feel supported by their line managers and teams. It is shared, that despite not having structured or frequent clinical supervision, they can speak and seek advice to their line managers or colleagues.

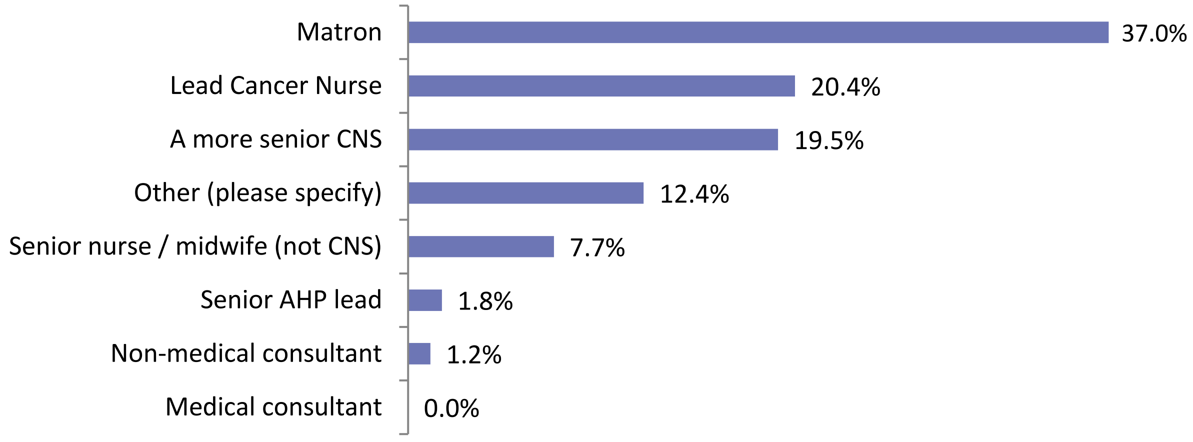

Figure 15. Job roles of line managers

CNSs are often also involved in facilitating the learning of others. This usually takes place in the form of mentoring (60.8%), ward/department-based teaching (57.7%), and supervision (52.8%). Examples include peer support, conference presentations, short placements, and teaching at various levels (e.g., BSc and MSc modules) and topics (e.g., end of life care, communications, clinical skills).

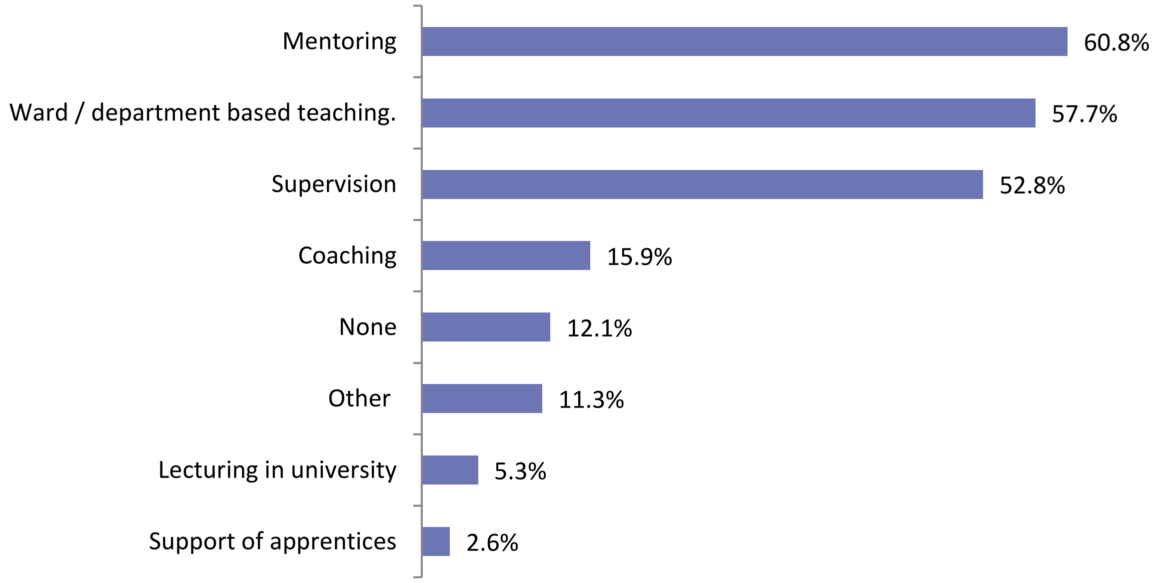

Figure 16. Provision of support to other staff

However, time constraints limited this activity.

> *"I would love the opportunity to lecture again or provide undergrad teaching, but I just don't have time to do this regularly. CNSs are ideally placed to provide this education. I feel we have the level of expertise to deliver excellent education on our areas and it's a pity (…) we don't have the opportunity to do this".*
>
> Macmillan Urology Oncology Clinical Nurse Specialist, The Christie NHS FT

Clinical supervision

Over three quarters of all respondents stated that they have access to clinical supervision (78%), and only 51% of these attend meetings on a monthly basis. Individuals indicated how this is largely due to the pandemic as many have not had time to attend due to a variety of arising challenges (e.g., redeployments, self-isolation, service pressures). This is particularly relevant for CNSs who have joined briefly before or after the first lockdown (March 2020) as they state that they have had limited information on how clinical supervision is organised and experienced delays in their Level 2 Psychological Support Training, which is meant to prepare them for this. COVID-19 also impacted the way clinical supervision was carried out, as many moved to online meetings which had a mixed reception by CNSs. A frequent issue raised in the comments is that the time for sessions is not protected, and it is often organised in non-working days for CNSs who work part-time.

Among those who do undertake supervision, the frequency of meetings is quite varied: half of them are scheduled to attend monthly meetings (51%), and the other half are a mix between ad-hoc (17%), every two months (11%), every quarter (4%) and weekly (3%). The rest shared how they rarely have meetings, or they have been suspended (13%). The format is also quite varied: structured group supervision (41%), open group supervision (30%) or one-to-one (18%) sessions. Psychological practitioners were the most frequent (66.5%) clinical supervisors, as well as more senior CNS (14.8%) and Matrons (5.9%).

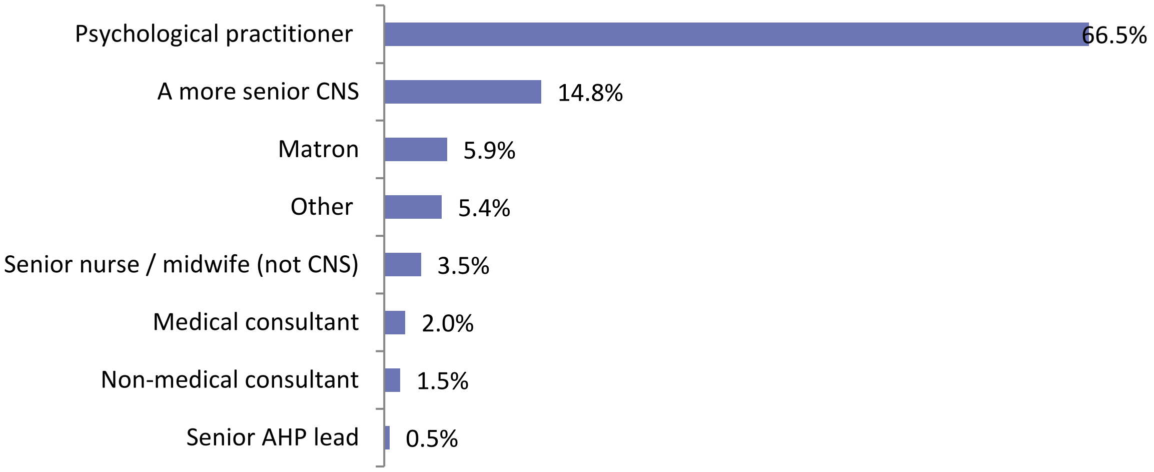

Figure 17. Main providers of clinical supervision

For those who access supervision, over 70% were satisfied/very satisfied with their clinical supervision, and only 6% were dissatisfied/very dissatisfied. In the comments, respondents highly praised their value.

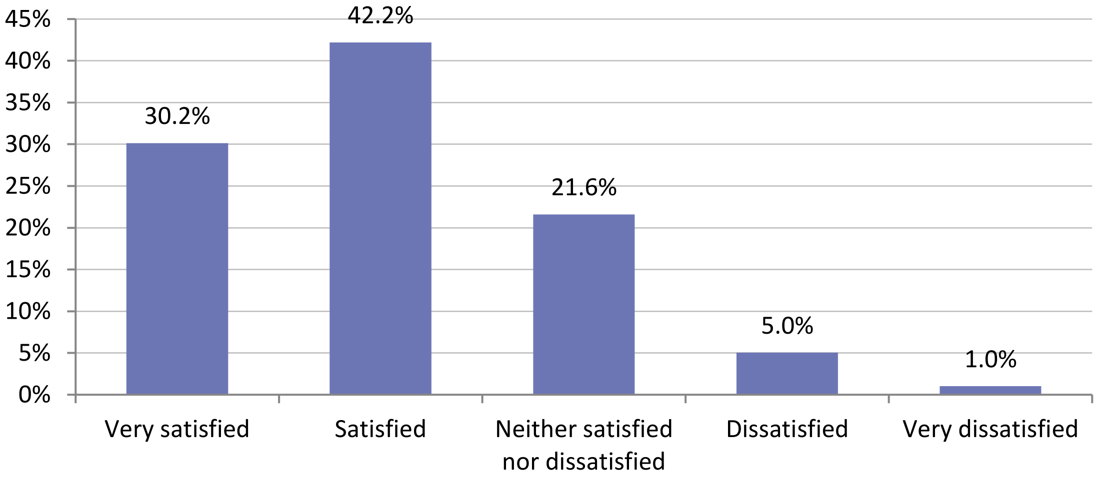

Figure 18. Satisfaction with clinical supervision.

> *"Clinical supervision has been very influential in the development of my role. I have found this support very helpful."*
>
> Macmillan Colorectal Clinical Nurse Specialist,
> Wirral University Hospital NHS Trust

Key takeaways – Supervision

- Matrons tend to be the **line managers** of most CNS staff, followed by Lead Cancer Nurses and Senior CNSs.
- A considerable majority of CNS staff have **access to clinical supervision**. This supervision is most likely to formally take place on a monthly basis, with other instances of supervision occurring more informally.
- Supervision tends to be conducted mostly in a **structured group** setting, however **less-structured** group supervision and **one-to-one** sessions also take place.
- Almost three-quarters of CNS staff are **satisfied** with their clinical supervision.
- CNS also are involved in **supporting others**, with many of them providing mentoring or ward/department-based teaching.

Impact of COVID-19

The pandemic had a substantial impact on more than half of the respondents (52.8%), with 32.6% of respondents being redeployed as a result.

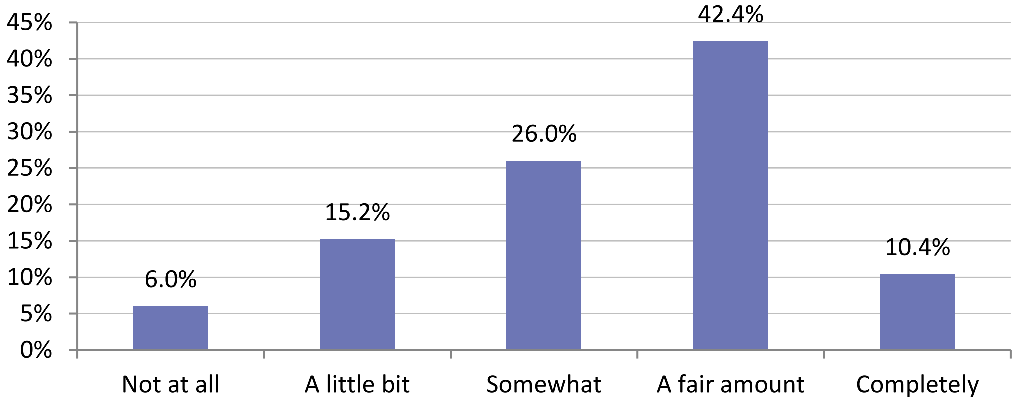

Figure 19. Extent to which COVID-19 has impacted on roles / responsibilities.

Staff were redeployed due to COVID-19, to wards (38.6%), to support COVID-19 patients (20.5%), critical care services (14.8%) and into family support services (11.4%). Other areas included palliative care, bereavement services and the vaccination programme.

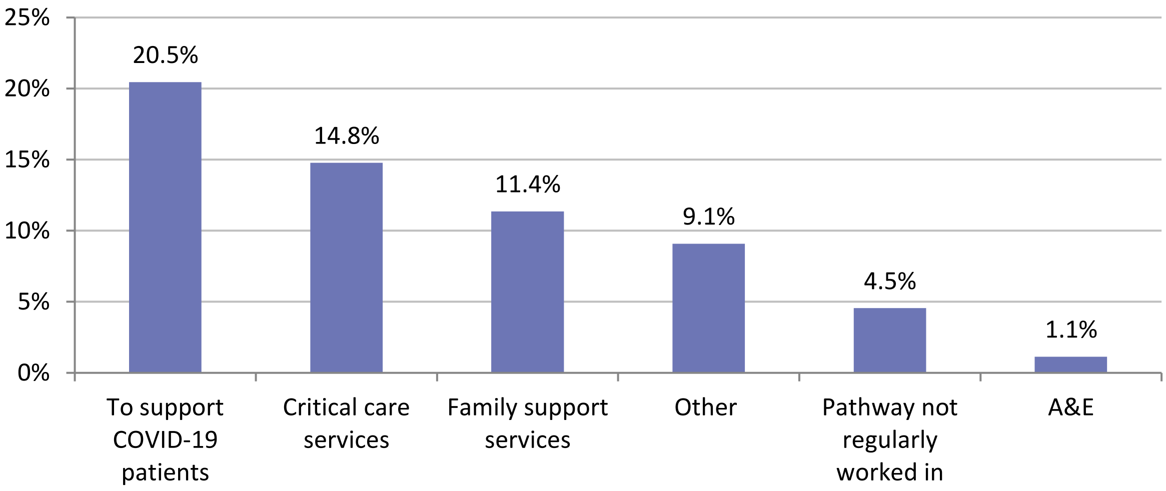

Figure 20. Redeployment destinations.

Additionally, the pandemic affected the CNS role and responsibilities in different ways which may be categorised in four main areas:

Patient care	Services
- Growing intensity of work - Increased need for psychological and emotional support in the absence of family relatives in premises. - Management of patient expectations in extraordinary circumstances. - Decrement of rapport with patients due to PPE, virtual communications, and loss of private spaces in premises. - Difficulties to assess patients remotely. - Increased number of patients with complex needs – impact on symptom management.	- Reduced and delayed services. - Increased workload - Surge of responsibilities as senior staff were redeployed. - Increased staff shortages. - Shifts in priorities of cancer services with the suspension of some (e.g., breast reconstruction surgeries). - Loss of space to carry out clinics due to high infection areas. - Redeployment and sickness left some clinics unattended. - Increased waiting times. - Increased need for virtual consultations.
Staff Wellbeing	**Learning & Development**
- Increased burnout and mental health issues. - Increased need for bereavement support.	- Decrement of learning funding. - Challenging induction and training of new CNSs. - Increased need of support for junior staff. - Difficulties in accessing clinical skills training. - Increased need of IT skills and improved access to technology. - Increased need for communication skills in a virtual setting.

> *"When no face-to-face appointments were taking place, I feel that patients care was affected massively. Not being able to see your patient and assess their responses to the information they have been given was awful. When I was making calls to them after their consultation, I didn't feel that I was providing sufficient information and support and the ability to stop and pause, and listen was impaired and often information was missed or not provided."*
>
> *Macmillan Uro-oncology Clinical Nurse Specialist, University Hospitals Morecambe Bay NHS FT*

> *"I have lost continuity of the service provided by my team. I suffered from burnout which has impacted on my confidence coming back to my job as a CNS."*
>
> *Clinical Nurse Specialist, Blackpool Teaching Hospitals NHS FT*

One of the consequences that stands out is the surge of responsibilities due to redeployment of senior staff. This included the redeployment of Lead Cancer Nurses or Consultants, but also of Band 7 CNSs themselves, which occasionally left Band 6 CNS in charge of some clinics.

Learning from COVID-19

Despite challenges, the pandemic offered opportunities for learning including positive outcomes to move forward in the same theme areas:

Patient care	**Services**
- More flexibility for patients: virtual consultations or face-to-face appointments - Reduced time and distance travelled to appointments for both patients and staff. - Development of virtual resources for patient (online videos, learning tools)	- Better team work and collaboration - Continuation of Family support services - Flexibility of working from home for staff (saving time and financial resources) - Increased efficiency in terms of consultations and non-clinic days - More integration with services - Opportunity for remote working for research and audit purposes - Replacement of initial traditional outpatient medical appointments with CNS telephone assessments - Increase of virtual / telephone consultations, remote clinics, assessments, and triage

	- Increased virtual meetings (e.g., MDTs, diagnostic planning)
Staff Wellbeing	**Learning & Development**
- Coping strategies development - Improved communication skills and resilience - Increased focus on staff wellbeing	- Increased hygiene and infection control awareness - IT skills - Virtual training more accessible for all (although not applicable to clinical skills)

> *"Home working has been effective and requires co-ordination with other team members but has allowed a better work life balance. We have developed improved communication skills over the phone having had to conduct assessments and new patient consultations via the phone."*
>
> *Lung Cancer CNS, The Christie NHS FT*

Key takeaways – Impact of COVID-19

- The **pandemic** has had a **considerable impact** on a substantial number of CNS staff.
- A third of all CNS staff were **redeployed** during the pandemic.
- **Redeployment** destinations included support to COVID-19 patients, critical care services and family support services.
- **Impact on individuals and teams** included increased workload, reduced services, staff shortages, additional patient support requirements, difficulties assessing and communicating with patients remotely, surge of responsibilities, staff burnout and adverse mental health issues.
- The pandemic did bring about some **opportunities for learning** which included better team collaboration, improved communication skills, resilience, increased efficiency, integration of services, increased hygiene and infection control awareness.

Findings from the interviews

42 semi-structured depth interviews were conducted by telephone/virtually with a sample of CNSs to further develop and expand on the themes originating from the online survey. The aims of the interviews were to:

- Review and refine the findings from the online survey.
- Develop and deepen the emerging themes.
- Create, understand, and develop opportunities for best practise.
- Form new lines of enquiry.
- Assess the areas of critical importance which require addressing.

Interview responses were collated and transcribed to enable coding of key themes which enabled a 'deep dig' into those themes and helped to produce robust insights and anecdotes. The output data was sorted, arranged, and classified using a thematic approach which enabled the exploration of relationships and the cross-examining of findings.

A workshop with the Expert Group[13] was conducted with representatives from a range of roles and levels of responsibility. Due to COVID-19 restrictions, the workshop was conducted as group sessions via video conference. The aim of the workshop was to verify the findings arising from both the online survey and the interviews, and next steps for the development of a capabilities framework for Cancer CNSs in the light of the current updating of the *Career and education framework for cancer nursing* (RCN, 2017) lead by the Royal College of Nursing. The workshop differed from the interviews in that they were driven by a collective dynamic, which introduced challenge, support, and validation. It helped to confirm insights derived from the semi-structured interviews, provided evidence of wider, shared experiences, further broadened, and deepened the emergence of common themes and validated the data findings.

The findings from the interviews are gathered under the dominant themes arising throughout the research – these reflect the combined views of all participants and cover specific topics related to the capabilities of the Cancer CNS, their experiences, and support they receive.

The key takeaways included in this section should be viewed from the perspective of how a capabilities framework can help to address each point raised – suggestions for how this might be accomplished appear in the recommendations section.

---

[13] The Expert Group is formed by a diverse group of stakeholders, including CNSs, Lead Cancer Nurses, Directors of Nursing representatives, Workforce Leads, Learning & Development leads, and patient representatives.

Theme 1: Duties/Core Capabilities

At first, many interviewees struggled to define the responsibilities of the role and find patterns as they stated how different being a CNS is from other nursing roles. However, a few themes are prevalent in their depictions.

Patient care

Unsurprisingly, patient care is at the forefront of CNSs priorities. They describe themselves as pathway coordinators and patient advocates, they are required to know the patient and their circumstances on a personal level in order to offer high quality care. Therefore, person-centred care, communication skills and holistic practice emerge as key capabilities. Overall, they provide constant support to all patients, via wards' rounds, and video/phone calls. Much of this is psychological support given the nature of cancer care, and functional issues arising from treatment.

> *"When we are really busy and need to do lots of things, with training, audits, meetings, calls... the patient always comes first. After I have done that, I will do the rest."*

The complexities of the role are tightly linked to the psychological support they offer to patients to help them navigate their diagnosis and receive the appropriate support (e.g., clinical, emotional, financial). The support may be provided via clinics, ward rounds or video/phone consultations.

> *"The remit is traumatising, and it is about supporting patients through their journey".*

> *"It's completely psychological".*

Communication skills emerge as a key capability of the role linked to other distinct capabilities. Firstly, the ability to provide psychological support to patients and their families, navigate difficult conversations around death, loss, risk, and life changes. For example, one Head & Neck CNS shared the difficulties surrounding the diagnosis of her remit, as speech, swallowing and voice were deeply affected by cancer and treatment. Therefore, linking up with other healthcare professionals was crucial to support patients, but remaining a constant in their journey and helping navigate life with cancer is a major aspect of their role. Another aspect of this is the provision of support while patients are waiting for their diagnosis and/or treatment, as this can be quite a long time and they feel increasingly anxious. Lastly, CNSs need to be able to have advocacy and teamworking skills in order to ensure the patient's needs are met, this is particularly important during Multidisciplinary Team Meetings (MDT) where they represent the patient and their needs as CNSs know their circumstances and symptoms best.

Clinical skills

CNSs are required to be experts in their cancer pathway. Many CNSs, although not all, lead a variety of clinics where they need to showcase high levels of independence and knowledge around procedures and cancer care. This includes, but not exclusively, the following:

- Clinical triage providing an accurate picture of the patient – referrals and signposting.
- Clinical assessments over the telephone or in person.
- Diagnostics and investigation.
- Clinical and therapeutic procedures.
- Symptom management.
- Some surgical interventions.

An important aspect of this theme is to provide accurate information about the condition, the symptoms, side-effects of treatment and risks. This can either be answering questions directly or knowing who the most appropriate person is to answer them. Thus, they draw from their own knowledge and experience, but also from the resources and people around them to educate and inform patients.

Many participants shared how the role has become increasingly complex due to advances in technology (e.g., robotic surgery) and increased number of people with complex needs (e.g., comorbidity). Managing complexity proved to be challenging, as staff-shortages and limited access to training affected the possibility of developing the capabilities necessary to fulfil this need. However, it was emphasised that an increased specialised knowledge was needed, which is not necessarily related to cancer care, but many found beneficial to be knowledgeable of the specific tumour group. For example, having worked in a gastro ward before becoming a Colorectal CNS.

It is important to recognise that some clinical skills vary from pathway to pathway, and whilst oncology knowledge and skills emerged as fundamental to all Cancer CNSs, specific tumour group training was notably sought after.

Another training that was perceived as incredibly beneficial for many was the non-medical prescribing, particularly for those nurses who run clinics and work highly independently from the consultants. Being able to prescribe certain medications allowed them to be more efficient and decrease waiting times for the patient. However, not all thought the same, a few CNSs did not consider it a priority as they worked closely with consultants and their tumour group did not require a follow-up of medication, thus if needed, they could ask the medical staff for assistance.

Leadership

All interviewees stressed the importance of being resilient, a self-starter, and proactive in the role.

> *"Nothing gets done, unless you start doing it."*

CNSs show high levels of leadership in different aspects of their role. Some of them are team leaders and line managers of a small group of CNSs and support workers. All of them participate in MDTs and need to showcase confidence, engage other professionals, share vision, and be accountable for patients' care. They all shared how managing multiple complex demands at once and being able to prioritise were key to be able to perform well.

> *"I feel like work is never completed, so prioritisation is crucial".*

Another theme emerges related to the patient care and clinical skills. This is the ability to influence and educate, whether patients, families, or colleagues. Their knowledge of the condition, the pathway, and the patient prepares them to be in an ideal position to lead their care.

Additionally, the role is mostly autonomous, and many CNSs work very independently, even when there are other CNSs and professionals in the room. Lone working has not emerged in the interviews as a distinct enough theme, as many CNSs work in hospital settings with colleagues, and community nurses were not in the scope of this project, but the level of independence they showcase differs from working in a ward. A few CNSs shared how they had carried out home visits in the past, but changes in the service halted this as it was deemed more efficient to centralise the service in one location (or two in some cases) and do phone consultations to reduce traveling. However, the pandemic introduced homeworking for many CNSs (usually, one day a week), which may require to re-assess the need of lone working as a core capability if homeworking remains.

CNSs are also a named support; this means that patients have their contact details to facilitate their access to information and care. But it also leaves CNSs vulnerable to complaints. A few participants shared that over 300 people have their mobile number. Being able to manage these pressures and a high caseload is also a key element of the role.

Other relegated activities:

In addition to patient care, clinical skills and leadership, there were a wide range of activities that CNSs get involved with, yet they shared their frustration to be unable to engage in them as much as they wished. However, they emerged as key capabilities that CNS should or could be involved with. These can be grouped as follows:

- Education and mentoring: this may include supporting new recruits, junior members of staff (nurses or doctors), participating in conferences on their cancer pathway, and educating ward staff about the work in the clinics and cancer care.
- Service development and improvement: this ranged from being involved in national CNS networks, meetings with CNSs and Lead Cancer Nurses in their Trust, sharing best practice, and seeking new ways of improving service (e.g., phone consultations, new clinics).
- Research: CNSs shared how they were involved in evaluation of their services and find and test ways to improve efficiency. A couple of CNSs were also involved in clinical trials.
- Further learning: all interviewees showed commitment to long-term learning and their enthusiasm to keep their knowledge updated and learn new skills.

- Additional patient support: some CNSs run and coordinated support groups for patients and were heavily involved in empowering and helping them navigate life with cancer (e.g., psychosexual support).
- Prevention: CNSs were also able to access resources and support patients who wished to engage in preventative lifestyle changes (e.g., smoke secession), but also through speaking up about cancer and its risk factors.

> *"So many data, but no time to produce intelligence".*

Key takeaways – Duties/Core Capabilities

- 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.

Theme 2: Training and entry routes

Within this theme, a few sub-themes emerge which are highly interlinked.

Induction and transition into the role

Many of the interviewees have pioneered the role of the CNS in the different pathways, as it did not exist before they came into post. Thus, they had to draw from their own strengths to form the role, and many times, the service, with limited support.

> *"I had to invent my own job and how I wanted it to be".*

Participants of different levels of experience share that the transition into the CNS role can be overwhelming as the level of responsibility and structure of the role is highly dependent on themselves and there is limited support available.

> *"If you go in naïve, the pressure can get to you quite quickly".*

> *"It can be overwhelming for some people. We currently have vacancies in the team because two people left after 6 months of starting".*

As a result, experience is a key component to the role, given the number of responsibilities they are given. Pressures arise both from ward and clinic staff, as well as consultants, patients, and relatives. This requires CNSs to be prepared to cope with the pressures and the workload, which induction rarely prepares them for, thus "learning on the job" was a regular theme in interviews.

> *"This is the type of job that no one prepares you for beforehand, you learn on the job".*

CNSs mostly relied on the other CNSs on their team to learn the intricacies of the role. Teams and more senior CNS design an induction package that is very variable from service to service for the newcomer depending on their needs and interests, but these are usually requested by the new CNS. For example, some nurses organised themselves visits along the patient cancer pathway, others shadowed experienced CNSs. More structured entry pathways have started to emerge in some areas, these include the implementation of "Development Posts". These posts are offered to nurses with the potential to become Band 7 CNSs, so they practice as Band 6 in the duration of the programme while also participating in some training.

Despite these challenges, Macmillan nurses state that having access to the support and resources from the charity helps them with their learning. This includes their Learning Hub, where they can access free recordings of training sessions as well as workshops.

Entry routes

Many CNSs' entry routes begin with a cover position or a secondment which then becomes a full-time job. Their previous role varies, some were nurse practitioners in a ward, some were ward managers, some had worked in research. Specialist tumour group knowledge was generally considered an advantage, although further training in clinical examinations and procedures were highly valued.

They are motivated to become CNSs as they see it as an opportunity to develop professionally in a way that keeps them close to patient care. They often see becoming a CNS as an alternative to ward manager.

Training

CNSs are interested in continuous learning and enhancing their skills. Their motivation to provide high quality care helps them identify the gaps in their knowledge and apply for a variety of training. Most CNSs have undertaken the Level 2 Communications Skills training which is found incredibly important. Refresher courses are also suggested by many as a course they would be interested in.

> *"It is like a mine field, so communication is key, and using your experience on the right things to say". – Macmillan Lung Cancer Nurse Specialist, East Cheshire*

But clinical skills are one of the most sought-after trainings which includes:

- Surgery course (e.g., complex incisions)
- Non-medical prescription training
- Pathway-specific cancer training – usually a master's module in a local university.
- Clinical examination skills (e.g., endoscopy).

Some of these courses would be included in an Advanced Clinical Practice (ACP) masters, which a few CNSs have already undertaken. A few others hold a master's in Clinical Practice which has some similarities with ACP. However, CNSs with no qualifications but decades of experience were also interviewed, they are the ones who struggle the most when accessing further training as entry requirements include formal qualifications. Results suggest a lack of consensus in the education requirements for the role, as well as the utilisation of a master's degree, and the career development pathways for CNS at Band 7. Whilst there is agreement on the need for CNSs to be senior nurses due to the level of responsibility and capabilities they need to display, there is not one set way of becoming a CNS, nor what opportunities lay for them if they wish to progress.

Limited funding and staff-shortages are the main barriers to the development of CNSs. When they do find some funding, CNSs share that their study days are not protected and there is not enough staff to cover while away on training, which results in delays and many times in not being able to attend. Not being able to keep learning and develop has a negative impact on their morale and engagement.

> *"I feel I encountered a brick wall".* – Upper GI CNS, Wirral University Teaching Hospitals.

Potential solutions were suggested during the interviews. These included having sectoral Personal Development Plans, protected study days, a review of the requirements to access to funding so it is more accessible to all, and expanding mandatory training to include some oncology and pathway specific master's modules.

Key takeaways – training and entry routes

- 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.
- There is no consensus on the career pathway for CNSs.

Theme 3: The team

The team a CNS works with is quite varied. However, it is evident from the research that CNSs rarely work alone. Most of the CNSs interviewed worked in small teams, of about 3-7 CNSs of usually Band 7s, some had one or two Band 6, and others had a Band 4 Cancer Care Coordinator or support worker. Flexible and part-time working was common in all teams.

When there is diversity in banding in the team, the Band 6 are mostly providing nursing support, and while sharing most of the core capabilities with their Band 7 counterparts, these are not at the same level of responsibility (e.g., leadership).

Most of the Band 4s are under temporary contracts, and whilst they were not interviewed, they were highly valued by the CNSs they work with as receiving their additional support has freed up much of CNSs' time. They tend to undertake administrative tasks including bookings, data tracking, but also clinical examination support, and in some instances, they complete the Holistic Needs Assessments (HNA). CNSs state that HNA increased the pressure when they were introduced as they are very time consuming. It is estimated that each assessment takes between 1-2 hours per patient, and then a few more hours depending on the actions needed resulting from the assessment (e.g., referrals, ensuring they are applying for benefits). Band 4s supporting with the HNAs provide a relief in their workload, which increased efficiency and quality of care for many of the teams. For example, one CNS shared how her team had to prioritise prior to recruiting the Band 4 and only provided full HNAs to palliative patients. Despite the challenges, it is generally understood that HNAs provide a structure and approach that is consistent with their capacity.

> *"It was nothing we were not already doing, but it did provide a better structure to capture it".*

A few CNSs also commented on the impact of their manager's role on their ability to receive support. Because the role is widely misunderstood by other teams, some CNSs felt that not being managed by another CNS, or someone who had been a CNS (e.g., Cancer Nurse Consultant) is challenging as they are not provided with cancer specific support, or feel their role and responsibilities are not fully understood.

> *"Our manager is not happy if she sees us on our desk as she says that nursing is about*

being on your feet. But our role is not going on rounds all day, there is a lot we need to do that is on the desk".

"It's really difficult, as quite often your manager is not a CNS themselves. That is why CNS Nurses need to be quite senior, as you go in quite blind and need to develop the job role yourself".

Teamworking, participating in MDTs, sharing clinics with wards staff, and participating in ward rounds were some of the suggestions that CNSs shared which were thought to help exchange knowledge and promote the role of Cancer CNSs.

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.

Theme 4: The evolution of the CNS role

The role has evolved in many ways since it was created. Experienced CNSs with over 10 years of experience share how when they started their role was mainly shadowing Consultants, and there were very few occasions where they could work independently.

Currently, the role is very autonomous and requires strong leadership as well as clinical skills. It is likely that the role will continue to evolve towards that direction, with more nurse-led clinics and nurses being able to perform independently more clinical examinations, diagnostic, and therapeutic procedures.

Changes to the role have been required due increased levels of complexity. As a result, CNSs capabilities have had to evolve to better support patients. For example, many of them have acquired advanced practice capabilities (e.g., non-medical prescribing), and it is thought that many more responsibilities related to advanced practice will be required in the future.

There is the potential for the role becoming more medicalised. The change is already happening as many CNSs are doing tasks that were traditionally assigned to medical staff, including: first assessment of patients (history, symptoms, home circumstances), first appointments (patients coming to the clinic for tests) and telephone follow ups (patients only go to the clinic once rather than multiple times as before). Patients attend the clinic to undertake more invasive tests only after the initial assessments have been undertaken by the CNS.

> *"Nursing has changed so much, we are much more autonomous, doing more extended roles than ever and we will continue to do so".*

Additionally, CNSs are likely to gain 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 CNSs across pathways. Their role will continue to become more holistic, engaging with other healthcare providers (e.g., dieticians, counsellors), as well as preparing the patients for treatment. CNSs will continue to undertake more roles and responsibilities. Going forward, some believe there is a need for more CNSs to be able to carry out surgical procedures, provide clinical examination, and use specialist equipment.

Further involvement in research and education is also likely to be required which is linked to the utilisation of CNSs skills and knowledge not only for patient care, but also to improve services. As previously mentioned, many CNSs have been highly involved in the creation of services and their improvement as they pioneered the role in either their area or their pathway. However, capabilities that would standardise the implementation of the role have not been prioritised until recently. Nevertheless, these nurses have accumulated a volume of knowledge and experience that would benefit this process and are currently looking for opportunities to do so.

Interestingly, CNSs working in Rapid Diagnostic Centres share that while the level of responsibilities will increase, a generalist knowledge will be required. This posed the question again about the utilisation and capabilities differences between CNSs and ANPs.

Concerns are also commonly shared in the interviews about the drivers that impact the role. Some express how staff shortages, time constraints and increases in service demands will drive the need for new ways of working.

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. For example, many Band 7s are undergoing prescribing training, and the role could potentially have more diagnostic responsibilities.
- 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.
- Risk for new ways of working to be needed as service demand increases but number of staff remains stable.

Theme 5: Professional identity

As illustrated in the previous section, the role of the CNSs is in constant evolution and responding to multiple demands. Changes in the role however brought a sense of uncertainty and frustration about their future, rather than empowerment and motivation. Despite changes, the descriptor of "key worker" or similar (e.g., "patient advocate") that stresses the close relationship between the patient and the CNS remains.

CNSs often feel that there is a general misunderstanding of their role, particularly from senior managers. Some share how they think managers perceive the role as a luxury in the pathway, rather than an integral part of the patient journey. Some managers have referred to them as "*the icing on the cake*" when CNSs believe to be "*the jam that keeps it altogether*".

There is a palpable concern about the increasing medicalisation of the role, and the overlaps with Advanced Nurse Practitioners (ANP). Whilst the concern is almost unanimous, there are two distinct perceptions of the ANP compared to the CNS. Some CNSs view the ANP role as a natural progression from cancer specialist nursing, whilst others view it as an alternative career pathway that is closer to the medical professional than nursing. In both instances, their concern is related to their motivations for becoming nurses and fearing to sacrifice this to progress in their careers. CNSs are generally motivated to become specialists as it provides an opportunity to increase their learning, showcase their clinical and leadership skills, whilst remaining close to patient care, and many times, it is perceived as alternative to managerial positions (e.g., Ward Manager). So, while some CNSs are prepared – and actively preparing – to become ANPs, it is unclear how the transition from specialist practice to advanced generalist practice is being carried out.

The medicalisation of the role also raises feelings of self-doubt and concerns about the value of nursing. Many believe that the role is going to get replaced by either a more advanced/senior role such as ANPs, or by a lower level one such as Healthcare Assistants. Whilst the increased levels of independence of the role are inevitable, concerns emerge around its potential erosion.

These thoughts and perceptions of the CNSs role and colleagues misunderstanding the role increase their feelings of isolation and self-doubt and eroding their professional identity as specialist nurses.

> *"I fear the role will disappear within secondary care as there is a lack of understanding".*

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.

Theme 6: Clinical supervision and other support

New pathways have been created over the years, and the role has rapidly been welcomed. Interviewees share how valued they feel by patients and families.

> *The role's value was quickly appreciated by patients".*

Regardless of pathway, Cancer CNSs fulfil an emotionally demanding job with high levels of complexity. There are however various methods used to cope. Three main methods have been identified in their discourses:

1. Team support: this is having and counting on colleagues they feel they can reach out to at times of need, whether they are other CNSs or Consultants.
2. Clinical supervision as an important support for many CNSs.
3. Unknown/personal resources: some interviewees stated how they do not need additional support and shared a more pragmatic approach.

> *"It's a psychologically and emotionally demanding job and you don't get used to it, but you learn to deal with it."*

Generally, one main source of support is line managers, yet CNSs often feel like it is difficult for them to ask for help and feel fully supported if they are not directly managed by nurses with cancer experience. However, death and loss (not necessarily of life – e.g., speech, sexual desire, financial stability) are common themes in Cancer CNSs' working lives. Whilst death can be distressing, in certain pathways it is part of their everyday. One CNS explained how this does not necessarily equate to more personal distress for them, but rather the uncertainty about people's futures experienced in other pathways may be more distressing.

> *"All of my patients die, some take 5 years others take 3 months, but they all die. This may seem very traumatic to others, but there is peace in that certainty. I always have closure".*

These situations are when managers and colleagues' support might not be sufficient, and clinical supervision can fill that gap.

Clinical supervision

Clinical supervision is an important element of the support available for CNSs. This is usually provided by a mental health professional (e.g., psychologist, counsellor, psychiatrist) who organises the meetings and invites CNSs to attend every so often. Avid attendees describe the multiple benefits of having access to clinical supervision.

> *"The supervision makes you realise that you're not on your own. It helps you find new solutions to problems. I always come out feeling uplifted because I feel that other people have got my back. It has made me not be so self-critical and not beat myself up. You can't always give 120% so it has made me manage my caseload better."*
>
> *"It gave me the confidence to do what I do and take care of myself".*

Overall, clinical supervision provides psychological support to CNSs and a space where they can share the challenges of their working lives, seek advice and comfort, build interpersonal skills, and exchange knowledge with other CNSs. For example, one interviewee shared how clinical supervision has helped them develop de-escalation skills to help them deal with an abusive patient's family. The role of facilitator in this is key, as the ability to provide additional support and act as a link to other professionals is highly valued (e.g., dietitian, sex therapist).

> *"The clinical psychologist has gone above and beyond".*

Attendees can rapidly identify what works for them. From their answers, the following factors emerge as main enablers:

- **Facilitator's skills** greatly influence the experience.
- The **make-up of the group**. It is preferred if the attendees are regular, and the groups are smaller in order to facilitate rapport. There are also advantages of having a mix of CNSs from different pathways and no line manager attending.
- Attending **consistently** helps building them into a routine.

Interestingly, a few attendees praised the opportunity to have clinical supervision, yet preferred to seek private support as some facilitators focus only on work and case discussions and provide little opportunities to explore how the nature of the role impacts their personal life.

Despite being able to identify the features for best practice, there are plenty of barriers that impede their uniform implementation. These are usually around time constraints and time for supervision not being protected. Challenges have been particularly exacerbated by COVID-19 as many who would attend supervision did not have time, were redeployed, or shortages in the psychology department have resulted in meetings being cancelled.

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.

Theme 7: COVID-19 impact

The pandemic and consequent lockdowns affected the responsibilities and working lives of CNSs in different ways. With the first lockdown, levels of work declined in some cases as they were not receiving referrals from GPs, yet this is starting shift. Currently, workload is estimated to be at similar levels as before the pandemic, and it is expected to increase in the following months as restrictions are lifted.

Redeployments and new ways of working were introduced which resulted in service redesign and the closure of a few clinics. A few Band 6 CNSs saw their levels of responsibility and autonomy increase as their colleagues and supervisors were redeployed and they had to manage the service. Homeworking has also become common and is perceived as a great advantage as it allowed a balance with caring responsibilities at home. There was an opportunity to continue and further implement video/telephone consultations. This worked particularly well for follow-up consultations as it allowed to monitor patients and save them time and costs in travelling to hospital premises. However, remote communications hindered the relationship building process with new patients as they tend to be more impersonal and there is a loss of body language cues.

> *"I don't like breaking bad news over the phone; I miss so much information on what they are experiencing, and it is very difficult to offer them support like that".*
>
> *"It was difficult for me to remember too. They suddenly became pieces of paper instead of actual people, so it became very impersonal".*

Some patients in certain pathways, for example, struggle with communication and rely in other cues (e.g., head and neck pathway). Therefore, whilst online/remote consultations were a positive addition for many patients, there is still the need for face-to-face consultations in order to adequately assess patients' needs.

Key takeaways – COVID-19 impact

- Telephone/video conferencing introduced and likely to remain for many follow-up 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.
- A few Band 6 CNS saw their levels of responsibility and autonomy increase as their colleagues and supervisors were redeployed and they had to manage the service.
- Flexible and homeworking was introduced successfully.

Key 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.

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.

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 to consider

The nature of any research means that as well as answering questions related to expected outcomes and objectives, it also uncovers and raises further questions and areas for inquiry. Many of the issues raised throughout this report, indicate that there is most definitely a need for further investigation which could be undertaken through various routes (further surveys to map progress; 'topic' focused research; working groups etc.) which will deepen, enrich and inform understanding responses and actions. In terms of the importance of identifiable actions required to address the recommendations, it would be beneficial to assess and rank all these recommendations in terms of scale. For example, assessing what can be achieved, by when and by whom. This should consider factors such as importance, reach, potential impact, ease of implementation. In this way, the recommendations could be usefully structured as follows:

- **Level 1: Rapid Impact** - Those recommendations that could be relatively 'quick and easy' to implement, that can be achieved with moderate effort and will provide opportunities for *rapid reach and impact*.
- **Level 2: Progressive Action** - Those recommendations which will require a degree of negotiation and compromise but provide the opportunity for *progressive action*.
- **Level 3: Ambitious Challenges** - Those recommendations which will require more time to embed with issues to manage that require senior buy-in but provide opportunities to *meet ambitious challenges*.

The key takeaways emanating from this research have been used to provide pointers for the following recommendations. They centre on the compelling messages, stories and issues raised by participating staff. These cover themes such as the need for better processes (systems and methods), improved communications; training and CPD; clinical supervision, definition of roles, and career pathways.

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.

As already stated, the above recommendations are driven by the key takeaways and findings drawn from a comprehensive programme of research that has been inclusive in its reach and critical in its efforts to understand a range of issues related to (but not restricted to) the development of a Cancer CNS Capabilities Framework. It goes much further than informing the second stage of the project, in offering ideas, guidance and advice on how to address and mitigate for the challenges faced by the CNS workforce. 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.

Annex 1: breakdown of responses

Breakdown of responses by Trust

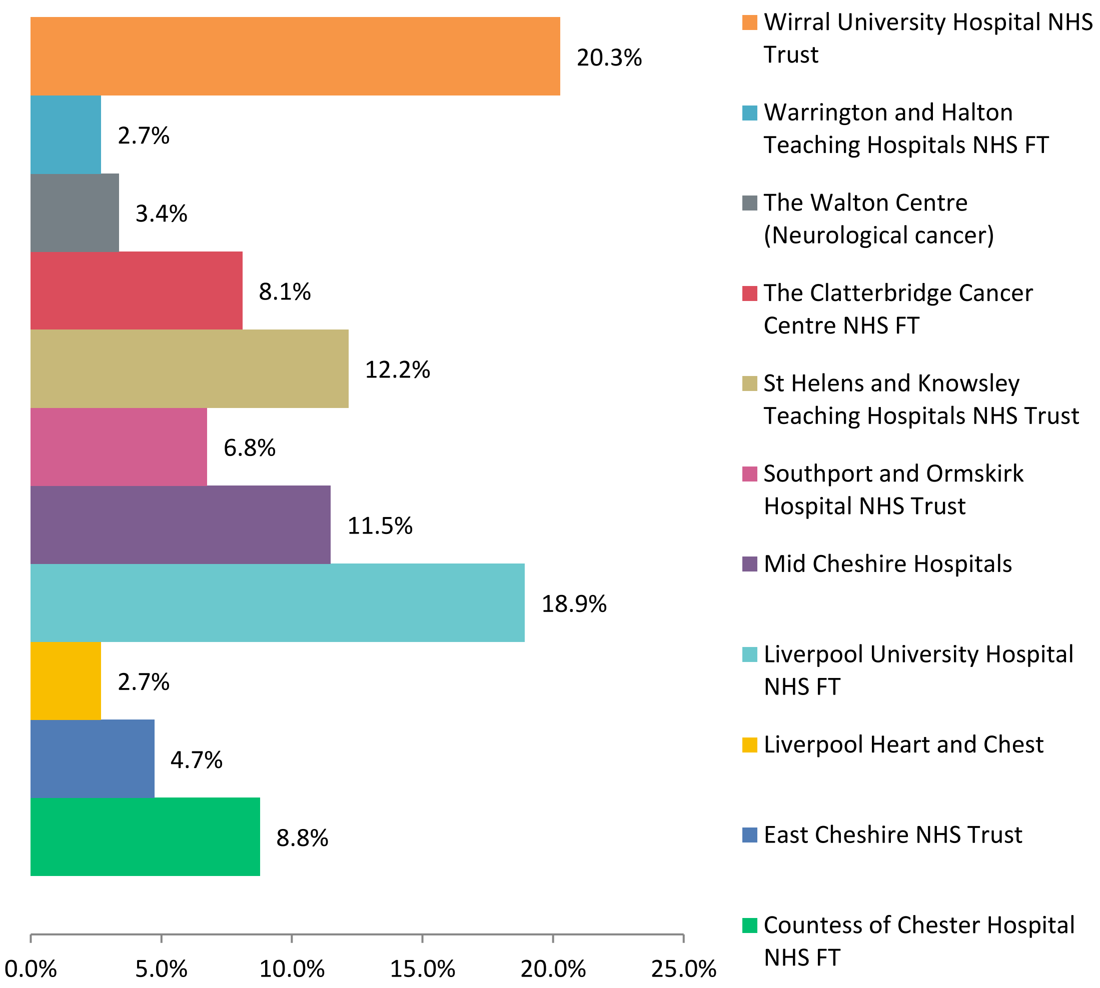

Figure 21. Respondents by Trust: Cheshire and Merseyside Cancer Alliance.

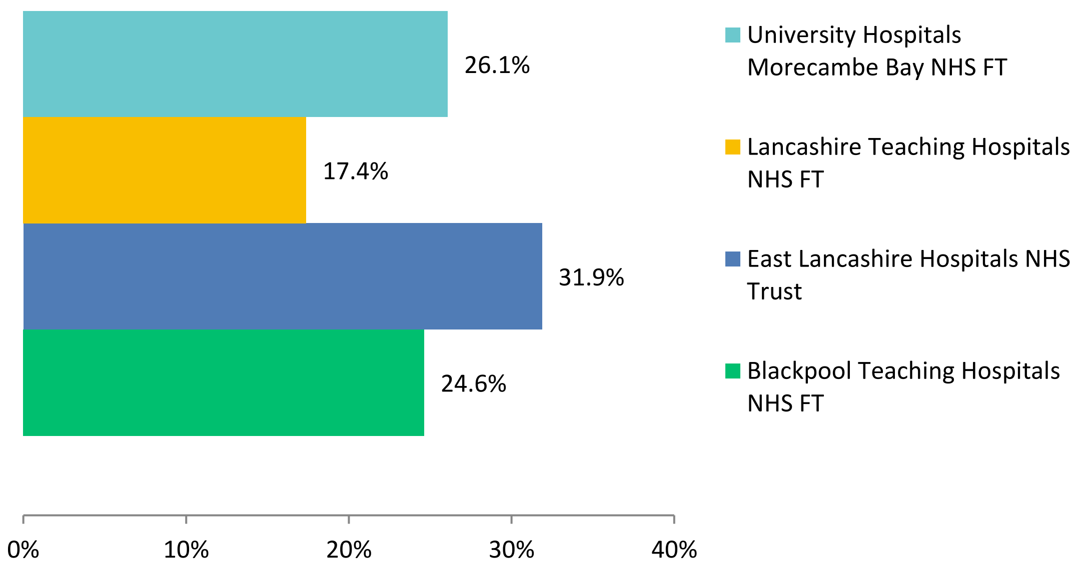

Figure 22. Respondents by Trust: Lancashire and south Cumbria Cancer Alliance

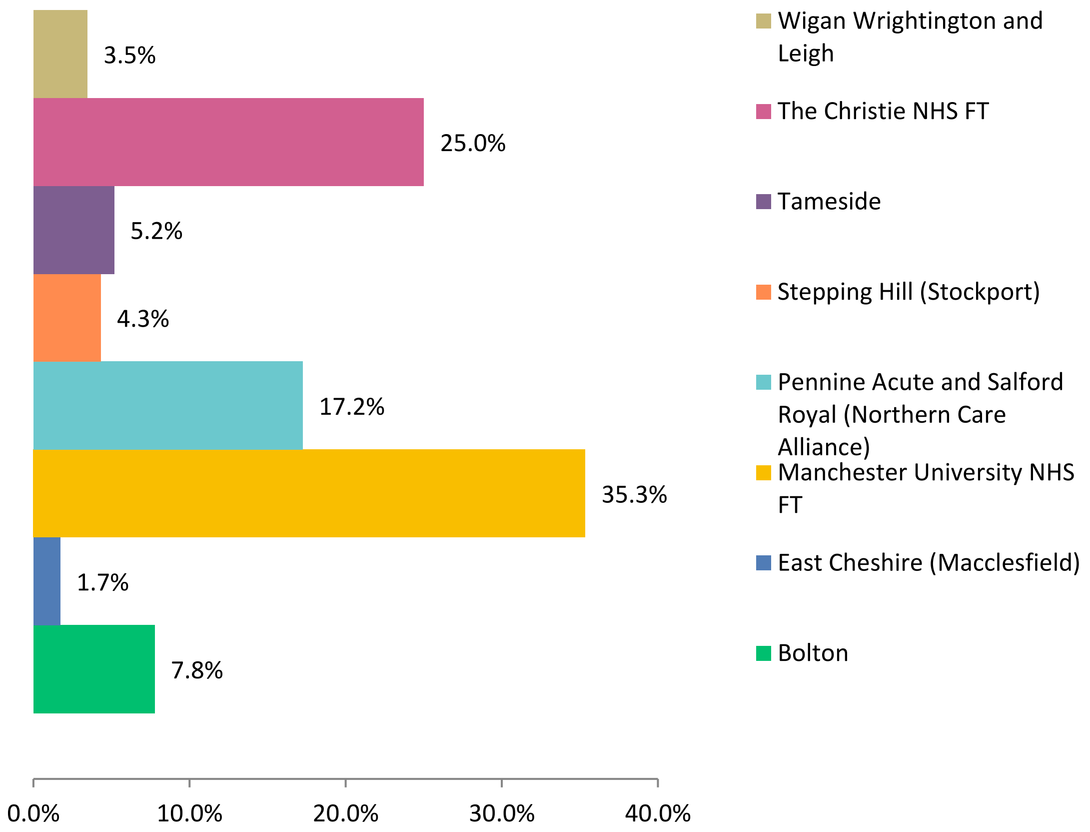

Figure 23. Respondents by Trust: Greater Manchester Cancer Alliance.

Analysis of relationships

This section provides an analysis of the relationships between independent prescribing, capabilities and cancer pathways. It offers a deeper exploration of the responses to important variables contained within the survey. Central to this report is the *issue of capabilities* and the different *cancer pathways* and these are used as anchors in this analysis. In addition, following discussions with the 'expert group' the issue of independent *prescribing* is covered in greater depth, to provide a deeper understanding of responses to this issue.

Capabilities - This focuses on those capabilities that are rated as most important to the role of Cancer CNS (based on the 'top 5' ranked capabilities) – these are *communication skills*, *patient advocacy*, *person-centred care*, *teamworking* and *specialist cancer care.*

Cancer pathways - There are a substantial range of cancer pathways covered in this report, however, the top 5 (based on the greatest number of survey responses) are covered below and these are *breast, colorectal, haematology, lung, and urolgy.*

The tables below commence with an analysis of the 'anchor' variables (pathways and capabilities). These represent the cross-tabulation of the 5 highest ranked capabilities measured against the 5 pathways which provided most responses. It indicates the percentage of those respondents from each pathway, that ranked the respective capability as *very important*. E.g. of those respondents indicating that they worked within the lung pathway, 97% thought that *teamworking* was very important

	Communication skills	**Patient advocacy**	**Person-centred care**	**Teamworking**	**Specialist cancer care**
Lung	100%	100%	100%	97%	97%
Urology	100%	100%	97%	97%	97%
Breast	100%	100%	100%	97%	94%
Colorectal	100%	100%	100%	100%	100%
Haematology	100%	100%	100%	100%	96%

Capabilities

The following table represents the cross-tabulation of the 5 highest ranked capabilities measured against length of service (within cancer care). In terms of the most valued capabilities, the responses demonstrated a great deal of uniformity regarding their importance in all relationships.

Capabilities by length of service (in cancer care)

	Communication skills	**Patient advocacy**	**Person-centred care**	**Teamworking**	**Specialist cancer care**
Less than a year	100%	100%	100%	100%	100%

Between 1-2 years	100%	100%	100%	93%	100%
Between 2-5 years	100%	100%	100%	97%	97%
Between 5-10 years	100%	100%	97%	96%	96%
Over 10 years	100%	995%	100%	97%	96%

Capabilities by Cancer Alliance Area

The following table represents the cross-tabulation of the 5 highest ranked capabilities measured against trusts within a specific cancer alliance area.

	Communication skills	**Patient advocacy**	**Person-centred care**	**Teamworking**	**Specialist cancer care**
Cheshire & Merseyside	100%	99%	99%	100%	95%
Greater Manchester	100%	100%	100%	97%	97%
Lancashire & S Cumbria	100%	100%	98%	94%	98%

Capabilities by Development Post

18% of respondents indicated that they occupied a Development Post.

	Communication skills	**Patient advocacy**	**Person-centred care**	**Teamworking**	**Specialist cancer care**
In a development Post	100%	100%	100%	100%	98%

Pathways

The following illustrates the findings from participants employed in those pathways for which the most responses were received. These relationships varied to a much greater extent than those focused on capabilities.

Pathways by development post

In the five most represented pathways, the extent of individuals in development posts varied from almost 1 in 10 of all posts within a pathway (Colorectal / Urology), to almost a third of all respondents in post (Breast).

	% of respondents in a development post
Breast	29.6%
Colorectal	9.7%
Haematology	13.3%
Lung	10.3%
Urology	9.5%

Pathways by factors Impacting on Role

Time constraints were cited as the biggest factor that will impact on roles across all pathways, followed by staff shortages. This has probably been exacerbated over the previous twelve months due to pressure exerted by dealing with the Covid-19 pandemic and will no doubt continue to influence roles for some time to come.

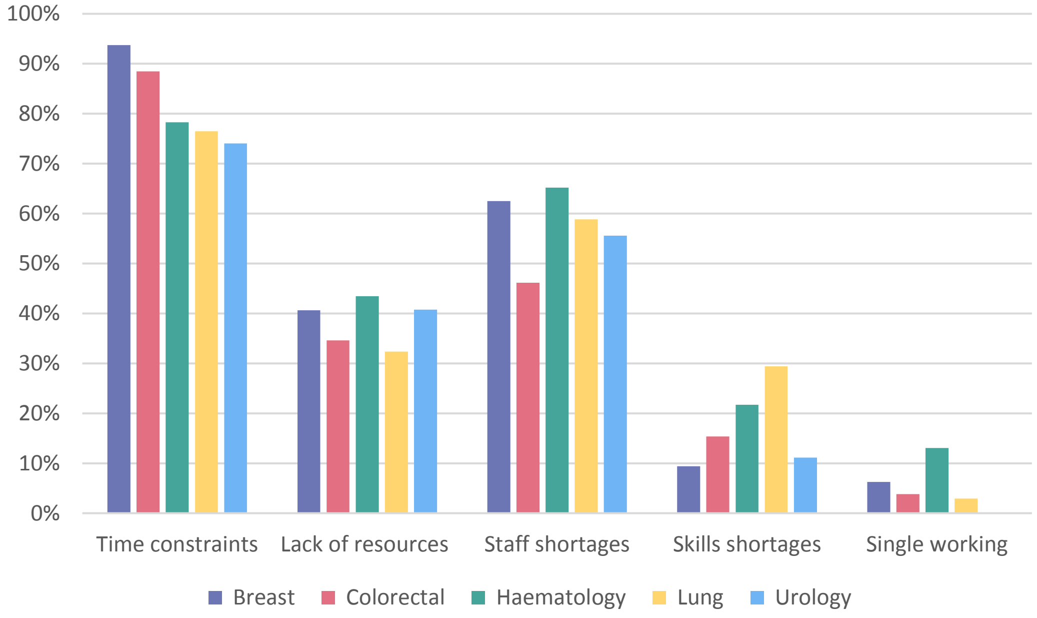

Figure 174. % of respondents indicating factors that will impact on roles and responsibilities

Pathways by job plans

There appears to be some consistencies in terms of respondents with job plans across the five pathways. Almost three-quarters of all respondents have job plans and this ranges from around 70% in Haematology and Urology to almost 80% in Breast and Lung pathways. A significant minority of respondents – approaching 1 in 10 – appear to not know whether or not they have a job plan in place.

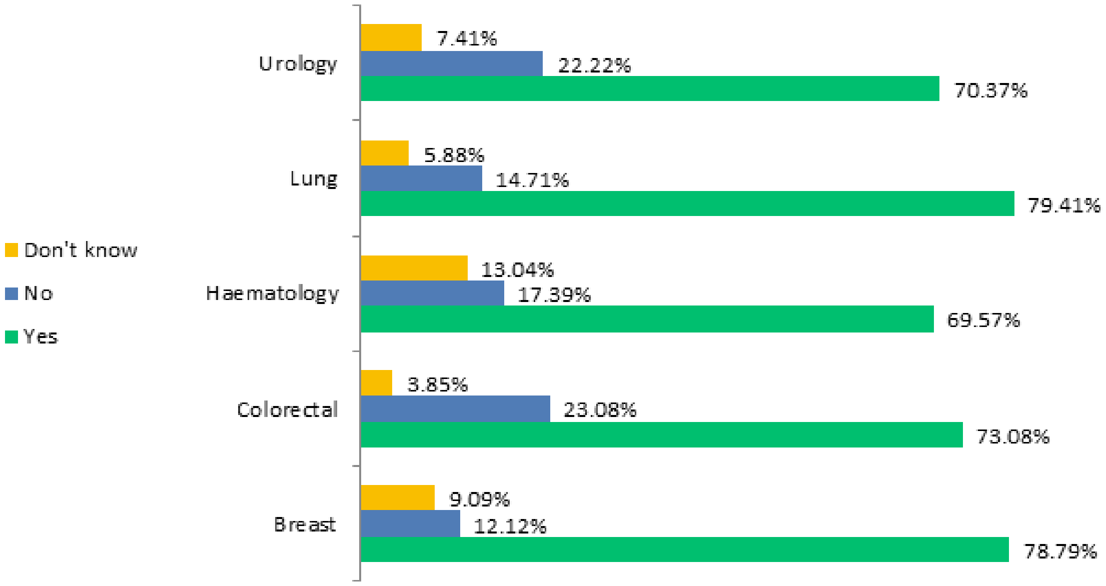

Figure 25. % of respondents who have job plans

Pathways by Professional Development Plan

The pattern in terms of personal development (PDP) plans is similar to job plans with around three-quarters stating that they have a plan in place. However, more respondents stated that they did not have a PDP in place (around one fifth of respondents).

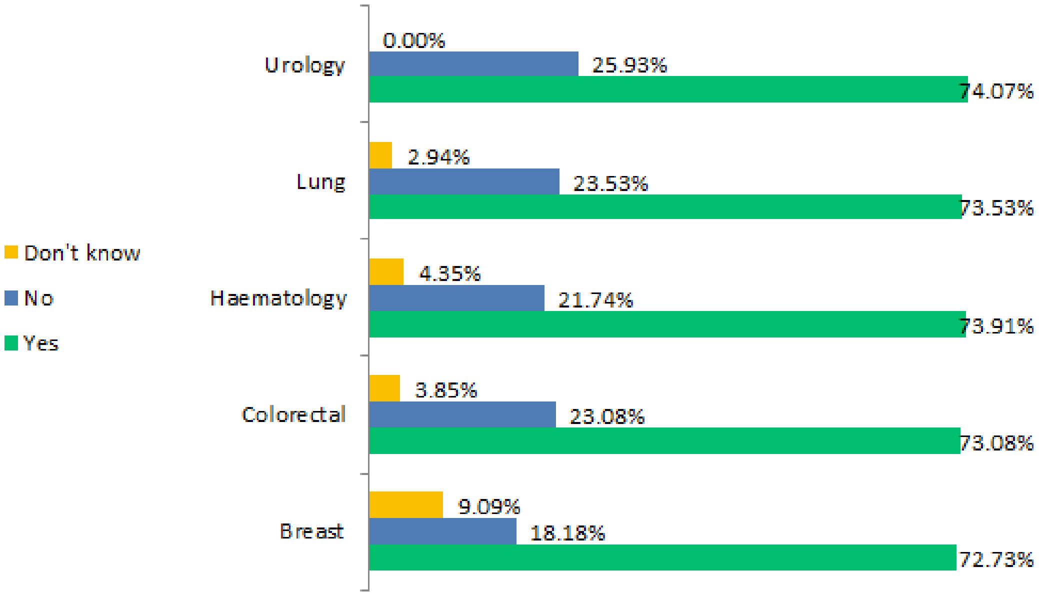

Figure 26. % of respondents who have professional development plans

Pathways by Clinical Supervision

The vast majority of respondents stated that they have access to clinical supervision across the five pathways, however a quarter did not in relation to Urology and Breast pathways. Of those that had access to supervision across the five pathways, the majority of respondents were satisfied with this supervision. However, one area with some cause for concern appears to be Urology, where around a quarter of respondents were dissatisfied with their supervision.

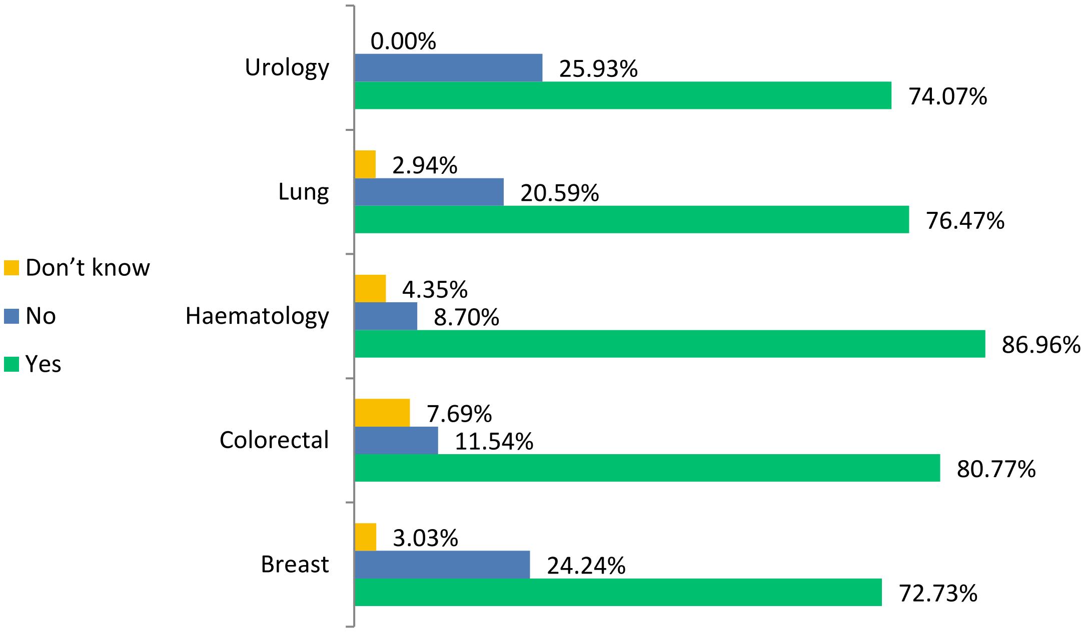

Figure 27. % of respondents who have access to clinical supervision

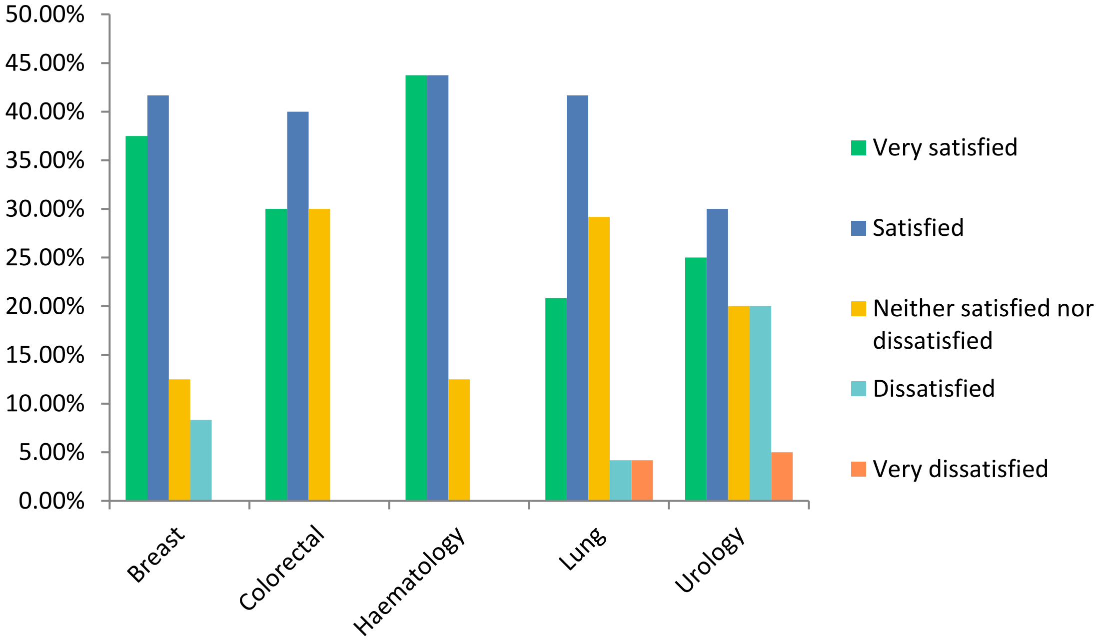

Figure 28. Satisfaction with clinical supervision

Pathways by Impact of COVID-19

It is clear that roles across all pathways to some extent have been impacted by COVID-19 with between one fifth (Haematology) and up to a half of respondents (Colorectal) stating that they had been redeployed from their respective pathway. This has no doubt had a knock-on effect on issues such as supervision, job plans and personal development plans. Redeployment has been to a number of areas and roles but primarily supporting COVID-19 patients and to critical care.

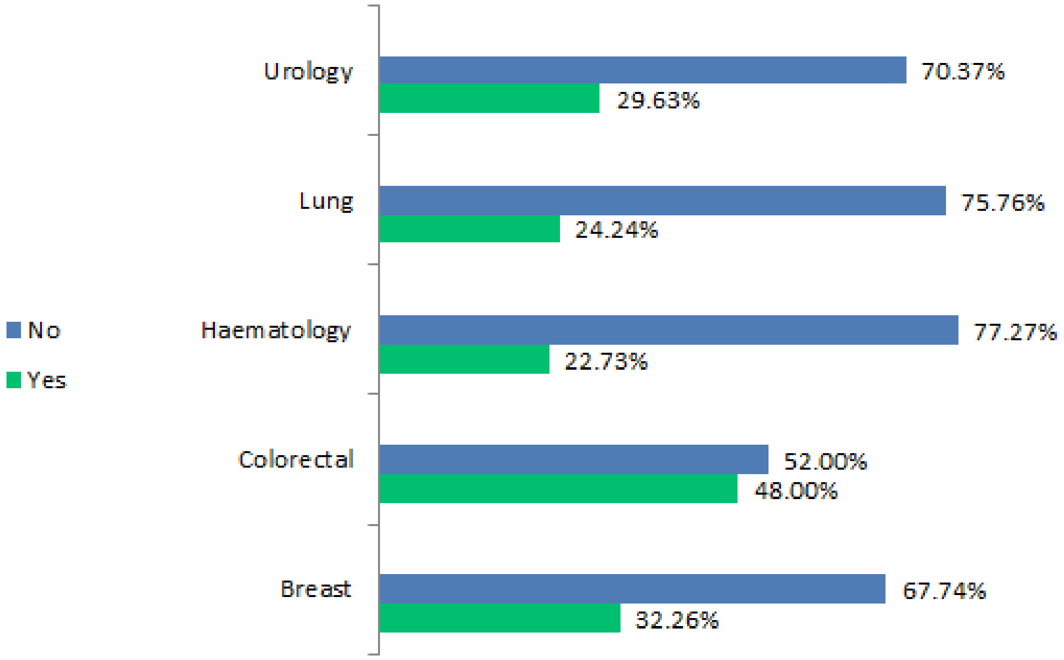

Figure 29. Respondents redeployed because of the pandemic

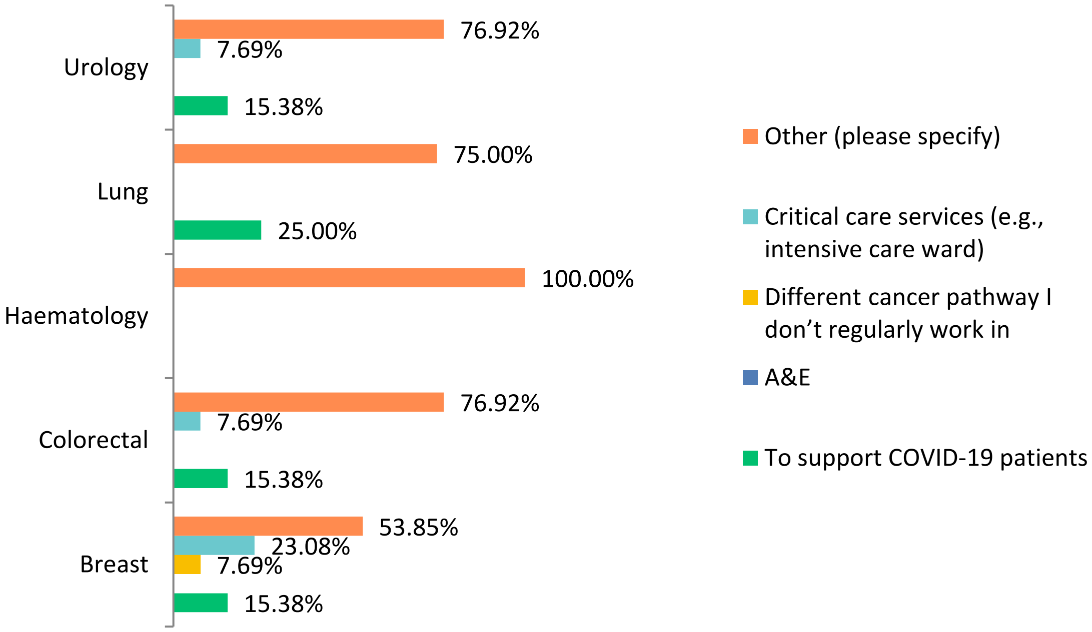

Figure 30. Location of redeployment

Independent Prescribing

There was a sizeable minority (21.9%) of respondents who felt that this capability was *of little or no importance*. The figure below illustrates the overall response to this issue and is followed by further breakdowns in terms of *cancer pathway, length of service (within cancer care)* and Cancer Alliance area.

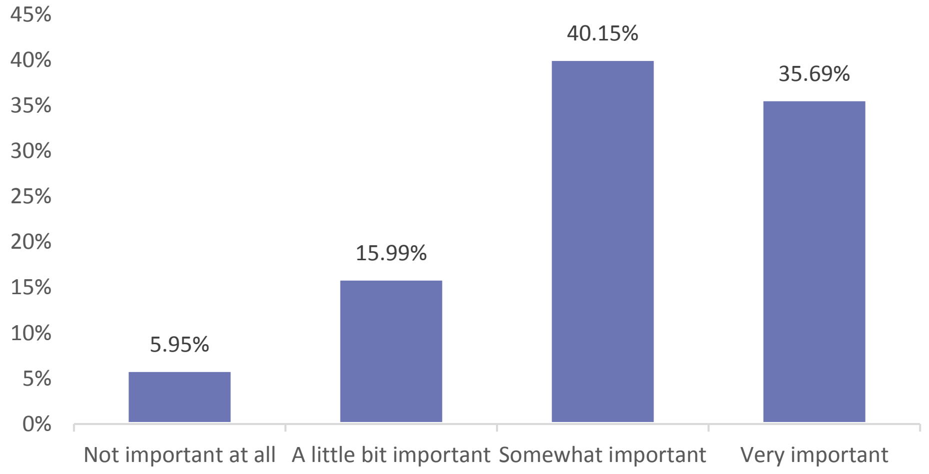

Figure 31. Importance of Independent Prescribing capability for Cancer CNSs in the future

Independent prescribing by pathway

	Of little or no importance
Lung	14.6%
Urology	17.4%
Breast	48.6%
Colorectal	34.6%
Haematology	22.7%

Independent prescribing by length of service (in cancer care)

	Of little or no importance
Less than a year	0%
Between 1-2 years	31%
Between 2-5 years	14%
Between 5-10 years	23%
Over 10 years	24%%

Independent prescribing by Cancer Alliance area

	Of little or no importance
Cheshire & Merseyside	18%
Greater Manchester	4%
Lancashire & S Cumbria	18%

Over 20% of all survey respondents feel that *independent prescribing* is *of little or no importance* in their role. Many of these responses originated from CNS nurses working in the Breast pathways; from those who had been in post for over 5 years; and a significant proportion were based in Cheshire & Merseyside and Lancashire & South Cumbria.

Annex 2: Bibliography

This is a compilation of texts that have guided the thinking and design of this research in some degree.

- Baileys, K., McMullen, L., Lubejko, B., Christensen, D., Haylock, P. J., Rose, T., ... & Srdanovic, D. (2018). Nurse Navigator Core Competencies: An update to reflect the evolution of the role. *Clinical journal of oncology nursing*, *22*(3).
- European Oncology Nursing Society (2018). The EONS Cancer Nursing Education Framework. Available at: https://swenurse.se/download/18.6664e7a81757a9aa361add1/1604499527225/EONSCancerNursingFramework2018.pdf
- European Specialist Nurses Organisations (2015). Competences of the Clinical Nurse specialist (CNS): Common plinth of competences for the Common Training Framework of each specialty. Available at: https://esgena.org/assets/downloads/pdfs/general/esgena_esno_statement_competences.pdf
- Health Education England (2016). Care Navigation: A Competency Framework. Available at: https://www.hee.nhs.uk/sites/default/files/documents/Care%20Navigation%20Competency%20Framework_Final.pdf
- International Agency for Research on Cancer / World Health Organisation: *Global Cancer Observatory – Cancer Tomorrow*. Available at: https://gco.iarc.fr/tomorrow/en
- Leary, A. (2019). Enhanced Practice A workforce modelling project for Health Education England.
- Macmillan staff induction hub. Available at: https://learnzone.org.uk/courses/course.php?id=108
- Macmillan (2020). The Macmillan Competency Framework for Nurses (MCFN) supporting people living with and affected by cancer.
- Macmillan & Skills for Health (2014). Advanced Practitioner Macmillan Clinical Nurse Specialist - Transferable Role Template. Available at: https://tools.skillsforhealth.org.uk/roles/documents/Role_0126.pdf
- National Cancer Action Team (2010). *Excellence in Cancer: The Contribution of the Clinical Nurse Specialist*. Macmillan.
- NHS (2021). 2021/22 priorities and operational planning guidance. Available at : https://www.england.nhs.uk/wp-content/uploads/2021/03/B0468-nhs-operational-planning-and-contracting-guidance.pdf
- NHS (2019). NHS Long Term Plan.
- NHS, HEE (2017). Multi-professional framework for advanced clinical practice in England. 2017. Pg. 16. Available at: https://www.hee.nhs.uk/sites/default/files/documents/Multi-professional%20framework%20for%20advanced%20clinical%20practice%20in%20England.pdf
- NHS (2017). NHS Cancer Workforce Plan.
- Royal College of Nursing (RCN). (2019). A competency framework for nurses providing care to people with breast cancer.

- Royal College of Nursing. (2017). Career and education framework for cancer nursing.
- Skills for Health (2020). Core Capabilities Framework for Advanced Clinical Practice (Nurses) Working in General Practice / Primary Care in England. Available at: https://www.hee.nhs.uk/sites/default/files/documents/ACP%20Primary%20Care%20Nurse%20Fwk%202020.pdf

Annex 3

Workforce numbers

Quantifying the Cancer CNS workshop remains a challenge. An excel spreadsheet was designed to facilitate the data capture which was then shared with the Project Board and Lead Cancer Nurses to complete. Engagement was inconsistent with a participation rate of 43%. The attachment below provides a summary of the data available and is completely dependent of the quality of the data returns. This exercise emphasizes the overall findings of the research in the need for consistency in terms of banding, titles, and responsibilities. This can be achieved through the successful implementation of a Cancer CNS Capabilities Framework.

CNS%20workforce%2
0-%20NORTH%20WE

Workshop materials

Attachment of the workshop material as result of the group discussions:

Cancer CNS
Workshop - 5July (1).

Who we are

Everything we do is designed to help people. As a not-for-profit organisation, we're committed to improving the healthcare industry and patient experience by working with employers to develop a workforce skilled in delivering high-quality services. We do this by providing them with innovative, best-in-class solutions, including consultancy, digital services and apprenticeship support.

☎ 0207 388 8800
✉ contactus@skillsforhealth.org.uk
🌐 skillsforhealth.org.uk

Skills for Health