LONDON CANCER ALLIANCE
West and South

Framework for Cancer CNS Development (Band 7)

Opening Statement

This framework provides a common understanding of the CNS role across the London Cancer Alliance and will be used to support the development of the cancer CNS from novice to expert. It will be held by the CNS, used as a framework for assessment and development, and provide evidence of personal development. Using a common framework for development across the London Cancer Alliance will ensure consistency in practice and facilitate transferable skills from one organisation to another.

Nurses working at this level will develop skills on a continuum to enable them to:

- Perform their clinical duties confidently and competently, consolidating and further developing their clinical skills
- Demonstrate ability to multi-task
- Undertake independent complex decision making based upon consistent and accurate analysis of the evidence
- Provide leadership and develop their knowledge and skills to enable them to function at an expert level
- Work across a broad spectrum of organisational and/or professional boundaries

The timeframe should be flexible depending on experience when starting the role. The following timeframes are provided as a guide and the focus is on role transition and role development within the Band 7 specialist cancer nursing role.

1. Knowledge of cancer, cancer treatment, and side effects

First 6 months	6 – 24 months	2 – 5 years
• Understands the pathology of cancer, likely routes of spread and difference between primary and secondary disease • Understands the principles of treatment for site specific cancer • Understands the physical, psychosocial, short and long term effects of cancer and its treatment • Knowledge of site specific treatment protocols • Understands site specific local policies and work programmes	• Has detailed knowledge and understanding of the patho-physiological effect and disease process on the individual with cancer • Has enhanced knowledge and understanding of cancer and cancer treatments relevant to the specialty • Recognises the symptoms of oncological emergencies and progression of metastatic disease • Ensures knowledge is kept up to date • Provides specialist advice to other healthcare professionals on the nursing management of cancer treatment and related side effects, including delivery of education to health and social care providers	• Supports the development and implementation of health promotion, lifestyle assessment, screening and preventative strategies into practice • Uses advanced knowledge and skills to assess, examine, diagnose and manage symptoms and side effects • Following assessment is able to provide specialist advice and education to other healthcare professionals on the appropriate interventions for suspected disease progression, treatment related side effects and oncological emergencies

2. Communication skills

First 6 months	6 – 24 months	2 – 5 years
• Completion of advanced communications skills training • Demonstrates the ability to communicate knowledge of holistic cancer care relating to areas such as screening, curative and palliative treatment, spiritual care, aspects of nutrition and pharmacology, rehabilitation, discharge and collaborative working • Recognises abnormal psychological reactions and refers onto appropriate agencies and healthcare professionals • Utilises techniques/interventions to promote patient/carer independence throughout the cancer journey • Initiates appropriate referral or access to sources of specialist support for those experiencing sexual or fertility difficulties as a result of their illness or treatment • Initiates and undertakes patient and carer education and training • Demonstrates the ability to ensure staff welfare by instigating team support	• Completion of Level 2 Psychological Support Training • Demonstrates skill in report writing • Confidently manages situations that have ethical implications • Demonstrates effective presentation skills • Enables patients to discuss their needs, preferences and concerns about their health and well-being to ensure care plans meet their goals and needs • Enables patients to reach their own decisions about their health and well-being and set their own priorities • Identifies and explains any benefits and risks arising from their decisions about their care to enable them to make informed choices • Develops protocols for patient and carer education and training • Facilitates the development of teaching strategies to educate patients, carers, and staff • Develops techniques to enhance communication with patients using telephone assessment skills and electronic communication methods as required • Develops skills in informing, influencing and negotiating with others to promote patient experience and service development	• Provides feedback to healthcare professionals on communication related issues • Challenges inappropriate communication • Acts as an expert resource for other healthcare professionals when dealing with complex and challenging communication issues, takes a lead in the management of complex cases • Uses reflective practice and assists others in reflecting on difficult or complex cases • Has highly developed skills in influencing, negotiating and communicating difficult concepts with colleagues and management to promote patient experience and service development

3. Knowledge of relevant site specific diagnostic and treatment pathways

First 6 months	6 – 24 months	2 – 5 years
• Develops an understanding of the role of various healthcare professionals through the pathway and routes of referral to facilitate optimal patient care • Critically understands diagnostic pathways, investigations and staging processes in specific area of practice • Demonstrates knowledge of national and London Cancer Alliance standards relevant for the site specific service including cancer targets and Peer Review measures	• Clearly identifies the stages of the pathway where the CNS can focus interventions to influence patient care • Identifies opportunities for health promotion and early detection • Understands principles underlying survivorship care, e.g. risk stratification, surveillance, self-management and self-care • Recognises indicators of end of life and the role of the CNS in onward referral • Educates patients to understand the signs, symptoms and situations that indicate concern in relation to the risks associated with their cancer and their current and previous cancer treatment • Works collaboratively with local health improvement initiatives for cancer prevention, uptake of screening, early detection and diagnosis of cancer within area of practice • Works collaboratively as part of the multi-professional team to optimise general health and well-being by promoting empowerment and supporting the development of supported self-care management • Escalates issues of non-adherence to standards or targets to senior MDT colleagues or to cancer management as required	• Utilises critical thinking and reasoning in clinical decision making and problem solving in managing complex situations • Develops strategies to improve adherence to standards and targets for the service, influencing colleagues to ensure routine implementation

4. Coordination of care for patients

First 6 months	6 – 24 months	2 – 5 years
• Works to meet the London Cancer Alliance Key Worker Policy • Understands the link between MDTs across organisations, and primary and tertiary care, and facilitates patient navigation between them, providing support and ensuring transfer of the key worker role • Understands the differences in roles and responsibilities of MDT members, including MDT coordinator	• Demonstrates a greater understanding of cross boundary working and opportunities for integrated working • Develops systems for transferring patient information across organisations • Contributes to the development of structures and processes to support the transfer of care across organisations • Assists in ensuring pathways for individual patients meet cancer targets, influencing and negotiating with others to promote timely investigations and results	• Recognises the symptoms of oncological emergencies and metastatic disease and is able to refer to appropriate services in a timely manner • Leads the development of pathways across service providers to facilitate rapid and effective movement of patients between acute services and other models of care, e.g. rapid re-entry to acute care services following signs of recurrence

5. Assessment of holistic needs at points along the pathway and its implications for practice

First 6 months	6 – 24 months	2 – 5 years
• Uses advanced communication skills and specialist knowledge to undertake a holistic needs assessment using agreed framework or tool • Understands the documentation and recording of assessment outcomes • Develops care plans to meet identified needs • Communicates care plan with the patient, GP and relevant MDT members • Develops an understanding of the routes of referral to associated allied health professionals and services to assist in meeting the identified needs	• Develops greater skills in assessing complex needs • Understands the CNS role in supporting the patient with co-morbidities • Ensures the MDT takes into account the co-morbidities in planning patient care • Uses specialist knowledge to assess need and plans appropriate management over the telephone or by electronic communication as required • Uses the findings from assessments to refer patients onto health and wellbeing events • Demonstrates skill in assessment and care planning at the end of treatment and contributes to end of treatment summaries	• Demonstrates a high level of autonomy and clinical decision making regarding assessment, care intervention, referral and service provision in complex situations • Acts as a role model and resource to other members of the nursing team in the assessment and provision of support to patients and carers

6. Provision of information depending on individual assessed need

First 6 months	6 – 24 months	2 – 5 years
• Assesses the information needs of patients and carers at significant pathway points • Appreciates the significance of providing both verbal and written information at significant stages of the cancer pathway • Signposts to a range of information resources using knowledge of information available at different points of pathway • Recognises equality and diversity, BME, physical and mental disabilities, and develops confidence in ability to provide information to patients with diverse needs, ensuring equality of access to information	• Identifies gaps in information and sources or develops local information • Critically assesses written information/websites prior to recommending them • Sources and critically reviews information materials that address the needs of patients and carers • Identifies misinformation held by patients and carers about cancer, cancer treatments, survivorship and late effects and acts appropriately to counteract this • Identifies and signposts patients and carers to wider sources of support, e.g. on-line forums, rehabilitation classes	• Leads on the development of service user focused education and information materials within area of practice both locally and nationally • Proactively ensures equality of access to information resources for hard to reach groups, ethnic minority groups and those with physical and mental disabilities

7. MDT working

First 6 months	6 – 24 months	2 – 5 years
• Acts as a patient advocate • Acts as a link between patients, carers and healthcare professionals to optimise effective coordination of care • Communicates effectively within MDT as a core member • Contributes and influences decision making and treatment plans using specialist knowledge to ensure optimal care	• Contributes to multi-professional group discussions related to significant event analysis and root cause analysis • Develops skills in presenting and leading MDT discussions • Within the MDT, challenges decisions that are not in keeping with patient preference • Recognises when to escalate issues to senior healthcare professionals	• Builds and maintains a therapeutic team to promote optimum outcomes of care • Develops in partnership with multi-professional groups management protocols which cover pathways of care across organisational boundaries • Facilitates the team in learning from significant event analysis • Develops, implements and evaluates action plans to support team learning

8. Knowledge of symptom management, recurrence, late effects, and end of life care

First 6 months	6 – 24 months	2 – 5 years
• Recognises acute oncological emergencies and recommends appropriate actions • Distinguishes between symptoms that can be managed with “simple” measures and those that require urgent and/or specialist intervention • Recognises the indicators of disease progression and end of life within specialty • Understands the role of the CNS with patients, carers and the MDT in discussing and enabling timely referral to specialist palliative care	• Understands the consequences of cancer treatment specific to the specialty area, including late effects and their management • Assesses symptoms to determine likely recurrence and appropriate pathways for further management • Provides appropriate information and opportunity for patients and carers to discuss their wishes for on-going treatment and end of life care • Recognises those at risk of abnormal grief reactions and escalates concerns to specialist services as appropriate	• Recognises and understands ethical issues in advanced disease and end of life care • Uses knowledge of advanced disease and symptoms of recurrence, clinical judgement and decision making skills to manage, advise and offer support to patients and carers in highly complex situations • Understands and utilises frameworks for end of life care in developing pathways for site specific management plans

9. Patient experience and service development

First 6 months	6 – 24 months	2 – 5 years
• Contributes to the strategy and development of the site specific service plan/work plan, identifies concerns or gaps in the service and shares them with senior colleagues and the MDT • Demonstrates awareness that the views of patients and carers are important to influence change in practice	• Develops strategies to understand patient experience issues • Influences working of the MDT and incorporates feedback from patients and carers • Acts as the resource within the MDT to reflect and utilise learning from patient feedback that influences and impacts service development	• Develops strategies for how to address patient experience issues • Demonstrates management and leadership skills in cancer care to collect evidence to support a business case for service development or redesign to enhance efficiency, cost and quality • Works with others to gain commitment and funding for initiatives designed to improve patient care and to lead a team in service redesign • Knowledge of commissioning frameworks and ability to collate and present relevant evidence to progress nurse led services • Implements appropriate evaluation tools to evidence the effectiveness of new services or service redesign • Uses knowledge of site specific cancer standards to review and critically appraise site specific policies and work programmes to ensure compliance with Peer Review and other quality standards

10. Audit and research

First 6 months	6 – 24 months	2 – 5 years
• Contributes to the development and completion of local and national service reviews, audit and local research • Understands the outcomes of audit and national surveys and how they impact on services • Understands the significance of the CNS role in supporting data collection for relevant audits	• Accesses research and information systems • Implements research findings into practice including the development of policies, protocols and guidelines • Uses a combination of research and/or audit to explore patient related issues • Develops strategy within the site specific team to address audit outcomes to ensure service improvement in line with recommendations • Develops skills in data collection for appropriate nursing audits	• Leads and initiates the audit cycle and works collaboratively to act on findings to enhance the care of patients and carers • Develops strategies for completion of baseline audits or employs research in order to explore patient related issues • Uses the audit cycle effectively to demonstrate the impact of nursing interventions

11. Education and personal development

First 6 months	6 – 24 months	2 – 5 years
• Identifies individual professional need for education and training • Participates in delivering local and national programmes of education on cancer, end of life, and survivorship, e.g. study days and conferences • Supports and teaches non specialist healthcare professionals in the implementation of cancer care • Accepts personal responsibility for professional development and the maintenance of professional competence and credibility • Engages in level 3/4 clinical supervision, reflective practice and self-evaluation and utilises to improve care and practice • Identifies and participates in the development and delivery of educational initiatives for health and social care providers that address the needs of patients and carers	• Acts as a formal or informal mentor to other members of nursing and the MDT • Ensures knowledge and skills are up to date by attending courses and conferences in line with service needs • Contributes and participates in professional networks • Develops learning within the workplace, utilising opportunities within the MDT and associated clinical services to support learning and development	• Works in partnership with education providers and contributes to the development of education programmes • Develops personal influence and authority by presenting own work at local and national conferences

Examples of evidence sources that may be utilised to demonstrate development in a CNS role include:

- Bachelor's/Master's degree
- Post basic cancer qualification Level III
- Personal development plan publications
- Participation in local/national research and development initiatives
- Leadership training
- Evidence of active participation and attendance at MDTs/other pertinent meetings
- Counselling skills
- Evidence of patient/user involvement
- Development of training and education packages
- Development of evidence based policies/protocols/guidelines
- Evidence of good team working/team objectives
- Evidence of engagement in integrated cancer system activities and national initiatives
- Attendance and/or presentations (PowerPoint, poster) at cancer related national/international conferences

This document was produced by London Cancer Alliance's Lead Cancer Nurses Group. A special thanks to Sheila Small and Jan Morrison for their contributions with support from Mairead Griffin and Amy Sherman.

Key documents reviewed:

- A framework for adult cancer nursing, Royal College of Nursing, 2003
- A Competence Framework for Nurses - Caring for Patients Living with and Beyond Cancer, Macmillan Cancer Support (MAC14735), June 2014
- Working with Individuals with Cancer, their Families and Carers. Professional Development Framework for Nurses, Specialist and Advanced Levels. NHS Education for Scotland, 2008

Review date: January 2015