Clinical nurse specialist (CNS) roles in the UK have been in existence and debated for decades (Humphris, 1994; Mills and Pritchard, 2004; Vidal et al., 2011; NHS England, 2013; 2016; Health Education England (HEE), 2017; Royal College of Nursing (RCN), 2018; NHS England and NHS Improvement, 2019; Nursing and Midwifery Council (NMC), 2020). Variations in the roles seem to remain widespread, accompanied by diverse clinical roles across healthcare settings, with differing titles, educational requirements and pay (Mills and Pritchard, 2004).

There are several definitions of the CNS (Affara and Styles, 1992; Affara, 2009; RCN, 2009). More than 10 years ago, the RCN (2009) suggested that CNSs and nurse practitioners should be educated to at least degree level. Furthermore, they should also possess specialist knowledge, skills, competencies and experience, with key role components including a clinical focus, consultancy, and involvement in education, research, liaison and administration. In practice, there is some consistency among CNS roles, with the majority of those in the roles acting as key workers, attending multiprofessional meetings and enhancing patient experiences. However, these roles can be specific to individual jobs and local service issues and provide a wide range of services. HEE and the RCN have set out frameworks defining CNS roles, specifying levels of advanced practice and educational levels (HEE, 2017; RCN, 2018). Yet, despite this, roles have not always been clearly defined (Affara, 2009; Mohr and Coke, 2018).

CNS roles developed steadily in the UK as a response to the publication of The Scope of Professional Practice by the UK Central Council for Nursing, Midwifery and Health Visiting (UKCC) (1992) and the subsequent NHS Plan (Department of Health (DH), 2000a). Today the role is well integrated into the healthcare environment. CNSs work closely with multidisciplinary teams to plan services and deliver programmes of care that reflect patients’ complex needs (Macmillan Cancer Support, 2012; Vidal et al., 2011; NHS England, 2013; 2016; HEE, 2017).

In 2009 the RCN described the need to provide opportunities for experienced nurses to extend their role across patient pathways and begin to extend their influence at both local and national strategic levels. It was suggested that CNSs should be:

- Educated to at least master’s (MSc/MA) level, ideally to doctorate (PhD) level
- Exhibit up-to-date specialist knowledge
- Have research, political, operational and clinical skills
- Key role components should include: expert practice, leadership, education and research (RCN, 2009).

However, in practice, CNSs may not be educated to MSc/MA/PhD level. Usually having a degree or to be willing to work towards a master’s qualification appears to be a more widespread approach, depending on the employing organisation. The guidance from more than a decade ago therefore appears no longer to be the current school of thought (Cooper et al., 2019).

The number of CNS roles, as well as the skills, competency and complexity of such roles, has increased markedly in the past decade, with these roles being incorporated into multidisciplinary teams (Mohr and Coke, 2018). The rise of specialisation in health care, a developing interface between primary and secondary care, and the reduction in junior doctors’
Improving quality and experience of care for patients and professional, ethical and legal practice

Education, training and development

Care provision and management, advocating a more leadership

Nurses holding a specialist practice qualification: these are Clinical practice (which includes direct patient care, delivery

Demonstrating leadership.

Professional and ethical practice (Redekopp, 1997; Donnelly, 2003; Carnwell, 2003).

Reinforcing safety

Professional, personal and quality development.

An international perspective

The UK experience is not unique. A CNS may be integral to many patients’ care pathways, although there is little uniformity in the evolution of nursing specialties with respect to role titles, scope of practice, education and practice standards, and paths of entry, according to the International Council of Nurses (ICN) (2009).

The ICN produced a competency framework for CNSs (ICN, 2009), highlighting three areas or domains of practice. However, these have not been applied with consistency across the globe. The three areas are:

Professional, ethical and legal practice
Care provision and management
Professional, personal and quality development.

The role and title have been in use in the USA for decades (Dunn, 1997; Hamric et al, 2005; Baldwin et al, 2009) and, as such, definitions of a CNS in other parts of the world often originated from the US context. A systematic review by Donald et al (2014) found only limited evidence of the quality and effectiveness of CNSs within randomised controlled trials (RCTs). This research mainly originated in the USA and many of these studies were found to be qualitative and mixed-method surveys or phenomenological studies, rather than RCTs. The review concluded that there is still considerable role confusion and ambiguity, despite the CNS role having been around in the USA for many decades.

In the southern hemisphere, a similar picture emerges. New Zealand lacks a national definition; the district health boards demonstrate limited areas of consensus regarding the essential requirements for the CNS role (Roberts et al, 2011). There are inconsistencies in how the roles are defined, most notably concerning requirements for postgraduate qualifications and professional development recognition programmes (Elsom et al, 2006; Brook and Rushforth, 2011; Sanchez et al, 2019).

There is inconsistency in what is meant by ‘expertise’ (Roberts et al, 2011). Studies have demonstrated the impact of the CNS in patient pathways (Macmillan Cancer Support, 2010; Young, 2010; Vidall et al, 2011) and have provided evidence of improving patient outcomes and effective and efficient care (Young, 2010; Vidall et al, 2011).

It has been demonstrated that investing in CNSs to perform routine consultations and conduct follow–up appointments allows doctors’ time to be released to see new patients, and is cost efficient (Macmillan Cancer Support, 2012; Lopatina et al, 2017).

A review of the global literature by the authors of this article highlighted five themed domains that appear to be repeated globally in the construction and regulation of nursing roles, including that of the CNS. There is recognition that the emphasis on these domains is not always equal in practice. The five domains were:

Clinical practice (which includes direct patient care, delivery of care, despite location)
Leadership
Education, training and development
Research and improvement
Professional and ethical practice (Redekopp, 1997; Donnelly, 2003; Mills and Pritchard, 2004; Bryant-Lukosius et al, 2004;

Within each domain, three subcategories were further identified within the literature and utilised as core components. These are illustrated in Table 1.

### Aims
This audit aimed to explore the parity of scope and content from a sample of CNS job descriptions within the UK. Advice was sought from local research and development experts and it was deemed that no ethics approvals were required because the project was categorised as an exploratory and evaluative audit (Health Research Authority (HRA), 2017).

### Method

#### Stage 1
Between September 2017 and January 2019, 100 job descriptions acquired from genuine roles advertised online were systematically sourced, without bias, from different NHS and healthcare organisations throughout the UK. These included acute and primary care trusts and local authorities, and privately and charity-funded organisations (such as hospices).

All of the job descriptions were externally advertised in public domains to recruit ‘nurse specialist’ posts in varying clinical specialties. The names of the organisations/providers were not relevant to the project and therefore were not used in any form to identify them. The only form of identification was with regard to specialty and type of provider. Each job description was numbered sequentially. These were then stored electronically and shared between the reviewing authors, who then reviewed each individual job description, completing an audit tool template.

One hundred samples were chosen in this first instance because this was perceived to be a manageable, practical number to deal with, considering the timeline of organising job description reviewing, discussing, analysing and writing up results.

#### Stage 2

An audit tool was developed to facilitate the assessment process by the authors. The audit tool contents were derived from our review of the literature, professional experience and discussions within the group with regard to organisation and relevance to the task.

The template included a number for each job description, area of practice/specialty (e.g., surgery), qualifications and experience required in the specific job description under review, followed by five identified clinical domains and subcategory headings (Table 1).

### Stage 3

Three registered nurse assessors (A-MC, PR and VC) independently reviewed each of the 100 job descriptions. Experience, qualifications and areas of specialty were coded. Communication between the three was undertaken by email, teleconference and some face-to-face meetings. Each domain and subcategory was assessed and marked either present (n=1) or absent (n=0) within the template. Assessors used their nursing expertise to interpret meaning and to record the inclusion of the subcategories within the job descriptions. Each assessor had their own electronic spreadsheet template to complete.

When completed, assessors 1 (A-MC) and 2 (PR) discussed and compared their assessments of each of the job descriptions. Differences of opinion with regard to the assessments were discussed, negotiated and then agreed upon, and a third completed combined audit spreadsheet was produced (template 3). Assessor 3 (VC) independently reviewed and assessed the 100 job descriptions, forming template 4. This was then compared with the agreed joint template from assessors 1 and 2 (template 3). Differences of opinion were discussed and negotiated until a final merged template was agreed and ready for analysis, forming the final audit spreadsheet 5 (combining the assessments of authors 1, 2 and 3).

### Findings

One hundred job descriptions were reviewed, utilising a predetermined template audit tool of core identified domains and subcategories (Table 1).

The samples originated from primary, secondary, local authority, private and charity-funded providers/organisations within varying clinical specialties sourced electronically from within UK job advertisements.

The two most frequent specialty areas were palliative care (n=27) and surgery (n=23) (Table 2).
No deliberate discrimination with regard to inclusion/exclusion criteria were considered for the project. There were 63 job descriptions acquired from acute trusts, 11 from charity-funded hospices, 24 from community providers and 2 from private care providers (mental health).

All job descriptions were reviewed. There were variations in the essential qualifications identified within the job descriptions; overall, 33% did not specify the qualifications that the organisation expected for their CNS role. All job descriptions specified that the applicants must be an active registered nurse (T able 3).

The levels of experience required by CNSs within the samples were segmented into three groups. These were substantial experience (5 or more years’ experience), less than 5 years’ experience requested, and no experience specified. The levels of essential experience required varied across the job descriptions (Table 4).

The five identified clinical role domains and subcategories showed less variation than qualifications and experience across the job descriptions. Clinical practice was the only domain that was included in all of the job descriptions (100%). The use of technology to enhance patient care and promotion of health to patients and their families were both recorded at 71%; these were the two least mentioned dimensions. The majority of scores were in the 90% range, indicating a high level of similarity and parity among the samples audited (Table 5).

Discussion

The review of CNS job descriptions highlighted that job description templates and the descriptive language used was diverse, but the domain scopes showed a high level of agreement on the role dimensions, falling within the 71%–100% range.

The new undergraduate programme for nurse registration (NMC, 2018a) highlights the changing world of practice and how nursing roles are being redefined to enhance patient care. The use of technology in future health care will expand as innovation provides new and exciting treatments and with greater involvement of patients in their own care. The domains interconnect and the opportunities that technology will bring to enhance health promotion and patient teaching may have greater emphasis in future CNS job descriptions.

The domains highlighted could also be used to map many nursing roles, but the level of practice should be linked to the level of qualification and practice competence. The qualification requirements in the job descriptions showed high levels of variation, with 33% of job descriptions not stipulating additional post-registration qualifications. Critical thinking, clinical knowledge and competence are evidenced in our society with a level of accredited education or qualifications and this is worth future consideration. Large variations may be due to shortages of nurses, but a range of expected post-registration qualifications may help professional practice and organisational governance, which would further enhance public protection and confidence. Experience is another component that requires consideration. Although many skills are transferable to other areas of practice and other skills can be learnt, experience in a senior role is key for CNSs. However, experience does not always mean competency. It is also acknowledged that different candidates will bring different experience and qualities to a role.
Table 5. Core clinical domains and their subcategories recorded as percentages

<table>
<thead>
<tr>
<th>Domain</th>
<th>Subcategory 1</th>
<th>Subcategory 2</th>
<th>Subcategory 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical practice</td>
<td>A clinical area of practice 100%</td>
<td>Communication skills 95%</td>
<td>Teamwork and collaboration 97%</td>
</tr>
<tr>
<td>Leadership and management</td>
<td>Leadership qualities and behaviours 95%</td>
<td>Quality improvement and safety 91%</td>
<td>Delegation and supervision of others 82%</td>
</tr>
<tr>
<td>Education, training and development</td>
<td>Sharing knowledge and teaching other health professionals 93%</td>
<td>Lifelong learning and self-development 88%</td>
<td>Promotion of health to patients and their families 71%</td>
</tr>
<tr>
<td>Research and improvement</td>
<td>Evidence-based practice—using evidence in daily practice 99%</td>
<td>Using technology to enhance patient care 71%</td>
<td>Developing and participating in research 80%</td>
</tr>
<tr>
<td>Professional and ethical practice</td>
<td>Accountability of a professional nurse, adherence to the Nursing and Midwifery Council Code (2018b), attitude 91%</td>
<td>Ethical practice, working as a professional nurse within the Nursing and Midwifery Council Code (2018b), patient advocate 86%</td>
<td>Legal implications, expectation of parameters as a professional nurse, practising within competencies, law 77%</td>
</tr>
</tbody>
</table>

**Limitations**

Only 100 job descriptions were examined from across the UK within this audit, which is a limitation of this study. Job descriptions have limitations in conveying the depth and breadth of these multifaceted roles. Replication of this work on a larger scale could be undertaken nationally and even internationally, which could build on this work to provide further clarity on role components. This would also provide a reference point or framework to ensure continuity and parity among this professional group and set the standard with regard to quality.

**Conclusion**

Nurse shortages may have exacerbated the level of variability of job descriptions as organisations reconsider the key education and experience required in an attempt to retain and develop talented staff in their professional roles. There is no simple solution but parity with regard to job descriptions, and career frameworks would help create a streamlined and unified approach. A national repository of job description templates, which could then be adapted locally, might be the answer to ensure a consistent approach. This is needed when dealing with the scope of roles, titles, educational requirements, professional expertise and levels of pay in the workplace, as well as career structure. This approach would consider an individual’s developmental needs, education and willingness to adapt and learn.

Consistency between CNS roles would enhance the profile of the role, the quality of training and the competency of care delivered. This would also enhance public understanding of the role. The role and its scope is a complex issue, but providing more guidance will strengthen the much-needed high level of consistency that can already be seen in UK job descriptions. Perhaps consideration could be given to linking job description templates to the NMC Code (2018b) and revalidation requirements to enable a structural framework to provide further guidance in the future. **BJN**

**Declaration of interest:** none

**Acknowledgements:** the authors would like to thank John Hudson, WHISE Library, The Royal Wolverhampton NHS Trust


Why do you think that clinical nurse specialists have variable experience?

Review your own job description and appraise its content.

What is good about the job description? What do you feel is missing and why?

BECAUSE CARING MATTERS

This article appraised 100 clinical nurse specialist (CNS) job descriptions from various settings, specialties and organisations.

A systematic approach was utilised to explore the parity and scope of content of all job descriptions.

There was a high level of consistency across all domains within the scope of a CNS role.

There was a high level of variability in both experience and post-registration qualifications in CNS job descriptions.

KEY POINTS

- Why do you think that clinical nurse specialists have variable experience and post-registration qualifications?
- Review your own job description and appraise its content.
- What is good about the job description? What do you feel is missing and how could it be improved?
- Think about what you have learnt from this exercise.


Royal College of Nursing. Specialist nurses make a difference. RCN Policy Unit Briefing 14/2009. London: RCN; 2009

Royal College of Nursing. Advanced level nursing practice section 1: the registered nurse working at an advanced level of practice. 2018. https://tinyurl.com/y68m4y2a (accessed 8 April 2020)


© 2020 The authors

Macmillan Press; 1994

© 2020 British Journal of Nursing