

# MACMILLAN COMPETENCY FRAMEWORK FOR NURSES (MCFN)



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The Macmillan Competency Framework  
for Nurses (MCFN) supporting people  
living with and affected by cancer

**MACMILLAN**  
**CANCER SUPPORT**

Sheffield Teaching Hospitals **NHS**  
NHS Foundation Trust

Comments from nurses who have reviewed the framework:

- The toolkit is very clearly explained and the helpful hints in it are very user friendly and relevant to individuals, teams and managers.
- Easy to use and very clear.
- It will really be a useful tool not just for appraisal but for clearly articulating what specialist practice is and the core skills and capabilities which are needed.
- It will cross generalist and specialist services effectively.
- It covers what is necessary whilst making it concise enough to be easy to use.

Reviewed and approved by the United Kingdom Oncology Nursing Society



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### Disclaimer

This publication contains information, advice and guidance for use by nurses supporting patients affected by cancer. It is intended for use within the UK. The information in this booklet has been compiled from professional sources, but its accuracy is not guaranteed. Whilst every effort has been made to ensure that Macmillan provides accurate and expert information and guidance, it is impossible to predict all the circumstances in which it may be used. Accordingly, Macmillan Cancer Support shall not be liable to any person or entity with respect to any loss or damage caused or alleged to be caused directly or indirectly by what is contained in this guidance document.

# Foreword

I am delighted to introduce the updated competence framework for all UK nurses involved in the care of adults living with and beyond cancer. This document builds upon the 2014 framework, which was the first to identify core domains of care that are relevant to the needs of people after cancer treatment and who are at risk of developing consequences of cancer and its treatment. This updated document now includes a very helpful toolkit that uses case vignettes so that the framework implementation is relevant and easy to use for all nurses working in frontline clinical practice, education, management or commissioning.

It is a changing and often challenging healthcare landscape that nurses now face when working within cancer care. In the future it is very likely that new and emerging roles, such as the Nursing Associate and Advanced Clinical Practitioner, will need to have detailed knowledge of cancer care pathways and the different treatments available. It is essential that we can continue to innovate and work adaptably across and between professional boundaries, organisations and settings to respond flexibly to the changing context of cancer as a long-term condition and develop shared competencies for cancer practice.

This framework has been developed for use by the registered nurse workforce. The Macmillan multi professional competency framework focusing on identifying and addressing common unmet holistic needs, that is in development, will complement this work.

People living with and affected by cancer, their carers' and families need information, support and interventions that will help them through what is often described as a traumatic time following a cancer diagnosis. As Chief of Nursing and Allied Health Professionals at Macmillan, it is my hope is that we will continue to work collaboratively in using and sharing this competence framework for nurses with the sole purpose of driving and improving standards of cancer care across the United Kingdom. Macmillan Cancer Support are delighted to be working in partnership with UKONS to endorse this publication. This framework can be used alongside other professional frameworks, guidelines and standards and build upon improving the patients' experience of cancer care.

**Dr Karen Roberts**  
**Macmillan's First Chief of Nursing and Allied Health Professionals**



# 1.0 Introduction and background

The Macmillan Competency Framework for Nurses (MCFN) is designed for use by UK registered nurses supporting people living with and affected by cancer in any adult care setting, regardless of their primary specialty.

The intention of the MCFN is to support individuals, teams and managers, by identifying the appropriate competencies in seven specific domains that apply to the majority of nurses supporting people living with and affected by cancer. This detail is presented in the form of a competency framework that describes the knowledge, skills and performance required by individuals to be effective in their job role. Ensuring that people living with and affected by cancer receive safe, appropriate, effective, high quality and accountable care, regardless of the care setting.

## Who is this for?

**Registered Nurses supporting people living with and affected by cancer:**

- Oncology Nurses**
- Surgical Nurses**
- Practice Nurses**
- Community Nurses**
- Clinical Nurse Specialists**
- Advanced Nurse Practitioners**
- Clinical Practitioners**

## For use in any adult care setting:

- Primary care**
- Community care**
- Secondary care**
- Within the NHS and private Healthcare settings**

The competency framework will:

- assist individuals and organisations to extend skill sets, support recruitment, workforce planning and career progression
- aid new and emerging role design and help determine individual and team needs to ensure that people affected by cancer are being supported
- Support the development of competencies that contribute to the provision of personalised care for patients affected by cancer, including the provision of holistic needs assessment and the use of personal care plans

In addition it is hoped that the MCFN will be widely adopted and help in the education of the workforce by informing academic curricula and professional development programmes.

The framework complements, and aligns with both:

- The Macmillan Allied Health Professions Competence Framework for Those Working with People living with and affected by cancer <sup>(1)</sup>
- The Nursing and Midwifery Council. Future Nurse: Standards of proficiency for registered nurses <sup>(2)</sup>

It can be used alongside existing competence frameworks for aspects of an individual role, where appropriate, such as aspects of advanced clinical practice:

- Skills for Health National Occupational Standards <sup>(3)</sup>
- Royal College of Nursing (RCN)/United Kingdom Oncology Nursing Society (UKONS) Career and Education Framework for Cancer Nursing<sup>(4)</sup>
- RCN Competency Framework for Advanced Nurse Practitioners <sup>(5)</sup>
- UKONS Acute Oncology Knowledge and Skills Guidance <sup>(6)</sup>

- UKONS Systemic Anti-Cancer Therapy Competency Passport <sup>(7)</sup>
- UKONS SACT Competency Passport Learning Outcomes Framework <sup>(8)</sup>

This framework aligns with recommendations contained in UK policy and practice for transforming and developing integrated cancer care models. <sup>(9,10,11,12,13,14)</sup>

The NHS Long Term Plan <sup>(9)</sup> has an ambition that, by the year 2021, where appropriate:

- every person diagnosed with cancer will have access to personalised care, including needs assessment, a care plan and health and wellbeing information and support
- every patient with cancer will get a full assessment of their needs, an individual care plan and information and support for their wider health and wellbeing
- all patients, including those with secondary cancers, will have access to the right expertise and support, including a Clinical Nurse Specialist or other support worker

In order to deliver on this ambition we will need to ensure that we have a skilled and knowledgeable workforce

It is hoped that the MCFN will support nurses, teams and managers to identify and agree the role specific competencies that are required to define and deliver personalised care for people living with and affected by cancer <sup>(9,10,14)</sup>

## 1.1 Background

The Macmillan Competence Framework for Nurses Caring for Patients Living with and Beyond Cancer (2014) was the first competency framework for all UK registered nurses regardless of their setting or primary specialty. This second edition entitled The Macmillan Competency Framework for Nurses (MCFN) Supporting People Living With and Affected by Cancer replaces the first.

This edition has been revised following a comprehensive engagement and consultation process. The MCFN has been updated to ensure that it remains relevant to current national guidance and practice. In addition this edition now includes a toolkit for users, consisting of:

- a competency assessment tool
- a competency development tool

This is intended to help nurses, individually or as teams, identify existing relevant competencies and complete a gap analysis.

# 2.0 Purpose and Scope of the Macmillan Competency Framework for Nurses

The MCFN is focused on all needs of patients, their families and carers as equal partners including medical, psychological, social and emotional needs.

Nurses play a fundamental role in supporting people living with and affected by cancer whether in hospital, primary care, community, or in their own homes. The framework does not generally specify the environment in which care takes place, only that care plans are provided and shared across organisations and professions. Interventions provided by nurses can have a significant impact across the patient pathway from diagnosis, through active treatment, living with cancer as a chronic illness or long-term condition, living beyond cancer or with cancer treatment consequences. The MCFN aims to provide competencies applicable to all these stages of care, with the exception of end of life care or care of the deceased person.

### Applicable stages of care

-  **Diagnosis**
-  **Receiving active treatment**
-  **Living with consequences of cancer**
-  **Living with cancer**
-  **Living beyond cancer**

The need to provide consistency of role expectations, language and skills has been voiced many times. It makes sense to have one common set of competency criteria to cover job roles.

This will help to ensure that the key criteria managers use to select and recruit individuals are also used to manage and monitor their performance and will help to focus training and development where it is most needed.

## 2.1 MCNF Application to practice

The MCNF may be used to support and enhance practice and service delivery in many ways and by a variety of roles.

### As a nurse the framework can:

- support continuing personal and professional development (CPPD) as part of the Nursing and Midwifery Council (NMC) revalidation requirements<sup>15</sup>
  - help a nurse to assess their competency against the framework and build a development plan as part of their employing organisation's Personal Development Review (PDR) process
  - support an individual nurse to 'visualise' the development steps required to plan towards a career development goal/aspiration in cancer care
  - competencies gained will enable care to be shared across different health settings
  - motivate staff by setting challenging objectives and providing positive feedback
  - help inform and direct nurses to move from one level of competency to another
- Types of evidence can consist of:
- having an up-to-date and accurate record of CPD activities
  - appraisal interviews including 360-degree appraisals
  - case studies, reflective accounts
  - verification of practice and structured observation of practice

**As a line manager the framework can:**

- help standardise care
- establish levels of performance
- determine competencies for those working with people living with and affected by cancer
- identify gaps in an individual's or a team's knowledge for care provision
- inform the development of new roles by informing job descriptions and role specifications
- manage succession planning by identifying individuals capable of progressing to the next level
- support and inform appraisals and continuous personal and professional development

**As an educator, trainer or practice developer the framework can:**

- identify the skills required to develop cancer services
- assist in the strategic development of learning and development programmes targeted at specific clinical areas
- determine competencies for those working with people living with and affected by cancer
- identify gaps in an individual's or a team's knowledge and develop educational plans

**For the wider organisation the framework can be used:**

- to identify gaps in skills and inform learning and development programmes
- to guide recruitment - for example a lead cancer nurse/nurse manager could use it as a guide to determine competencies for nurses working with people living with and affected by cancer
- by commissioners, teams or nurses as a service development guide to identify competencies needed specifically by nurses at various levels in services working with people living with and affected by cancer

Whilst the MCFN framework covers many aspects of work nurses undertake, it is not intended to be a definitive or instructive list of all that an individual must achieve or aspire to. It is unlikely that an individual will need to achieve 100% of the competencies outlined in this document, so the framework has been designed with flexibility in mind to be used by all registered nurses working with people living with and affected by cancer and can be tailored to meet individual needs.



**We don't need to know everything**



**We need to know enough to fulfil our role in the pathway**

**The framework is not:**

- likely to be applicable to ALL professional scenarios where nurses work with people living with and affected by cancer
- designed to include all competencies needed for professional roles

**The framework does not include:**

- competencies for nurses caring for patients with disease-specific requirements of advanced cancer
- competencies for nurses working in Acute Oncology<sup>6</sup>
- competencies relating to those who require end of life care<sup>16</sup>
- competencies for nurses caring for children (aged 15 years or under)
- competencies regarding the smooth and effective transition from young people's services to adult services designed to cover children and adolescents apart from during transition to adult services<sup>17</sup>
- competencies for cancer rehabilitation<sup>1</sup>

Some teenagers and young people aged 16 to 24 may be cared for in adult services. An existing age-appropriate RCN competence framework is recommended in addition to that presented here.<sup>17</sup>

**The framework does not:**

- set out to determine grades for specific roles. Indeed, some nurses will be working across the different levels within the framework – i.e. core level in some aspects of their work and specialised or highly specialised in others. It is anticipated that individuals working at specialised and highly specialised will have acquired all or most of the competencies at the preceding level/s
- address the learning needs of the unregistered work force, including the Cancer Support Worker role or the Associate Nurse. However some core competencies may be appropriate for unregistered and Nursing Associate roles, depending on their scope of practice and patient needs. It may be beneficial to also refer to the Macmillan competency framework for person centred care

**The framework does not include:**

policies and procedures that are mandatory for the workforce to meet individual organisations corporate governance standards. These will include, for example, health and safety, information governance, manual handling, infection control and safe guarding.

To save confusion, the term nurse will be used through-out the document and covers a wide variety of role names associated with registered nurses supporting people living with and affected by cancer; for example, Clinical Nurse Specialist, Advanced Nurse Practitioner, Practice Nurse, and Ward Manager. The term carer is used to describe someone of any age who provides unpaid support to a family member or friend with cancer who could not manage without this help.

## 3.0 Benefits of the Macmillan Competency Framework for Nurses

The main benefit of the MCFN is that patients will gain from improved care and specific benefits for nurses, their managers and clinical and education providers are described in the table below.

Nurses	Managers
Performance is assessed against a well defined set of skills, behaviours and knowledge	Managers can manage resources more effectively by recruiting and retaining the right people to the right jobs
Improves communication and the understanding of roles between nurses, their manager and wider members of the multi-disciplinary team	Improves communication and the understanding of roles between nurses and their manager
Establishes a framework for constructive feedback at specified intervals	Managers are able to assess transferable skills and manage skill mix across services
Nurses are clear about how they are expected to perform their jobs	Employers are able to identify required behaviours regardless of background
Appraisal and recruitment systems are consistent, fair and open and helps provide clear direction for learning new job skills	Helps in the management of day-to-day staff performance constructively, fairly and promptly
Processes are measurable and standardised across organisational and geographical boundaries	Processes are measurable and standardised across organisational and geographical boundaries
Outlines potential professional development and career progression	Provides effective management support

Clinical Strategy	Education providers
It provides a framework for leadership and accountability at all levels	Improves understanding when considering the educational needs of nurses working with people living with and affected by cancer
Improves communication and understanding of roles when commissioning new and existing services	Identifies areas that the workforce needs to be competent in to support delivery of services for people living with and affected by cancer
Provides a baseline for discussions about service provision and developments	It provides a framework for the assessment of professional skills and knowledge for individuals and teams supporting continuing professional development plans
Workforce details will enable benchmarking with other services and help inform development of service specifications	Workforce details will enable benchmarking with other services
Emerging health needs can be targeted with appropriate staff with the appropriate skills and can support decisions about skill mix	Emerging health needs can be targeted with appropriate education and training
Helps to facilitate effective partnerships across teams, voluntary agencies, community resources and the independent sector to ensure resources are used efficiently	Provides a framework to inform post registration education development, provision and commissioning
Contributes to and informs contract details to support service specifications and service level agreements	Contributes to ongoing developments in post registration education

# 4.0 Competency Levels and Domains within The Macmillan Competency Framework for Nurses

## Competencies are comprised of:

- **professional skills** – defined by the profession concerned and encompassed in ‘scope of practice’<sup>2</sup>
- **knowledge** – nurses are required to have a level of knowledge to achieve registration and this is enhanced through ongoing continuing professional development. Nurses working in specialist settings, such as cancer care, are required to have an additional level of post-registration cancer care specific education and training to fulfil their roles
- **behavioural skills** – most professions and organisations recognise sets of behavioural skills, such as conscientiousness, attention to detail, patient-focus and respect for colleagues
- **experience and qualifications** – these validate an individual’s capability by certifying elements of skills and knowledge or by providing a practical demonstration of capability

## 4.1. Levels of competency

An individual’s progression through the defined competency levels will depend on their access and engagement with learning and development opportunities, service needs and individual abilities.



## The competency levels are defined as follows:

### 1. Core

The competencies at this level are usually straight forward to perform and do not present significant issues of complexity or uncertainty, nor deal with a high level of risk. They are applicable to the majority of the registered nursing workforce who will provide care for people living with and affected by cancer, including those in which cancer care is not their primary or specialist role. The competencies at this level may be considered to be the minimum level of knowledge and skill required when dealing with people living with and affected by cancer.

### 2. Specialised

The competencies at this level address some issues of complexity and uncertainty and may require the management of significant areas of risk. They are applicable to registered nurses who’s primary or specialist role is in a cancer specialist setting. The competencies at this level would be additional to the core competencies.

### 3. Highly specialised

The competencies at this level address issues of clinical leadership, autonomous practice and local, regional and national service development. They are applicable to advanced or consultant level nurses working predominantly or exclusively with people living with and affected by cancer.

Nurses working at this level often provide clinical leadership and have a wider geographical profile, including clinical credibility at regional and sometimes national level.

### 1. Core

Applicable to the majority of the registered nursing workforce who will provide care for people living with and affected by cancer, including those in which cancer care is not their primary or specialist role.

### 2. Specialised

Applicable to registered nurses who’s primary or specialist role is in a cancer specialist setting.

### 3. Highly specialised

Applicable to advanced or consultant level nurses working predominantly or exclusively with people affected by cancer.

You can tailor the framework to meet your needs - e.g. your role may require all of the core competency measures and some from the specialised competencies

## 4.2. Case management by complexity and need

The MCFN has adapted the approach used in the case management competencies framework for the care of people with long-term conditions<sup>18</sup> and applied it to the context of people living with and affected by cancer and defines high-risk and high-intensity-need patients as those:

- who have a high-risk of developing late effects complications and require close surveillance
- require complex physical care/interventions due to their cancer and its previous treatment (or co-morbidities)
- are finding it difficult to adapt psychologically or socially following their cancer and its treatment
- are vulnerable or hard to reach and may not attend for monitoring and surveillance or to use the services provided

## 4.3. The Competency Domains

The domains and the subsections within each domain are set out below.

**Domain 1. Clinical nursing practice** - describes the broad comprehensive range of knowledge which underpins the need for clinical interventions to support the complex needs of people living with and affected by cancer. It includes the foundation and context in which clinical practice is delivered, the additional knowledge, understanding and skills that nurses need to work with people living with and affected by cancer and the complexities of the late effects of cancer and its treatments.

### The subsections are:

- a. knowledge of cancer and its treatment
- b. tests and investigations in cancer treatments, monitoring, surveillance and late effects care
- c. medication in adult services for people living with and affected by cancer
- d. symptom management for the consequences of cancer and its treatment
- e. assessment of holistic needs of adult patients affected by cancer

**Domain 2. Personalising the care pathway** - focuses on the role of the nurse in coordinating and integrating person-centred care, including care planning that ensures that multiple disciplines and agencies can be accessed and the transfer of care between agencies.

### The subsections are:

- a. care plans, surveillance plans and treatment summaries – personalising the cancer pathway for people living with and affected by cancer
- b. transitional care – supporting moves between acute services, from acute hospital care to primary care services

### Domain 3. Proactive management: supporting self-care, self-management and enabling independence

- focuses on the knowledge and skills nurses need to provide fully participatory person-centred care to help people make informed choices as they live with or beyond cancer. It emphasises the role of nurses being at the heart of supporting people to take real control of their condition by avoiding secondary problems and supporting them to maintain levels of health and function for as long as possible.

**The subsections are:**

- a. proactive management
- b. promoting self-management
- c. providing information to support self-management

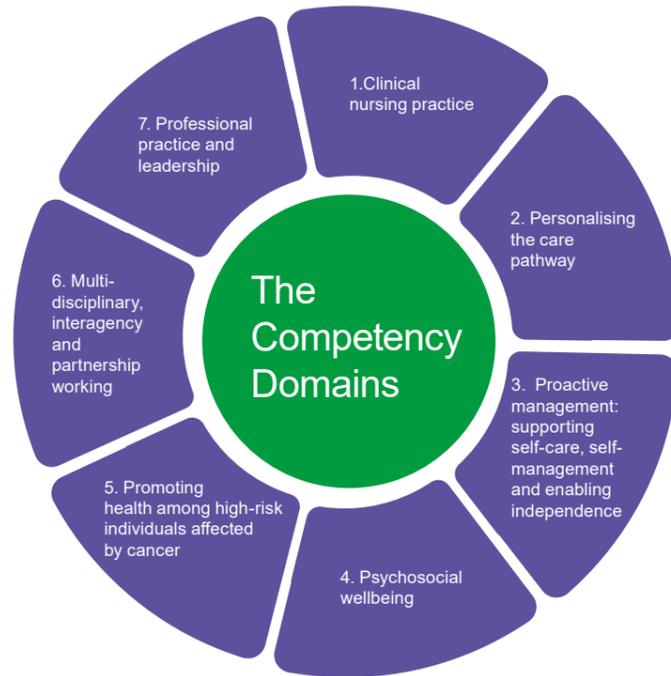
**Domain 4. Psychosocial wellbeing** - includes the skills and knowledge nurses need to effectively communicate, assess and provide appropriate strategies to support people living with and affected by cancer with their psychosocial well-being.

**Domain 5. Promoting health among high-risk individuals affected by cancer** - focuses on the role of nurses in the care of high-risk patients who require close monitoring and complex care plans for a variety of reasons such as vulnerability, hard to reach group, high risk of recurrence, high risk of treatment complications or experiencing adjustment challenges.

**Domain 6. Multi-disciplinary, interagency and partnership working** - focuses on complex care being delivered across agencies by effectively managing relationships and facilitating professional cooperation which will enhance the experience of people living with and affected by cancer and ensure their needs are met.

**Domain 7. Professional practice and leadership** focuses on recognising the need for nurses to maintain continuing professional development and to use current best practice to achieve optimal outcomes for people living with and affected by cancer and their families. **The subsections in this domain are:**

- a. research and audit
- b. service development
- c. education of service providers



**4.4 Self-Assessment against the MCFN**

There are three columns linked to each competency and level of practice. These form the basis of the competency toolkit and may be used to recognise your strengths (or those of your team), including your existing knowledge and skills, identify gaps and support your ongoing development. These are explained in more detail in section 5.

## 5.0 A Toolkit to Support the Benchmarking, Evidencing and Development of Practice

One of the first steps in the development process for any individual nurse, manager or commissioner is to explore and reflect on current practice against a set of competencies. It is with this insight that practitioners and services can begin to benchmark and assess practice, before interpreting findings and creating a development plan. This toolkit guides users through this process.

**5.1 What is the MCFN toolkit?**

The toolkit consists of:

**A) The Competency Framework Assessment Tool**, this details the competencies required for each level across the domains. The assessment tool will support nurses to:

- **Explore and reflect** on their current practice and performance, service delivery and career aspirations against the MCFN. This can be done by individual nurses, by managers with their teams or by educational teams/providers considering whole service or individual education interventions
- **Assess, record and evidence** performance findings against the competency framework, with attention to existing strengths and skills, as well as knowledge and skill gaps and development needs
- **Plan ongoing learning and development** opportunities, to meet individual, team and service needs
- **Continually review, evidence and update skills** and knowledge against the competencies in line with service needs and future career aspirations

**B) The Competency Development Tool**, provides a table to support you to identify, prioritise and action plan areas of competency for development.

**5.2 How to use this MCFN Toolkit**

There now follows three sections that will guide you through using the MCFN toolkit, namely:

- i) **Preparation** – things to consider before using the MCFN
- ii) **Using the MCFN assessment tool**
- iii) **Development planning**

i) **Preparation** - things to consider before using the MCFN

Before you start using the assessment tool to reflect on your practice against the competency framework, it may be useful to undertake some preparation, including:

**Define why you are assessing your competency or the competency of your team/service?**

There are many reasons, such as:

- supporting your professional development as part of your NMC revalidation<sup>15</sup> and/or PDR process
- career development
- recruitment planning and service development

**Is your line manager aware that you are using the MCFN to assess your competency?**

While self-assessment is an important part of using the MCFN, it is recommended that your manager is fully involved in the competency assessment process, along with a practice supervisor. This will ensure that the assessment is discussed and development plans prioritised as:

- part of, and in line with, your employing organisation's PDR/appraisal process
- the requirements of the NMC revalidation process

#### You should ask:

- Are they able to support you?
- Will this be linked in with your appraisal/PDR process?

#### Have you identified a practice supervisor?

A practice supervisor might support you with the following:

- Discussions and feedback to strengthen your competency assessment
- Identifying what CPD might best support your ongoing competency development
- Reflecting on the strengths and skills that you are building on within the domains
- Gathering and verifying evidence to demonstrate that the competency is met

#### You can also consider the following points to get as prepared as possible:

- Have you spared some time to reflect on your role or service, perhaps considering areas where you feel more/less confident?
- Have you recently considered your career goals and aspirations and how this process might contribute to that?
- Are you familiar with the 7 domains within the MCFN, as well as the assessment tool and the development tool within the toolkit? Having a look at these first may save you time as you go
- Have you set some time aside to consider the MCFN domains and competencies, seek out the observations of practice supervisors/line manager and plan/prioritise your development?
- Potential buddies and role models may also be important to consider at the outset, to support you with specific domains and competencies – who might they be for you?

#### ii) Using the competency framework assessment tool

The competency framework assessment tool (MCFN section 6.0) lists each domain and describes the associated competencies at each level. For each competency, there are three columns that may be used to support your thinking:

#### A = Competency relevant to role

This column allows you to record whether that competency is relevant to your role. If it is relevant, mark 'yes'. If it isn't relevant, mark 'no'. This will help you to prioritise your development areas later. If you, your line manager and/or practice supervisor are agreed that a competency is not relevant to your current role, then you may consider it a lower priority for development.

#### B = Competency demonstrated

This column is for marking that you are confident and can evidence, in discussion with your line manager and/or practice supervisor, that the competency has been demonstrated and met. When it is believed that a competency has been demonstrated, simply mark 'yes' in that column. This should be dated and the evidence to support this assessment recorded. If, however, a competency is considered 'not demonstrated' then the 'competency demonstrated' column should be marked as 'no' and that particular competency can then be transferred directly on to the development tool for prioritisation.

#### C = Evidence recorded

This column can be marked 'yes' when you, and ideally, your line manager and/or practice supervisor, have determined that a competency has been met and the evidence to support this decision has been recorded. It is recommended that each competency that is considered 'demonstrated' has evidence to support it. This supports your decision and may be useful for NMC revalidation purposes too. Suggested evidence to retain for nursing CPD activities can be found in the NMC 'Guidance Sheet – Examples of CPD Activities'<sup>20</sup>.

Here are some questions that you might want to consider when completing the Competency Assessment Tool:

#### What do I/the team/the service do well?

#### Which areas of knowledge and skill do I/the team/the service feel more confident in?

#### Is this competency important and relevant to my role or service now and/or is it important to my future career or service development plans?

#### In which areas do I/the team/the service have strengths that could be used to support and enhance patient care and also the knowledge and skills of others e.g. teaching/mentoring?

#### Which areas do I/the team/the service feel less confident or skilled in?

#### What evidence do I have to support my assessment decision for each competency, who have I discussed and checked it with (e.g. line manager/practice supervisor) and have I recorded it?

#### What practice feedback and reflective discussions/observations have I had with my manager/team/colleagues/patients/families to inform this process?

#### Have I considered and met the requirements of my professional revalidation body and my employing organisation?

#### What aspects do I/the team/the service need to develop and strengthen to support my current role and why? Looking through the levels of competency in the MCFN (i.e. core, specialised and highly specialised), what might I/the team/the service like to develop to support my future career plans or service development plans and why?

#### iii) Development planning

**The Competency Development Tool** - has been developed to support you to interpret what you found out when using the Assessment Tool by clearly identifying the competencies that you wish to work on and develop within each of the 7 domains. The development tool provides a table to support you to identify, prioritise and action plan areas for development.

**Reflect** on what you have recorded on the Macmillan Competency Assessment Tool once completed and use the Macmillan Competency Development Tool to identify all the competencies that were not demonstrated in areas relevant to your role/service or future plans. These competencies might then form the basis of your development plans.

#### Capture and build on your strengths.

In addition to considering development areas, record areas of particular strength, expertise, leadership and skill in your practice. These could be valuable to be aware of, share with your team and use to widen expertise in your work area.

#### Support career or service development.

The 'levels of competency' may also support ongoing career and service development planning by identifying competencies that are not yet achieved and which may not be important to current role or current service, but which may form a key part of your future development plan to support either individual career or service aspirations. Please see the reflective account from a Macmillan Nurse Consultant in Colorectal Cancer (appendix 1 P.62) for an example of how the framework has been used in practice to support career development and how it will be used to guide development and recruitment in the future.

For each competency that you identify as a development area from the assessment tool, there are five key areas:

- **Target date** – in discussion with your manager and/or practice supervisor and in line with your appraisal/PDR objectives, prioritise your development areas (e.g. competencies that are relevant to your role and that you may not yet have demonstrated) and set a target date for meeting that competency
- **Area for development** – use this column to describe more specifically what skills and/or knowledge you need to develop to meet the competency, and why. An example is given in the tool
- **Development action plan** – describe here what CPD you plan to undertake in order to meet your development need. You might also want to be more specific about how and where you might do this and who might support you. Once again, an example is shown in the tool

- **Evidence of meeting the competency** – this column allows you to record the evidence that illustrates how you (and your manager and/or practice supervisor) know that the competency has been met
- **Date achieved** – this provides a record of the date that the competency was recorded as demonstrated

The following are examples of the types of questions you may also want to consider with your line manager and/or mentor, when completing this Development Tool:

**What are your top 3-4 development priorities? Why are these development priorities for you (or the service)?**

**What difference will development in these areas make to your current practice, your future career plans, to patient care and/or to the service area you work in?**

**What do you need to do to complete these development priorities?**

**From a CPD/development point of view, what is realistic to achieve over the next 6 months?**

**Who are your role models for these development areas and can they support you?**

**In discussion with your line manager and/or mentor, how will you know that you have met the competency?**

### 5.3. Example of how the MCFN Competency Development Tool can be used: Competency Development Tool

Having reflected on the assessment framework -  
DOMAIN 1: CLINICAL NURSING PRACTICE, I have identified:

- the competencies I require in my current practice
- the competencies I possess currently
- the competencies I am working on and have listed these below

Name: **Edwina James**  
Date of initial assessment: **20/09/20**

Domain	Competency no.	Date identified	Target date	Date achieved
1a	5c	20/09/20	20/03/21	15/02/21
<b>Area for development (e.g. what do I need to achieve and why?) NB: where applicable, demonstrate links to appraisal and PDR objectives</b>		<b>Development Action (e.g. what CPD do I need? How will I achieve this?)</b>		<b>Evidence of meeting the competency (e.g. How do I know this has been achieved?)</b>
I have been supporting more older adults with dementia recently. I feel less confident in this area re. communication, information-giving etc. Need to understand more to support people more effectively.		Arrange a practice visit to work with a Dementia Specialist Nurse to increase my knowledge and build networks. Research an introductory course that may be relevant.		Certificate of attendance from a Dementia Awareness training course and a reflective account of work-shadowing a Dementia Specialist Nurse, which the specialist nurse has countersigned.

Your reflections and evidence from this domain, to support your ongoing development, including areas of strength identified:

**I have worked with my mentor to review the competencies in Domain 1 of framework, and have agreed the competencies required for my role and personal development. I have provided evidence of existing competency as indicated. Of the outstanding competencies we have identified the above as priorities and will be working towards completion.**

# 6.0 Competency Framework Assessment Tool

## 6.1. Domain 1: Clinical Nursing Practice

### 1a. Knowledge of cancer and its treatment in relation to people living with and affected by cancer

Core (c)	Specialised (s)	Highly specialised (h)
Has knowledge of the following that underpins own practice and clinical care	As core, plus knowledge of the following used for specialised practice and developing services in own area	As specialised, plus knowledge of the following used for autonomous practice and local, regional and national service development

A = competency relevant to role

B = competency demonstrated

C = evidence recorded

Core (c)	Specialised (s)	Highly specialised (h)
<b>1c.</b> Demonstrates knowledge of cancer biology, aetiology and treatments and common long term or late effects common to own area of practice	<b>1s.</b> Demonstrates knowledge of a range of care pathways including: treatment, adjustment, survivorship, living well, active surveillance, complex symptom management and end of life care	<b>1h.</b> Demonstrates knowledge of interventions that can be used to manage complex physical and psychological consequences of cancer and its treatment
<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C	<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C	<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C

Core (c)	Specialised (s)	Highly specialised (h)
<b>2c.</b> Demonstrates knowledge of a range of psychological and social consequences of cancer, including the impact on relationships, employment, social life and finances	<b>2s.</b> Demonstrates knowledge of symptoms and care interventions for late effects appropriate to own client group/specialty (e.g. endocrine, bone health, cardiac toxicity, psychosexual issues, fertility, dental health, early menopause)	<b>2h.</b> Demonstrates knowledge of current and emerging local and national policies, pathways and evidence that may inform the care of people living with and affected by cancer
<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C	<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C	<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C

**3c.** Demonstrates knowledge of symptoms associated with cancer, cancer treatment and late effects in relation to own speciality

 A    B    C

**3s.** Demonstrates knowledge of the relative risks of complications associated with different cancers and treatments, and the monitoring required for specific complications

 A    B    C

**3h.** Demonstrates knowledge of local and national organisations and networks involved in providing services for people living with and affected by cancer

 A    B    C

**4c.** Demonstrates knowledge of the principles underlying ongoing care for people living with and affected by cancer e.g. late effects risk stratification, surveillance, self-management, screening

 A    B    C

**4s.** Demonstrates knowledge of the core concepts under-pinning the care of people living with and affected by cancer (e.g. coping and adjustment, loss and grief, quality of life, living well)

 A    B    C

**4h.** Demonstrates knowledge of the wider influences on service delivery for people living with and affected by cancer e.g. commissioning, strategy and planning

 A    B    C

**5c.** Demonstrates knowledge of other influences on the care of people living with and affected by cancer e.g. the normal ageing process, other long-term conditions

 A    B    C

**1b. Tests and investigations used in cancer treatments, monitoring, surveillance and late effects care**

Core	Specialised	Highly specialised
A = competency relevant to role	B = competency demonstrated	C = evidence recorded
<p><b>1c.</b> Demonstrates knowledge of tests and investigations commonly used in cancer care, including rationale for use and normal ranges of results</p> <p>A B C</p>	<p><b>1s.</b> Develops individualised patient care plans for tests and investigations and initiates them in accordance with guidelines and protocols</p> <p>A B C</p>	<p><b>1h.</b> Prescribes, initiates, interprets and monitors diagnostic tests and investigations independently according to the individual's clinical need</p> <p>A B C</p>
<p><b>2c.</b> Carries out investigations appropriate to own area of practice ensuring privacy and dignity, health and safety and consent issues are met</p> <p>A B C</p>	<p><b>2s.</b> Accurately interprets the findings of tests and investigations used in cancer treatment, monitoring and surveillance</p> <p>A B C</p>	<p><b>2h.</b> Acts as an expert resource for other healthcare professionals (HCPs) dealing with challenging situations relating to tests, investigations and results</p> <p>A B C</p>
<p><b>3c.</b> Requests or initiates tests and investigations at the request of clinicians or according to protocols and guidelines</p> <p>A B C</p>	<p><b>3s.</b> Makes appropriate changes to the care plan in the light of findings, in conjunction with clinicians or within protocols and guidelines</p> <p>A B C</p>	<p><b>3h.</b> Plays a leading role in developing protocols and clinical guidelines relating to tests and investigations used in cancer treatment, monitoring and surveillance</p> <p>A B C</p>
<p><b>4c.</b> Provides appropriate explanations to individuals regarding the procedures involved and the reasons for tests and investigations</p> <p>A B C</p>	<p><b>4s.</b> Ensures the needs of patients with complex needs are met when obtaining consent for tests and investigations e.g. learning difficulties, dementia, challenging issues relating to consent</p> <p>A B C</p>	

<p><b>5c.</b> Makes appropriate decisions in relation to the findings of tests and investigations, including deviations in expected results e.g. seek advice from other staff, refer to services</p> <p>A B C</p>	<p><b>5s.</b> Uses knowledge and expertise to provide detailed information to individuals about tests and investigations, including significant news relating to results or the need for new or additional tests</p> <p>A B C</p>
<p><b>6c.</b> Demonstrates a good working knowledge of the legal framework and guidelines relating to the consent process</p> <p>A B C</p>	<p><b>6s.</b> Identifies new support or information needs relating to tests, investigations and results, providing appropriate interventions to help people cope with their implications</p> <p>A B C</p>
<p><b>7c.</b> Provides support and further explanation to the patient and family after the clinician has discussed test results</p> <p>A B C</p>	

## 1c. Medication for people living with and affected by cancer

Core	Specialised	Highly specialised
A = competency relevant to role	B = competency demonstrated	C = evidence recorded
<p><b>1c.</b> Demonstrates knowledge of medications commonly used in own area of practice in relation to cancer, cancer treatment and late effects care, including indication, mode of action and adverse effects</p> <p>A B C</p>	<p><b>1s.</b> Demonstrates a comprehensive understanding of the medications appropriate to own client group/specialty and how they impact on health and wellbeing</p> <p>A B C</p>	<p><b>1h.</b> Works with the multi-professional team (MPT) to develop protocols and guidelines for medications e.g. Patient Group Directions, treatment pathways</p> <p>A B C</p>
<p><b>2c.</b> Demonstrates understanding of the principles of safe handling and administration of systemic anti-cancer therapy (SACT). Has necessary competencies for any roles carried out</p> <p>A B C</p>	<p><b>2s.</b> Evaluates effectiveness and outcomes of medication, changes the treatment plan within competence (e.g. non-medical prescribing) and consults with clinician regarding changes</p> <p>A B C</p>	<p><b>2h.</b> Develops patient information on medicines used in services for people living with and affected by cancer</p> <p>A B C</p>
<p><b>3c.</b> Provides advice and explanation on medication and ensures it is given safely according to protocols and guidelines (e.g. education of patients/relatives)</p> <p>A B C</p>	<p><b>3s.</b> Uses specialised knowledge to monitor, prevent and manage side-effects associated with medications used in cancer care</p> <p>A B C</p>	<p><b>3h.</b> Works with other service providers to develop policies and pathways to promote safe practice in relation to cancer medicines used across service settings</p> <p>A B C</p>

**4c.** Provides accurate advice and information in relation to the management of side effects of medication used in own area of practice

**4s.** Provides individualised patient information about medications used in cancer care to facilitate informed consent, decision making, self-management and self-monitoring

**4h.** Evaluates interventions and services provided to support medication provision in terms of their impact on patient outcomes and service effectiveness

A B C                      A B C                      A B C

**5c.** Identifies side effects that require urgent and/or specialist intervention and seeks appropriate help. Signposts and refers patients to care teams for management of medicines-related issues

**5s.** Discusses issues relating to concordance with the patient, explaining potential benefits while exploring their reasons for non-adherence

A B C                      A B C

**6c.** Evaluates adherence to medications, identifies practical and information needs and makes appropriate interventions to support people with taking their medications

**6s.** Provides advice about dietary supplements and herbal/homeopathic remedies and their interactive properties with prescription medicines

A B C                      A B C

**7c.** Demonstrates ability to access the range of sources of information available to ensure that own knowledge about medicines is up to date

A B C

**1d. Symptom management for the consequences of cancer and its treatment**

Core	Specialised	Highly specialised
A = competency relevant to role	B = competency demonstrated	C = evidence recorded
<p><b>1c.</b> Demonstrates knowledge of the principles of symptom management in relation to cancer, cancer treatments and common late effects complications</p> <p>A B C</p>	<p><b>1s.</b> Distinguishes between symptoms and intervenes to ensure individuals are on the appropriate care pathway e.g. treatment related, late effects, recurrence, progression</p> <p>A B C</p>	<p><b>1h.</b> Uses expert knowledge to independently diagnose, assess and evaluate symptoms</p> <p>A B C</p>
<p><b>2c.</b> Identifies symptoms of common co-morbidities that can also affect individuals living with cancer e.g. diabetes, dementia, cardiac/respiratory conditions</p> <p>A B C</p>	<p><b>2s.</b> Has a comprehensive knowledge of the range of interventions and services available to support symptom management and ensures these are used appropriately in individual care plans</p> <p>A B C</p>	<p><b>2h.</b> Acts as an expert resource for other Health Care Professionals (HCP) when dealing with complex symptoms</p> <p>A B C</p>
<p><b>3c.</b> Provides information and support regarding symptoms that can be managed with simple measures such as diet, activity and medications</p> <p>A B C</p>	<p><b>3s.</b> Uses specialised knowledge to evaluate the effectiveness of symptom management and tailor interventions according to individual assessment</p> <p>A B C</p>	<p><b>3h.</b> Develops guidelines and pathways to facilitate effective symptom management across the health, social care and voluntary sectors</p> <p>A B C</p>

<p><b>4c.</b> Identifies symptoms that require urgent and/or specialist intervention and facilitates appropriate referrals and care</p> <p>Refer to Acute Oncology competence framework as appropriate</p> <p>A B C</p>	<p><b>4s.</b> Provides specialist interventions and advice to support symptom management including complex symptoms arising from cancer, cancer treatment and late effects</p> <p>A B C</p>	<p><b>4h.</b> Provides leadership in the management of complex symptoms including those that some find difficult to discuss (e.g. sexual dysfunction, incontinence) and those that are difficult to resolve</p> <p>A B C</p>
<p><b>5c.</b> Signposts and refers individuals to appropriate sources of support and information for symptom management</p> <p>A B C</p>	<p><b>5s.</b> Provides interventions to support those whose symptoms are having a significant negative impact on physical, psychological or social function</p> <p>A B C</p>	<p><b>5h.</b> Develops systems for documenting symptoms that help to build knowledge about cancer and its treatment, survivorship, late effects and late effects services</p> <p>A B C</p>
<p><b>6c.</b> Provides support to help patients come to terms with long-lasting symptoms</p> <p>A B C</p>		<p><b>6h.</b> Evaluates interventions and services provided for symptom management in terms of the impact on patient outcomes and the effectiveness of service delivery</p> <p>A B C</p>

**1e. Assessment of holistic needs of people living with and affected by cancer**

Core	Specialised	Highly specialised
A = competency relevant to role	B = competency demonstrated	C = evidence recorded
<p><b>1c.</b> Understands the concept of Holistic Needs Assessments and their implications for practice</p> <p>A B C</p>	<p><b>1s.</b> Uses specialist skills and knowledge to carry out clinical assessments within protocols and guidelines (e.g. nurse led clinics and services)</p> <p>A B C</p>	<p><b>1h.</b> Independently reviews and assesses patients to develop appropriate care plans according to their needs</p> <p>A B C</p>
<p><b>2c.</b> Carries out nursing and other assessments using structured assessment tools and care plans</p> <p>A B C</p>	<p><b>2s.</b> Carries out holistic assessments, recognising the range of physical, psychological and social consequences of cancer and its treatment assessing the individual's concerns and priorities for care</p> <p>A B C</p>	<p><b>2h.</b> Acts as an expert resource for other HCPs when dealing with complex or challenging situations relating to assessment</p> <p>A B C</p>
<p><b>3c.</b> Recognises actual and potential problems identified in assessments and care plans that might require further attention and facilitates appropriate care</p> <p>A B C</p>	<p><b>3s.</b> Uses knowledge of cancer, its treatment and the risks of late effects complications to ensure assessments are appropriate to individual needs (e.g. type of cancer, treatment received, age, co-morbidities)</p> <p>A B C</p>	<p><b>3h.</b> Works with others to develop and implement assessment tools and clinical guidelines required for services for people living with and affected by cancer</p> <p>A B C</p>

**4c.** Makes appropriate decisions to seek help in relation to findings following patient assessments, prioritising those who require urgent intervention

A B C

**4s.** Recognises signs and symptoms requiring a change in the care pathway e.g. side effect grading, psychological concerns (such as depression and anxiety) cancer recurrence and end of life care and initiates appropriate interventions

A B C

**4h.** Evaluates the effectiveness of assessment tools and guidelines in terms of their impact on patient outcomes and services

A B C

**5c.** Assesses lifestyle issues that are of concern for individual patients based on objective measurements (e.g. BMI, alcohol consumption) and individual priorities

A B C

**5s.** Recognises other common co-morbidities that may be identified during assessment and makes appropriate referrals for ongoing care

A B C

**5h.** Develops systems for documenting assessment findings that help to increase wider knowledge about cancer, its treatment consequences and survivorship, late effects and care services

A B C

**6c.** Accurately documents the findings from assessments

A B C

**6s.** Ensures that assessments and assessment tools reflect current best practice and are evidence-based

A B C

# Competency Development Tool

Having reflected on the assessment framework - DOMAIN 1: CLINICAL NURSING PRACTICE, I have identified:

- the competencies I require in my current practice
- the competencies I possess currently
- the competencies I am working on and have listed these below

Name: \_\_\_\_\_ Date of initial assessment: \_\_\_\_/\_\_\_\_/\_\_\_\_

Domain	Competency no.	Date identified	Target date	Date achieved
Area for development (e.g. what do I need to achieve and why?) NB: where applicable, demonstrate links to appraisal and PDR objectives	Development Action (e.g. what CPD do I need? How will I achieve this?)	Evidence of meeting the competency (e.g. How do I know this has been achieved?)		
Domain	Competency no.	Date identified	Target date	Date achieved
Area for development (e.g. what do I need to achieve and why?) NB: where applicable, demonstrate links to appraisal and PDR objectives	Development Action (e.g. what CPD do I need? How will I achieve this?)	Evidence of meeting the competency (e.g. How do I know this has been achieved?)		

Domain	Competency no.	Date identified	Target date	Date achieved
Area for development (e.g. what do I need to achieve and why?) NB: where applicable, demonstrate links to appraisal and PDR objectives	Development Action (e.g. what CPD do I need? How will I achieve this?)	Evidence of meeting the competency (e.g. How do I know this has been achieved?)		
Your reflections and evidence from this domain, to support your ongoing development, including areas of strength identified:				

## 6.2. Domain 2: Personalising the Care Pathway

### 2a. Care plans, surveillance plans, survivorship care plans and treatment summaries — personalising the cancer pathway for people living with and affected by cancer

Core	Specialised	Highly specialised
A = competency relevant to role	B = competency demonstrated	C = evidence recorded
<p><b>1c.</b> Provides accurate and appropriate information when assisting others with developing care plans and treatment summaries</p> <p>A B C</p>	<p><b>1s.</b> Works with individuals to develop care plans that reflect their priorities and concerns</p> <p>A B C</p>	<p><b>1h.</b> Independently develops, implements and evaluates care plans for people living with and affected by cancer</p> <p>A B C</p>
<p><b>2c.</b> Liaises with the MDT in creating care plans or treatment summaries for people living with and affected by cancer</p> <p>A B C</p>	<p><b>2s.</b> Uses protocols and guidelines to create holistic individual care pathways and documentation e.g. care plans, treatment summaries, late effects surveillance</p> <p>A B C</p>	<p><b>2h.</b> Takes a leading role in developing systems and processes to support the development of care and surveillance plans and treatment summaries</p> <p>A B C</p>
<p><b>3c.</b> Provides verbal and written information and explanations to individuals and their family members in relation to their care plan</p> <p>A B C</p>	<p><b>3s.</b> Coaches individuals to be aware of concerning signs, symptoms and situations in relation to the risks associated with their cancer and their current and previous cancer treatment</p> <p>A B C</p>	<p><b>3h.</b> Ensures physical, psychological and social assessments are incorporated into local care planning systems e.g. health promotion, psychosocial adjustment, work and social functioning</p> <p>A B C</p>

**4c.** Demonstrates adherence to policies and good practice guidance with respect to governance and confidentiality issues relating to care plans and patient records

A B C

**4s.** Uses specialist knowledge to recognise and intervene when deviations occur from the expected progress of an individual in relation to their care plan

A B C

**4h.** Works with local service providers to develop pathways that facilitate rapid access to services when the need to do so is identified e.g. re-entry to acute care services following signs of recurrence

A B C

**5c.** Recognises when changes may be needed in the care plan and takes appropriate action

A B C

**5s.** Works with individuals, their families and the MPT to manage complex situations arising from care plans e.g. differing perspectives of treatment plans

A B C

**5h.** Evaluates the effectiveness of the systems and methods used for care planning, surveillance plans and treatment summaries in terms of patient outcomes and the effectiveness of service delivery

A B C

**6c.** Effectively communicates on-going care needs and care plans to other healthcare providers

A B C

**6s.** Ensures care plans are evidence-based and reflect current best practice

A B C

**2b. Transitional care — supporting the move from acute hospital care to primary care services**

For transition of children and young people to adult services or for transition to end of life care, please refer to the appropriate competence framework reference numbers <sup>16</sup> and <sup>17</sup> on page 66

Core	Specialised	Highly- specialised
A = competency relevant to role	B = competency demonstrated	C = evidence recorded
<p><b>1c.</b> Understands the issues facing individuals as they complete cancer treatment or are discharged from acute hospital follow-up</p> <p>A B C</p>	<p><b>1s.</b> Provides information and support to ensure individuals are prepared for changes in care pathways and feel fully involved in transition plans</p> <p>A B C</p>	<p><b>1h.</b> Works with other agencies to develop clear pathways and guidelines for the transfer of long-term follow-up to primary services and to different models of follow-up care</p> <p>A B C</p>
<p><b>2c.</b> Has a knowledge of the range of services available to support people across the care pathway and how to refer/sign-post to them</p> <p>A B C</p>	<p><b>2s.</b> Assesses the emotional and psychological readiness of individuals to take more responsibility for their care, and develops individualised interventions to support them</p> <p>A B C</p>	<p><b>2h.</b> Acts as a specialist resource for local health, social care and voluntary sector services regarding transitional care</p> <p>A B C</p>
<p><b>3c.</b> Understands the roles that primary care services play in supporting people living with and affected by cancer</p> <p>A B C</p>	<p><b>3s.</b> Communicates effectively and works with other HCPs and services to ensure individuals receive appropriate ongoing cancer care</p> <p>A B C</p>	<p><b>3h.</b> Develops approaches to monitoring transitional arrangements and services to ensure that they meet the needs of service users</p> <p>A B C</p>

<p><b>4c.</b> Provides information to individuals regarding the changes in care and service provision associated with the transition to care outside of the hospital setting</p> <p>A B C</p>	<p><b>4s.</b> Supports individuals with complex needs to ensure that they receive appropriate care during transitions in care (e.g. completing cancer treatment, discharge from acute care)</p> <p>A B C</p>	<p><b>4h.</b> Develops programmes of education to support staff involved in transitional care</p> <p>A B C</p>
<p><b>5c.</b> Helps individuals navigate the services and resources that are available outside of the hospital setting</p> <p>A B C</p>	<p><b>5s.</b> Takes an active role in working with others to minimise the occurrence of potential crises e.g. inappropriate admission to hospital</p> <p>A B C</p>	<p><b>5h.</b> Evaluates services developed to support transitions in terms of patient outcomes and the effectiveness of service delivery</p> <p>A B C</p>
<p><b>6c.</b> Provides accurate information about individual patients when making referrals within own service and to other agencies</p> <p>A B C</p>	<p><b>6s.</b> Provides information and support to primary care staff regarding ongoing late effects surveillance</p> <p>A B C</p>	
<p><b>7c.</b> Understands the role of the treatment summary and surveillance plan in communication between hospital and primary care services</p> <p>A B C</p>		

# Competency Development Tool

Having reflected on the assessment framework - DOMAIN 2: PERSONALISING THE CARE PATHWAY,

I have identified:

- the competencies I require in my current practice
- the competencies I possess currently
- the competencies I am working on and have listed these below

Name: \_\_\_\_\_ Date of initial assessment: \_\_\_\_/\_\_\_\_/\_\_\_\_

Domain	Competency no.	Date identified	Target date	Date achieved
<p>Area for development (e.g. what do I need to achieve and why?) NB: where applicable, demonstrate links to appraisal and PDR objectives.</p>				
<p>Development Action (e.g. what CPD do I need? How will I achieve this?)</p>		<p>Evidence of meeting the competency (e.g. How do I know this has been achieved?)</p>		
<p>Area for development (e.g. what do I need to achieve and why?) NB: where applicable, demonstrate links to appraisal and PDR objectives.</p>				
<p>Development Action (e.g. what CPD do I need? How will I achieve this?)</p>		<p>Evidence of meeting the competency (e.g. How do I know this has been achieved?)</p>		

Domain	Competency no.	Date identified	Target date	Date achieved
<p>Area for development (e.g. what do I need to achieve and why?) NB: where applicable, demonstrate links to appraisal and PDR objectives.</p>		<p>Development Action (e.g. what CPD do I need? How will I achieve this?)</p>		<p>Evidence of meeting the competency (e.g. How do I know this has been achieved?)</p>
<p>Your reflections and evidence from this domain, to support your ongoing development, including areas of strength identified:</p>				

**N.B.** For transition of children and young people to adult services or for transition to end of life care, please refer to the appropriate competence framework referenced on page 66

### 6.3. Domain 3: Proactive management: supporting self-care, self-management and enabling independence

#### 3a. Helping people make informed choices as they live with or are affected by cancer

**Core**                      **Specialised**                      **Highly specialised**

A = competency relevant to role      B = competency demonstrated      C = evidence recorded



**1c.** Provides information and advice appropriate to the needs, priorities and concerns of individuals

A    B    C

**1s.** Responds to individuals' descriptions of their needs, preferences and concerns to ensure that care plans meet their goals and needs

A    B    C

**1h.** Acts as an expert resource for other HCPs when dealing with complex communication issues (e.g. when an individual's choices place them at risk)

A    B    C



**2c.** Acknowledges and respects decisions made by individuals concerning their health and wellbeing in relation to cancer, cancer treatments, survivorship and late effects care

A    B    C

**2s.** Explains options, risks and benefits to individuals to enable them to reach their own decisions about their treatment, health and wellbeing and set their own priorities

A    B    C

**2h.** Collaborates with other providers to promote services to help individuals make informed choices about their health and wellbeing

A    B    C



**3c.** Makes appropriate decisions to seek help and report concerns to colleagues when an individual's choices place them at risk

A    B    C

**3s.** Identifies factors that can affect an individual's ability to request, organise or access services or assistance and takes appropriate action to help them receive the care they require (e.g. knowledge, confidence, physical constraints, social isolation)

A    B    C

**3h.** Develops systems and processes to identify factors that may exclude or prevent individuals and groups from accessing the range of services and support available

A    B    C



**4c.** Provides information and assistance to help individuals access the services and resources they require to implement their decisions

A    B    C

**4s.** Identifies external factors that may exclude or prevent individuals from being able to access the range of services and resources available and works with other agencies to minimise their impact

A    B    C

**4h.** Takes a leading role in ensuring that factors that prevent or exclude individuals from using services are addressed and minimised

A    B    C



**5c.** Promotes the participation and inclusion of all service users and ensures that potential barriers are reported to the appropriate personnel

A    B    C

**5s.** Works to ensure that services are inclusive and promotes equal opportunities for access and service provision

A    B    C

### 3b. Promoting self-management

Core	Specialised	Highly specialised
A = competency relevant to role	B = competency demonstrated	C = evidence recorded
1c. Recognises the contribution of healthy lifestyle behaviours to promoting and sustaining recovery and well-being	1s. Has an understanding of models and concepts of health-related behaviour change	1h. Carries out specialist rehabilitation assessments in conjunction with therapist colleagues
A B C	A B C	A B C
2c. Assesses the ability and motivation of individual patients to manage self-care	2s. Teaches individuals to carry out self-monitoring and self-care and mentors them in the process	2h. Works with other agencies to develop referral pathways to services supporting self-care and independence
A B C	A B C	A B C
3c. Has an awareness of health beliefs and lifestyle risks that could influence adherence with care instructions or advice	3s. Works in partnership with individuals to develop tailored plans of care to promote health behaviours that meet their priorities and concerns	3h. Proactively promotes the self-care principle at local, national and international forums
A B C	A B C	A B C
4c. Promotes self-management for individuals recognising factors that act as barriers and facilitators	4s. Teaches individuals about symptoms that require further advice/investigation and the pathways available for accessing this care	4h. Develops educational programmes/forums that facilitate knowledge, confidence and skills for self-management, self-care and healthy living
A B C	A B C	A B C

5c. Provides encouragement to individuals attempting to change or adopt new health-related behaviours providing positive reinforcement when they are finding it difficult or achieving less than they hoped to	5s. Enables individuals to develop realistic short- and long-term goals and focused plans where they want to change or adopt new lifestyle or health behaviours	5h. Evaluates care and services that promote self-management in terms of patient outcomes and the effectiveness of service delivery
A B C	A B C	A B C
6c. Involves the family in supporting self-management and self-care where this is appropriate	6s. Works with individuals to support adherence to care, identifying potential barriers to following care instructions and developing strategies to address them	
A B C	A B C	
7c. Signposts to local services supporting healthy living e.g. exercise facilities, walking groups, adult education, smoking cessation	7s. Works with agencies and services to support people with self-management, independence and adherence to care plans and advice	
A B C	A B C	
8c. Provides practical and emotional support to encourage individuals to take an active role in communicating with health professionals where this is needed		
A B C		

**3c. Providing information to support self-care and self-management and enable independence**

Core	Specialised	Highly specialised
A = competency relevant to role	B = competency demonstrated	C = evidence recorded
<p><b>1c.</b> Has knowledge of the range of services available to support individuals across the care pathway e.g. voluntary agencies, health promotion services and support groups</p> <p>A B C</p>	<p><b>1s.</b> Acts as a point of contact for own caseload of patients</p> <p>A B C</p>	<p><b>1h.</b> Works with other agencies to develop information and support resources to ensure individuals receive information appropriate to their needs</p> <p>A B C</p>
<p><b>2c.</b> Directs individuals and family members to appropriate agencies and information sources</p> <p>A B C</p>	<p><b>2s.</b> Assists individual patients to evaluate information from the range of sources available according to their preferences and needs</p> <p>A B C</p>	<p><b>2h.</b> Leads on the development and evaluation of information resources for people living with and affected by cancer</p> <p>A B C</p>
<p><b>3c.</b> Provides written, online and verbal information to individuals about their condition, treatment and services available to support self-care and independence</p> <p>A B C</p>	<p><b>3s.</b> Understands the concept of the teachable moment and maximises its potential when patients are receptive</p> <p>A B C</p>	<p><b>3h.</b> Organises and plans support groups for individuals living with and affected by cancer</p> <p>A B C</p>

<p><b>4c.</b> Evaluates individual's understanding of information, corrects misunderstandings, gives further information and explains complex medical terminology in lay terms</p> <p>A B C</p>	<p><b>4s.</b> Accesses information from a range of resources, and uses them to meet the individual needs of service users</p> <p>A B C</p>	<p><b>4h.</b> Implements and informs local and national initiatives regarding the development of information and support resources</p> <p>A B C</p>
<p><b>5c.</b> Participates in support groups for people living with and affected by cancer</p> <p>A B C</p>	<p><b>5s.</b> Critically assesses written information/websites before recommending them</p> <p>A B C</p>	
<p><b>6c.</b> Offers guidance and support with accessing appropriate online sources of information</p> <p>A B C</p>	<p><b>6s.</b> Contributes to the development and evaluation of patient information resources for people living with and affected by cancer</p> <p>A B C</p>	
<p><b>7c.</b> Directs individuals to support/information networks on issues that may affect them following cancer treatment, including work and finance matters</p> <p>A B C</p>	<p><b>7s.</b> Assists in the provision of planned education programmes and/or support groups</p> <p>A B C</p>	

# Competency Development Tool

Having reflected on the assessment framework - DOMAIN 3: PROACTIVE MANAGEMENT: SUPPORTING SELF-CARE, SELF-MANAGEMENT AND ENABLING INDEPENDENCE

I have identified:

- the competencies I require in my current practice
- the competencies I possess currently
- the competencies I am working on and have listed these below

Name: \_\_\_\_\_ Date of initial assessment: \_\_\_\_/\_\_\_\_/\_\_\_\_

Domain	Competency no.	Date identified	Target date	Date achieved
Area for development (e.g. what do I need to achieve and why?) NB: where applicable, demonstrate links to appraisal and PDR objectives				
Development Action (e.g. what CPD do I need? How will I achieve this?)		Evidence of meeting the competency (e.g. How do I know this has been achieved?)		
Domain	Competency no.	Date identified	Target date	Date achieved
Area for development (e.g. what do I need to achieve and why?) NB: where applicable, demonstrate links to appraisal and PDR objectives				
Development Action (e.g. what CPD do I need? How will I achieve this?)		Evidence of meeting the competency (e.g. How do I know this has been achieved?)		

Domain	Competency no.	Date identified	Target date	Date achieved
Area for development (e.g. what do I need to achieve and why?) NB: where applicable, demonstrate links to appraisal and PDR objectives.				
Development Action (e.g. what CPD do I need? How will I achieve this?)		Evidence of meeting the competency (e.g. How do I know this has been achieved?)		
Your reflections and evidence from this domain, to support your ongoing development, including areas of strength identified:				

## 6.4. Domain 4: Psychosocial wellbeing

Core	Specialised	Highly specialised
A = competency relevant to role	B = competency demonstrated	C = evidence recorded
<p><b>1c.</b> Communicates effectively and appropriately with people of different ages, cultural and socio-economic backgrounds along the cancer journey</p> <p>A B C</p>	<p><b>1s.</b> Applies knowledge and experience to provide psychological support on a wide range of diverse issues to people living with and affected by cancer</p> <p>A B C</p>	<p><b>1h.</b> Demonstrates advanced communication skills e.g. counselling and motivational interviewing techniques</p> <p>A B C</p>
<p><b>2c.</b> Understands the range of sources of support available e.g. family and friends, social and leisure activities, religion, spirituality, work</p> <p>A B C</p>	<p><b>2s.</b> Carries out assessments to assess psychological needs, including screening for distress, and makes appropriate interventions based on the findings</p> <p>A B C</p>	<p><b>2h.</b> Acts as an expert resource for other HCPs when dealing with complex and challenging communication issues</p> <p>A B C</p>
<p><b>3c.</b> Uses local pathways to refer individuals with psychosocial support needs to appropriate services</p> <p>A B C</p>	<p><b>3s.</b> Identifies when referral to specialist services is indicated and facilitates this process e.g. psychiatric or clinical psychology services</p> <p>A B C</p>	<p><b>3h.</b> Develops, implements and evaluates different approaches to assessing psychosocial needs in local services e.g. distress thermometer, SPARC</p> <p>A B C</p>

**4c.** Makes appropriate decisions to seek help where there are concerns about an individual's mental wellbeing

A B C

**4s.** Supports individual patients in developing strategies for coping and managing their own mental well-being that are effective for them

A B C

**4h.** Works with other agencies to develop pathways for complex psychosocial support needs

A B C

**5c.** Uses effective communication skills to provide opportunities for individuals and those close to them to share their thoughts, feelings and concerns

A B C

**5s.** Provides advice and interventions that enable individuals to manage the impact of cancer and its treatment on their relationships with those important to them

A B C

**5h.** Evaluates care and services developed to support psychological wellbeing in terms of patient outcomes and the effectiveness of service delivery

A B C

**6c.** Has an awareness of legal frameworks governing cancer and work, such as the Equality Act

A B C

**6s.** Works with other agencies and services to ensure that cancer, late effects and survivorship is fully integrated into the care plans of individuals with new and pre-existing mental health illness

A B C

**7s.** Makes appropriate interventions to reduce the potential for individuals to be inappropriately disadvantaged at work by the consequences of cancer and its treatment

A B C

# Competency Development Tool

Having reflected on the assessment framework - DOMAIN 4: PSYCHOSOCIAL WELLBEING I have identified:

- the competencies I require in my current practice
- the competencies I possess currently
- the competencies I am working on and have listed these below

Name: \_\_\_\_\_ Date of initial assessment: \_\_\_\_/\_\_\_\_/\_\_\_\_

Domain	Competency no.	Date identified	Target date	Date achieved
Area for development (e.g. what do I need to achieve and why?) NB: where applicable, demonstrate links to appraisal and PDR objectives	Development Action (e.g. what CPD do I need? How will I achieve this?)	Evidence of meeting the competency (e.g. How do I know this has been achieved?)		
Domain	Competency no.	Date identified	Target date	Date achieved
Area for development (e.g. what do I need to achieve and why?) NB: where applicable, demonstrate links to appraisal and PDR objectives.	Development Action (e.g. what CPD do I need? How will I achieve this?)	Evidence of meeting the competency (e.g. How do I know this has been achieved?)		

Domain	Competency no.	Date identified	Target date	Date achieved
Area for development (e.g. what do I need to achieve and why?) NB: where applicable, demonstrate links to appraisal and PDR objectives	Development Action (e.g. what CPD do I need? How will I achieve this?)	Evidence of meeting the competency (e.g. How do I know this has been achieved?)		
Your reflections and evidence from this domain, to support your ongoing development, including areas of strength identified:				

## 6.5. Domain 5: Promoting health among high-risk individuals living with and affected by cancer

High-risk patients are those who require close monitoring and complex care plans for a variety of reasons. They include patients who:

- have a high risk of developing late effects complications and require close surveillance;
- require complex physical care/interventions due to their cancer and its previous treatment (or co-morbidities);
- are finding it difficult to adapt psychologically or socially following their cancer and its treatment; and/or are vulnerable or hard to reach and may not attend for monitoring and surveillance or use the services provided.

Core	Specialised	Highly specialised
A = competency relevant to role	B = competency demonstrated	C = evidence recorded
<p><b>1c.</b> Understands factors that can increase individuals' needs for support and services e.g. physical effects of cancer treatment, difficulty coping, mental health concerns, isolation, frailty, drug and alcohol misuse</p> <p>A B C</p>	<p><b>1s.</b> Has a comprehensive knowledge of the range of factors that can result in individuals requiring complex care plans and/or close monitoring for people living with and affected by cancer</p> <p>A B C</p>	<p><b>1h.</b> Acts as an expert resource for other staff and services when dealing with complex and challenging issues in delivering care for high-risk individuals living with and affected by cancer</p> <p>A B C</p>
<p><b>2c.</b> Has an awareness of factors that can influence whether individuals or groups are likely to use services</p> <p>A B C</p>	<p><b>2s.</b> Has an understanding of models and concepts relating to health-related behaviour change and their application to high-risk individuals and groups</p> <p>A B C</p>	<p><b>2h.</b> Collaborates with individuals, agencies, networks and communities to promote health and wellbeing and access to services among high-risk individuals living with and affected by cancer</p> <p>A B C</p>
<p><b>3c.</b> Has an understanding of factors that influence health and wellbeing among groups and individuals with high levels of needs</p> <p>A B C</p>	<p><b>3s.</b> Works with high-risk individuals to identify obstacles to their health and wellbeing to develop appropriate interventions and care plans</p> <p>A B C</p>	<p><b>3h.</b> Has an indepth knowledge of key concepts associated with health and health promotion and their application to high-risk individuals and groups.*</p> <p>A B C</p>

<p><b>4c.</b> Assists families in supporting high-risk individuals living with and affected by cancer</p> <p>A B C</p>	<p><b>4s.</b> Communicates effectively with local agencies and service providers to ensure individuals with high-risk needs have access to appropriate services and support</p> <p>A B C</p>	<p><b>4h.</b> Leads in evaluating services to ensure that they meet the needs of high-risk individuals/groups and are evidence based</p> <p>A B C</p>
<p><b>5c.</b> Directs individuals and family members to appropriate agencies and information sources that support high-risk individuals within cancer, survivorship and late effects services e.g. voluntary agencies, health promotion services and support groups</p> <p>A B C</p>	<p><b>5s.</b> Contributes to the development of systems of data collection and monitoring to identify patients with increased needs for services and their access to and use of services</p> <p>A B C</p>	<p><b>5h.</b> Works with others to involve high-risk individuals/groups in the development and evaluation of services for people living with and affected by cancer</p> <p>A B C</p>
<p><b>6c.</b> Encourages and enables high-risk individuals to take part in initiatives to review and develop services for people living with and affected by cancer</p> <p>A B C</p>	<p><b>6s.</b> Works with high-risk individuals to promote their inclusion in the development and review of services</p> <p>A B C</p>	<p><b>6h.</b> Plays a leading role in developing data collection systems for identifying and monitoring high-risk individuals and the factors that influence their access to and use of services</p> <p>A B C</p>

### \*Key concepts associated with health and health promotion

- i. social constructions of health and illness, their effect on perceptions and beliefs
- ii. models of behaviour change; health promotion strategies
- iii. inequality and discrimination and their impact on health and wellbeing.



## 6.6. Domain 6: Multi-disciplinary, interagency and partnership working

Core	Specialised	Highly specialised
A = competency relevant to role	B = competency demonstrated	C = evidence recorded
<p><b>1c.</b> Liaises between service users, relatives and other members of the multi-disciplinary team (MDT) involved in an individual patient's care pathway to optimise care</p> <p>A B C</p>	<p><b>1s.</b> Uses communication and coaching skills to encourage individual patients and their family to be involved in consultations with the MDT and the wider range of care and service providers</p> <p>A B C</p>	<p><b>1h.</b> Coordinates interventions for individuals with complex care needs after cancer and cancer treatment, working with the MDT and health, social care and voluntary sector agencies</p> <p>A B C</p>
<p><b>2c.</b> Makes appropriate referrals to other members of the MDT involved in late effects services</p> <p>A B C</p>	<p><b>2s.</b> Coordinates MDT interventions relating to a patient's care plan e.g. ongoing care, discharge and surveillance community care plans</p> <p>A B C</p>	<p><b>2h.</b> Provides expert advice to other members of the MDT and health, social care and voluntary sector agencies</p> <p>A B C</p>
<p><b>3c.</b> Liaises with HCPs and services to facilitate care across care pathways</p> <p>A B C</p>	<p><b>3s.</b> Works with health, social care and voluntary sector agencies to ensure coordinated care that meets current and anticipated future needs of individuals e.g. employment, financial, educational, late effects</p> <p>A B C</p>	<p><b>3h.</b> Plays a leading role in developing MDT operational policy and activities of the MDT meeting</p> <p>A B C</p>

<p><b>4c.</b> Understands the contributions of health, social care and voluntary sector services in meeting holistic care needs (e.g. financial, vocational, practical and emotional support)</p> <p>A B C</p>	<p><b>4s.</b> Actively contributes to the development of services in the MDT</p> <p>A B C</p>	<p><b>4h.</b> Builds partnerships with the health, social care, voluntary and independent sectors to promote engagement with cancer services and late effects care</p> <p>A B C</p>
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A B C      A B C      A B C

<p><b>5s.</b> As a core member, presents patients at MDT meetings</p> <p>A B C</p>	<p><b>5h.</b> Plays a leading role in local, network and national audits of late effects and cancer services</p> <p>A B C</p>
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A B C      A B C

# Competency Development Tool

Having reflected on the assessment framework - DOMAIN 6: MULTI-DISCIPLINARY, INTERAGENCY AND PARTNERSHIP WORKING, I have identified:

- the competencies I require in my current practice
- the competencies I possess currently
- the competencies I am working on and have listed these below

Name: \_\_\_\_\_ Date of initial assessment: \_\_\_\_/\_\_\_\_/\_\_\_\_

Domain	Competency no.	Date identified	Target date	Date achieved
Area for development (e.g. what do I need to achieve and why?) NB: where applicable, demonstrate links to appraisal and PDR objectives	Development Action (e.g. what CPD do I need? How will I achieve this?)	Evidence of meeting the competency (e.g. How do I know this has been achieved?)		
Domain	Competency no.	Date identified	Target date	Date achieved
Area for development (e.g. what do I need to achieve and why?) NB: where applicable, demonstrate links to appraisal and PDR objectives	Development Action (e.g. what CPD do I need? How will I achieve this?)	Evidence of meeting the competency (e.g. How do I know this has been achieved?)		

Domain	Competency no.	Date identified	Target date	Date achieved
Area for development (e.g. what do I need to achieve and why?) NB: where applicable, demonstrate links to appraisal and PDR objectives	Development Action (e.g. what CPD do I need? How will I achieve this?)	Evidence of meeting the competency (e.g. How do I know this has been achieved?)		
Your reflections and evidence from this domain, to support your ongoing development, including areas of strength identified:				

## 6.7. Domain 7: Professional practice and leadership

Core	Specialised	Highly specialised
A = competency relevant to role	B = competency demonstrated	C = evidence recorded
<p><b>1c.</b> Collects data required for service evaluations, audits or research in services for people living with and affected by cancer</p> <p>A B C</p>	<p><b>1s.</b> Carries out service evaluations and audits of key aspects of own and shared practice e.g. patient satisfaction, local service standards</p> <p>A B C</p>	<p><b>1h.</b> Initiates, leads and guides investigation and review of services and subjects relating to people living with and affected by cancer</p> <p>A B C</p>
<p><b>2c.</b> Understands the ethical and legal issues around data collection and information handling, including confidentiality and consent</p> <p>A B C</p>	<p><b>2s.</b> Contributes to the development and completion of peer review, service review, audits and research within local services</p> <p>A B C</p>	<p><b>2h.</b> Presents and explains the findings of data using language and terminology appropriate to the intended audience (e.g. service users, MDTs, network meeting)</p> <p>A B C</p>
<p><b>3c.</b> Demonstrates an understanding of the principles of clinical research, and can explain to service users common terms and concepts (e.g. placebo, randomisation, informed consent)</p> <p>A B C</p>	<p><b>3s.</b> Applies principles of ethical practice in relation to research, audit and service evaluation (e.g. working within local governance systems, informed consent, confidentiality)</p> <p>A B C</p>	<p><b>3h.</b> Develops systems for measuring outcomes for individuals, groups and services that enable accurate and meaningful reviews of progress and services</p> <p>A B C</p>

**4c.** Accesses appropriate sources of evidence to support their practice e.g. nursing journals, literature reviews, research articles

A B C

**4s.** Actively involves patients and carers in designing and evaluating research, audit and service evaluation projects

A B C

**4h.** Ensures that systems are in place to guarantee that project design and data management and dissemination meet ethical practice standards

A B C

**5s.** Writes for publication/presents at conferences on own specialty

A B C

**5h.** Writes for publication in peer-reviewed journals/presents at conferences on own projects

A B C

**6h.** Develops relationships with other agencies to promote research and enterprise partnerships services for people living with and affected by cancer

A B C

# Competency Development Tool

Having reflected on the assessment framework - DOMAIN 7: PROFESSIONAL PRACTICE AND LEADERSHIP, I have identified:

- the competencies I require in my current practice
- the competencies I possess currently
- the competencies I am working on and have listed these below

Name: \_\_\_\_\_ Date of initial assessment: \_\_\_\_/\_\_\_\_/\_\_\_\_

Domain	Competency no.	Date identified	Target date	Date achieved
Area for development (e.g. what do I need to achieve and why?) NB: where applicable, demonstrate links to appraisal and PDR objectives				
Development Action (e.g. what CPD do I need? How will I achieve this?)		Evidence of meeting the competency (e.g. How do I know this has been achieved?)		
Domain	Competency no.	Date identified	Target date	Date achieved
Area for development (e.g. what do I need to achieve and why?) NB: where applicable, demonstrate links to appraisal and PDR objectives				
Development Action (e.g. what CPD do I need? How will I achieve this?)		Evidence of meeting the competency (e.g. How do I know this has been achieved?)		

Domain	Competency no.	Date identified	Target date	Date achieved
Area for development (e.g. what do I need to achieve and why?) NB: where applicable, demonstrate links to appraisal and PDR objectives		Development Action (e.g. what CPD do I need? How will I achieve this?)		Evidence of meeting the competency (e.g. How do I know this has been achieved?)
Your reflections and evidence from this domain, to support your ongoing development, including areas of strength identified:				



Claire Taylor,  
Macmillan Nurse Consultant

## Appendix 1: Reflective account

A reflective account of using the MCFN from Claire Taylor, Macmillan Nurse Consultant, Colorectal Cancer:

### Is your role predominantly clinical, leadership, research or education?

My role is a mix of all. I spend at least 50% of my time in clinical practice with teaching and research activity taking up the other 50% and within all these activities I am working in a leadership role

We would be grateful to hear your reflections on the Macmillan Competency Framework for Nurses and how it might support your work in your practice area. Please consider the following areas (where applicable):

- Appraisals, and NMC revalidation (if applicable)

I think it could be a very useful tool for all cancer nurses in the revalidation process.

- Your professional development

The Macmillan Competence Framework for nurses (MCFN) offers a great way to look at your development priorities.

- Your career development

I have been a Nurse Consultant (NC) for 2.5 years and I have used the MCFN intermittently over this time (whilst it has been in development) as a 'career check' i.e. it makes sense of where I am at and where I am heading next.

It helped demarcate the breadth of the role and gave me new language with which to describe to others what it is that I do which is different from a CNS role. When you are the only one working at this 'highly specialist' level and operating without any clear national guidance on the NC role then this is important.

I believe the MCFN does clearly articulate what a 'highly' specialised nurse can offer in addition to specialised competencies.

I realised at the start of this new post that my competencies were stronger in education and service development than I had appreciated. By contrast some strategic aspects of my work required further attention, which I may not have thought about otherwise.

In the first six months in this post, I found the descriptors within the highly specialised domains 1 and 2 particularly useful to refer to in determining what I 'should' be aiming to do within this more senior nursing role e.g. working with local agencies to develop pathways and clinical guidelines. I think these indicators demarcated what opportunities I could get involved with and this motivated me to engage with a range of different agencies and partnership activities. I am now more established in my post, and having re-read the MCFN it has made me aware that role has developed further within Domain 7 with more time spent working on research in multi professional groups with a more certain rationale to my involvement.

- Team development

The 3 levels with the framework are easy to understand and help distinguish educational needs when teaching nurses we support within the hospital and community who have little experience of working with people with cancer with specialised nurses who have greater competencies in cancer care

- Recruitment and job description development

Many of the Job Descriptions I see have a very traditional template and are constrained by Trust headings. The MCFN offers a broader conceptualisation of cancer nursing roles that is refreshing and inspiring.

It shows the difference in knowledge, skills and activities transition from the essential to the highly specialised. This is useful to me as a manager in monitoring performance. We shall also be using the competencies within this document when recruiting staff to development posts so they have clear competencies about what they will be expected to achieve to attain a Band 7 CNS post.

- Development and evaluation of nurse roles

The competencies helped me to think about good monitoring and recording systems, not just to ensure we provide the right support to those who might be at high risk of ill-health but also to enable us to evaluate outcomes.

- Developing and/or commissioning clinical services

I haven't applied the MCFN to this role yet however the MCFN offers a novel way of conceptualising care and capturing how specialist services may be cost-effective in the longer-term.

- Developing nurse education interventions

The MCFN has stimulated my thinking on what interventions we need to consider at key transitions in people's care. By this I mean ensuring we remain orientated to nursing interventions which this document does very well through its focus on holistic needs, self-care strategies and consequences of treatment. In supporting people along a cancer pathway, it is easy to get caught up in administrative tasks that take CNSs from these essential nursing activities. This document is a good reminder of what it is that a nurse brings to the table, and their unique contribution to the MDT team.

- Please include any other reflections that you have on the use of the Macmillan Competency Framework for Nurses:

I look forward to being able to reference this document in future publications and presentations.

## Appendix 2: How these competencies were derived

The foundation work from which these competencies were derived involved a two-part process. First, a workforce readiness steering committee, via (and during) the National Cancer Survivorship Initiative (NCSI), developed a structured training needs analysis. This part of the project used evidence from the literature and clinical practice, alongside the perspectives of patients and clinical experts, to identify the scope of patient's care needs. This provided the foundation for the initial areas of competencies.

Second, in 2011 a workforce survey of nurses and AHPs in England and Wales was conducted to scope the readiness of the existing health workforce to manage the growing healthcare needs of cancer patients requiring long-term follow-up (21, 22). The data were collected by e-surveys targeted at healthcare professionals working directly with cancer patients or supporting cancer patients in both oncology and community care. Web links were disseminated through the Queens Nursing Institute, UK Cancer Network and professional bodies. The primary focus of the questionnaire was to establish which services were provided after cancer treatment had been completed, the symptoms and concerns that were commonly addressed, and the skills and confidence of nurses and AHPs in meeting the care needs of this group of patients.

From this detailed report (21), a competency framework team was convened and detailed competencies were written using the case management competencies framework for the care of people with long-term conditions (18) (see 'The underpinning principles of the competency framework'). The draft framework went through an iterative process with the project team and was further reviewed by members of the Macmillan Consequences of Cancer Treatment Collaborative (CCaT) before being submitted for the next stage of the process: stakeholder evaluation. Detailed feedback was sought through a national stakeholder evaluation event for cancer nurses convened through both United Kingdom Oncology Nursing Society and Macmillan Professionals.

Service users' opinions and feedback were sought through Macmillan Cancer Voices, and feedback from senior clinicians and management was sought via an e-survey cascaded through members of the NCSI consequences of treatment workstream.

The second edition involved streamlining the competencies and entire document and aligning it as closely as possible with The Macmillan AHP Competence Framework. A further "how to" section was developed by the Macmillan L&D team to promote uptake, implementation and, ultimately, impact.

### Funding and Support

The foundation work (21,22) from which this competence project is derived, was originally commissioned as part of a programme of work by the National Cancer Survivorship Initiative's Consequences of Cancer work-stream, funded by the Department of Health in partnership with NHS Improvement and Macmillan Cancer Support. Developing the competence framework was supported by the Consequences of Cancer Treatment Collaborative (CCaT). The Stakeholder evaluation event held for the first edition and processes were supported by both CCaT and Macmillan Cancer Support.

For the first edition, this work was coordinated at Sheffield Teaching Hospitals NHS Foundation Trust, in partnership with the University of Surrey, and supported by CCaT. For the second edition this work was coordinated at Sheffield Teaching Hospitals NHS Foundation Trust, in partnership with Macmillan Cancer Support's Learning and Development team, and supported by CCaT. Funding for the second edition was provided by Macmillan Cancer Support UKO.

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## Support for CPD:

Learning opportunities with Macmillan Cancer Support are varied and flexible, constantly improving, changing and modifying. Readers are encouraged to log onto the main Macmillan website and Learnzone to access current opportunities. <http://learnzone.org.uk/>

## Relevant reading

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## Feedback

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We're here to help everyone with cancer live life as fully as they can, providing physical, financial and emotional support.

So whatever cancer throws your way, we're right there with you.

For information, support or just someone to talk to, call 0808 808 00 00 or visit [macmillan.org.uk](https://www.macmillan.org.uk).