Livewell Southwest

Competency Guidance and Template

Version No.1.3

Review: September 2018

Notice to staff using a paper copy of this guidance

The policies and procedures page of Intranet holds the most recent version of this guidance. Staff must ensure they are using the most recent guidance.

Author: **Competency Ratification Group (CRG)**

Asset Number: **894**

Reader Information

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Document review history

Version No.	Type of change	Date	Originator of change	Description of change
0.1	New document	May 2015	Professional Lead	New Guidance
1	Ratified	July 2015	Policy Ratification Group	Ratified minor amends.
1.1	Amendment	January 2016	Professional Lead	New appendix C
1.2	Amendment	August 2016	Professional Lead	Addition of paragraph on importance of ensuring competency evidence based.
1.3	Amendment	November 2016	Professional Lead	Revised appendix C

Competency Guidance and Template

1. Introduction

The NHS constitution DOH 2010 – section 2a) states “YOU (the public) have the right to be treated with a professional standard of care, by appropriately qualified and experienced staff, in a properly approved or registered organisation that meets required levels of safety and quality”.

Livewell Southwest (LSW) is committed to ensuring that all directly employed staff have the appropriate knowledge and skills required for their role.

Clinical practice is a combination of theoretical and practical knowledge and competencies should identify the skills, knowledge and attitudes needed to perform in a particular clinical setting. Clinical competencies will be created to support the delivery of high quality care and to enable the development of new and distinct roles which cross traditional boundaries.

Following on from the Francis report sessions in Livewell Southwest, a clear message was given by staff that they needed support of the Organisation to maintain and achieve high standards of patient care. One such theme was support in achieving and maintaining competency levels of staff.

The quality and effectiveness of service provision depends upon the ability of staff to deliver interventions, and of their managers to support them. A competent member of staff consistently applies relevant knowledge and skills to meet the standards of performance required.

Competent staff members therefore benefit an organisation by supporting it to achieve its aim of delivering effective interventions and by allowing the organisation to be assured of the quality of its services. There are benefits for staff themselves as working within national occupational standards means that they can clearly understand what the expected levels of performance are in their own and other organisations in the sector. They will therefore be able to demonstrate to current and future employers that they are competent.

This document provides the expected standards and format Livewell Southwest authors follow when preparing and reviewing competencies for LSW approval.

2 Purpose

2.1 The purpose of this guidance is to provide staff with a framework for producing competencies that conform to professional guidelines, evidenced based practice and LSW standards and branding guidelines.

2.2 This Policy also gives information on how these competencies will be recorded, received and acted upon.

3 Definitions

3.1 The **Competency Ratification Group** (CRG) is a multi-professional group of clinical and non clinical leads or managers. It is a subcommittee of the Safety, Quality and Performance Committee and established to assure the quality and standardisation of LSW competencies.

3.2 A **competency can be defined as:** "The state of having the knowledge, judgement, skills and experience to respond adequately and appropriately to the demands of one's professional responsibilities".

Competencies describe what staff must know or do to enable them to work in their designated employed role. There should be only one competency for a particular task – there should not be, for example, separate nursing and physiotherapy competencies which relate to the same procedure.

3.3 A **procedure** describes how something should be done. Usually, but not always, a procedure supports a competency. Its length may vary, but it must be operational and written for the staff that are to implement it. There are two types of procedure:

a) A **protocol** is the mandatory way of undertaking a task, and must be followed.

b) A **guideline** is an indication of the course that is usually followed, unless there are good reasons for not doing so. The rational of which should be recorded appropriately.

4 Duties & Responsibilities

4.1 The **Chief Executive** is ultimately responsible for the content of all competencies, implementation and review.

4.2 Only the **LSW Board** or its **sub-committees** with delegated powers can approve new documents. The CRG is one such sub-committee.

4.3 **Professional Leads** working in conjunction with clinical and professional groups are responsible for developing competencies.

4.4 **Locality Managers and Deputies** are responsible for implementing LSW competencies relevant to their area however they should work in conjunction with clinical and professional groups and leads to develop and implement competencies.

4.5 Competencies **authors** (by job title) are responsible for designing, drafting and developing competencies in accordance with this competency guidance, ensuring that draft competencies are circulated for appropriate consultation, and their implementation. Authors should ensure that competencies align with relevant standards, clinical / NICE guidelines, policies, professional codes, standard operating procedures.

The author is also responsible for conducting a full review of the competency either on a one yearly, two yearly or three yearly basis dependent upon the author's own risk assessment. Please note that minor changes can be made to the competency before its full review date by completing the minor changes which should be forwarded to CRG.

4.6 The **CRG Secretary** has responsibility for ensuring that the process set out in Appendix A is followed and for maintaining the database and prompting for review.

4.7 **Line Managers** are responsible for ensuring that all competencies, new competencies and changes to competencies are communicated to, understood and followed by staff, including any identified training needs.

4.8 **All staff member** are responsible for completing competencies ascribed to their role and working in conjunction with the Assessor and Line Manager and reviewing their competencies at Line Management and Supervision.

4.9 **Assessors** are responsible for working with staff to formally assess their competence against the agreed competencies for their role. Provide advice and support to staff, provide additional support to staff who have difficulty achieving competence, provide line managers with up to date information on progress.

5 Competency development

5.1 The competency template can be found in **Appendix C**. Blank templates can be downloaded from the intranet or by contacting the CRG secretary.

5.2 Documentation and templates to facilitate the development of new competencies can be found in the Appendices of this document.

5.3 Professional body competencies will support the professional requirements and Code of Conduct for each Regulatory body, if applicable, as well as LSW Policies and procedures.

5.4 Competencies should:

- Use action word and phrases.
- Use Arial font 12.
- Include page numbers.
- Acronyms should be defined on first use.
- Abbreviations should be limited.
- Use language appropriate to the task.
- Be concise, specific and functional.
- Be easily understood by the target audience.
- Be developed with full involvement of relevant staff, user and involvement groups.
- Define training implications.
- Make reference to other relevant documents. For example standards, clinical / NICE guidelines, policies, professional codes, standard operating procedures as appropriate to ensure the competency is underpinned with supporting evidence.
- Be compatible with equality legislation

5.5 Some competencies may be adapted or adopted for use for example: National Stroke Competencies.

6. Monitoring compliance

6.1 The CRG is charged with ensuring that all documents it approves and ratifies follow this guidance.

6.2 Where there are interagency documents, the lead agency is responsible for formatting, distribution and archiving. Wherever possible, each interagency document must have a relevant member of LSW staff on its working group to ensure that appropriate consultation at the development stage is achieved.

All Policies are required to be electronically signed by the Lead Director. Proof of the electronic signature is stored in the competencies database.

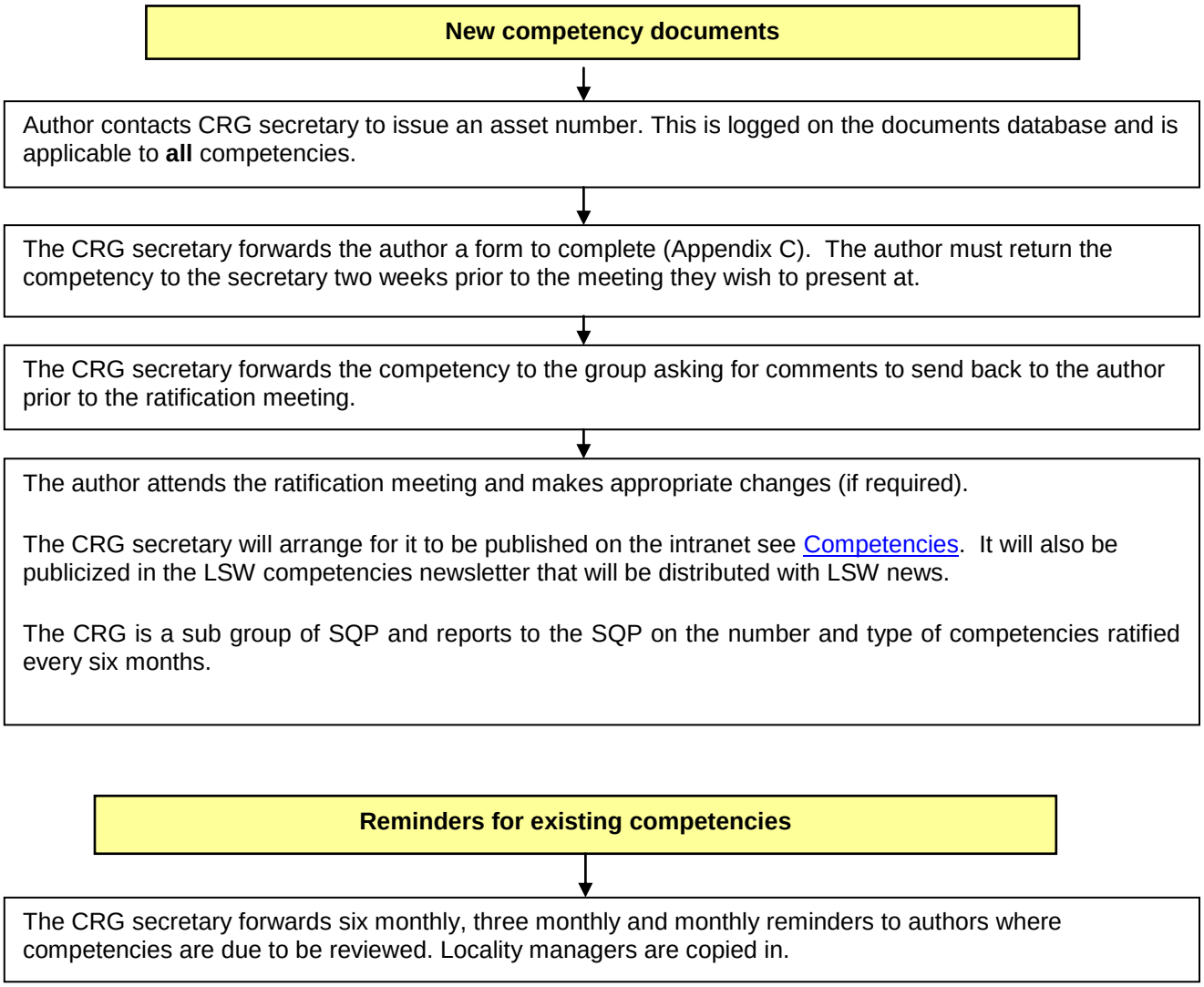
The Lead Director approves this document and any attached appendices. For operational competencies this will be the Locality Manager.

The Executive signature is subject to the understanding that the competency owner has followed the organisation process for competency Ratification

Signed: Director of Professional Practice Safety and Quality

Date: 17 September 2015

Appendix A Process flowchart for the ratification of competencies



Appendix B Competency completion guidelines

Registered Staff

All registered staff **new to LSW** will be formally assessed, deemed competent and signed off for each competency relevant to their role, by a competent registered practitioner within 6 months.

Existing registered members of staff should in the first instance self-assess their competencies relevant to their role. Formal review of competencies timelines should be discussed and agreed with the line manager but should not be outside of the timescale recommended for each individual competency. Completed competencies should then be stored in the staff members staff management file, personal portfolio and recorded on ESR.

Non-registered staff

All non-registered staff will need to be formally assessed, deemed competent and signed off for each competency by a competent registered practitioner. Non-registered staff should agree with their manager competencies to be completed depending on current role. Completed competencies should then be stored in the staff member's personal file and copied to be entered into their personal portfolio.

All competency reviews should be undertaken **annually**. This includes self-assessment for registered staff and reassessment of non-registered staff, to establish that their competency has been sustained and the competency document completed accordingly. **Every 3 years** all staff should provide evidence of formal assessment for each individual competency at appraisal.

This could include:

- attending a study/training session
- e learning
- relevant research for an assignment / project/link meeting
- working with a specialist or the education team

Evidence should include how knowledge was updated and sustained/ enhanced your competency/practice.

Record of competencies to be kept in staff personal files and as evidence for IPRs and a copy stored in individuals Professional Portfolio.

Appendix C. Competency document template

Please open link:-

Competency Document Template

Appendix D

Form: Rationale for developing a new Competency

Form to be completed with name and designation:	
Document number and title of competency (if known).	
Reasons/rationale for competency to be written	☐ Department of Health guidelines ☐ Meet legislative requirements ☐ Local management issue ☐ Risk management ☐ New clinical evidence ☐ Other - please advise:
Signature of named Designator:	
Date.	

This section to be completed by the Competency Ratification Group	
Are the rationale/reasons for developing this competency acceptable to the CRG? Yes/No. If no, reasons to be recorded	
Date	

Note:
The outcome of the decision will be fed back as soon as practicable after the CRG meeting by the CRG secretary. If the decision is in dispute it can be taken up with the CRG Chair.

Appendix E

Form: Declaration of either no changes or minor changes to

Please email this completed form to the Competency Ratification Group (CRG)

Form to be completed by the person undertaking the competency review	
Document number.	
Title of competency.	
Does this document require any minor[1] changes Yes/No?	
Consultation: Have you involved key stakeholders? Yes/No. If yes, please list who you have consulted with to discuss minor/no change(s). If you have not involved key stakeholders please explain why.	
Name of Professional Lead and confirmation of how they have been informed regarding the completion of declaration e.g. email, meeting etc. and the date it took place.	
If applicable, please provide a brief overview of the minor changes required.	
Name & title of person undertaking the review.	
Date.	

secretary with the updated competency before the review date. The CRG secretary will ensure that the competency follows the correct format and layout.

[1] A minor change will have very little impact/risk on staff, patients and/or the public e.g. the change will not affect practice.

Appendix F

Form: Removal of competencies from the intranet

To be completed by the Competency Ratification Group (CRG) Secretary	
Document number, author and title of competency.	
Reasons for the removal of this competency.	
Has the removal of this competency been agreed by the Professional Lead? Insert the name and date when this was agreed.	
Date discussed/emailed to CRG.	
Date removed from intranet.	

The CRG secretary will notify parties of its removal and will contact the Communications Department to include the competency removal in LSW's staff news bulletin.