Competency Framework for Primary Care Network Nurses and Primary Care Coordinators

CONTENTS

FOREWORD

In the rapidly evolving landscape of primary care and with the launch of Healthier SG in July 2023, the roles of nurses and primary care coordinators (PCCs) are pivotal in delivering holistic and coordinated person-centred services.

The Nursing Committee was set up under the Primary Care Network (PCN) Council to develop a competency framework to support the continuous professional development of nurses and PCCs employed under PCNs and ensure they are well-prepared to meet the diverse needs of patients in the primary care setting.

The competency framework not only sets the foundation for high-quality patient care but also promotes team-based care and professional growth. It may be reviewed and revised as and when necessary, in response to developments in the primary care landscape. PCNs are encouraged to utilise the framework as a reference and adapt to ensure relevance in their settings.

We extend our gratitude to all the healthcare professionals and supporting stakeholders who contributed to the creation of this competency framework and hope that it will be beneficial for the users.

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INTRODUCTION

A PCN refers to a virtual network of General Practitioners (GPs) supported by nurses and PCCs, that adopts a team-based care model approach to patient care.

Under the PCN scheme, patients receive holistic care through a multi-disciplinary team for more effective health promotion and management of their chronic conditions.

The **Competency Framework for PCN Nurses and PCCs** (hereby known as **Competency Framework for PCN**) was developed to articulate the *specific and unique roles, responsibilities, and competencies* of PCN nurses and PCCs, as an add-on to supplement the general competencies mapped out in the Community Nursing Competency Framework **(CNCF)** published by the Ministry of Health (MOH) in 2019.

The **CNCF**, originally developed for nurses in various care settings outside of acute care, including primary care, outlines the general competencies of a PCN nurse or PCC.

The **Competency Framework for PCN** is *not a standalone document* and *should be read together with the **CNCF***.

You may download a copy of the **CNCF** by scanning the QR code below.

PURPOSE

The **Competency Framework for PCN** functions as a guide to provide clarity on the roles and responsibilities for nurses and PCCs working under various models of PCN, namely GP-led PCNs, GP-RHS/Polyclinic-led PCNs and large group PCNs.

It serves to *map out the standards required* for PCN nurses and PCCs across the listed key competency elements that are highly relevant to them.

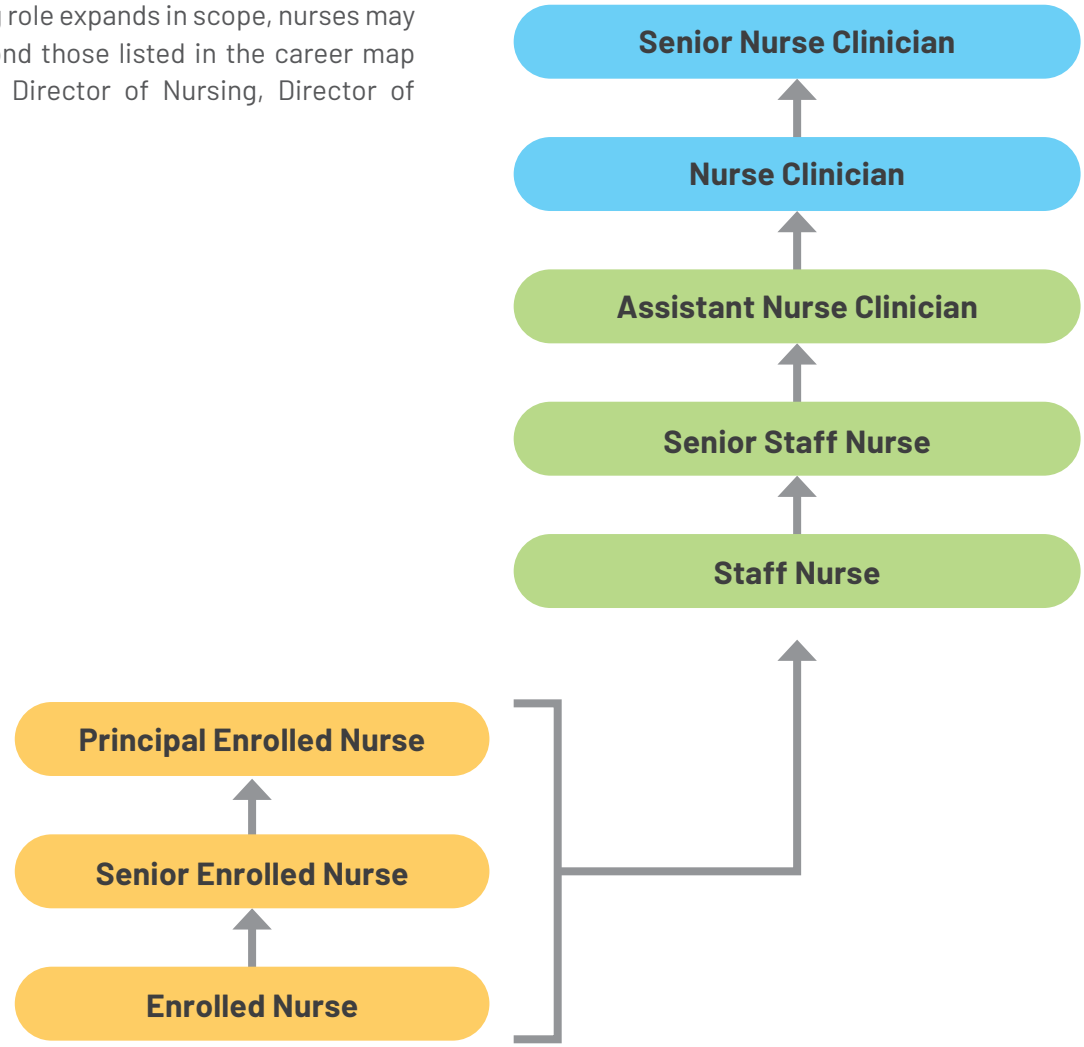
Read in conjunction with the **CNCF**, this framework provides a platform for PCN nurses and PCCs to understand their competencies in terms of requisite knowledge and abilities.

It supports PCN nurses and PCCs in their professional developmental needs by serving as an *objective tool to identify their competency gaps* and *provide guidance on the required training and education* to bridge the identified gaps.

The **Competency Framework for PCN** also comprises *Job Role Profiles (JRPs)* to provide reference for PCNs designing Job Descriptions (JDs) for current staff and potential new hires.

CAREER MAP | Nurses

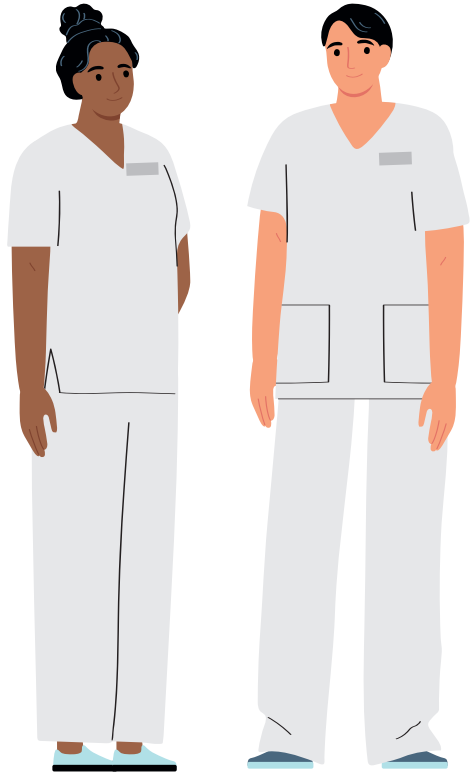
As the PCN landscape evolves and the nursing role expands in scope, nurses may take on more roles and responsibilities beyond those listed in the career map e.g., Assistant Director of Nursing, Deputy Director of Nursing, Director of Nursing and Advanced Practice Nurse (APN).

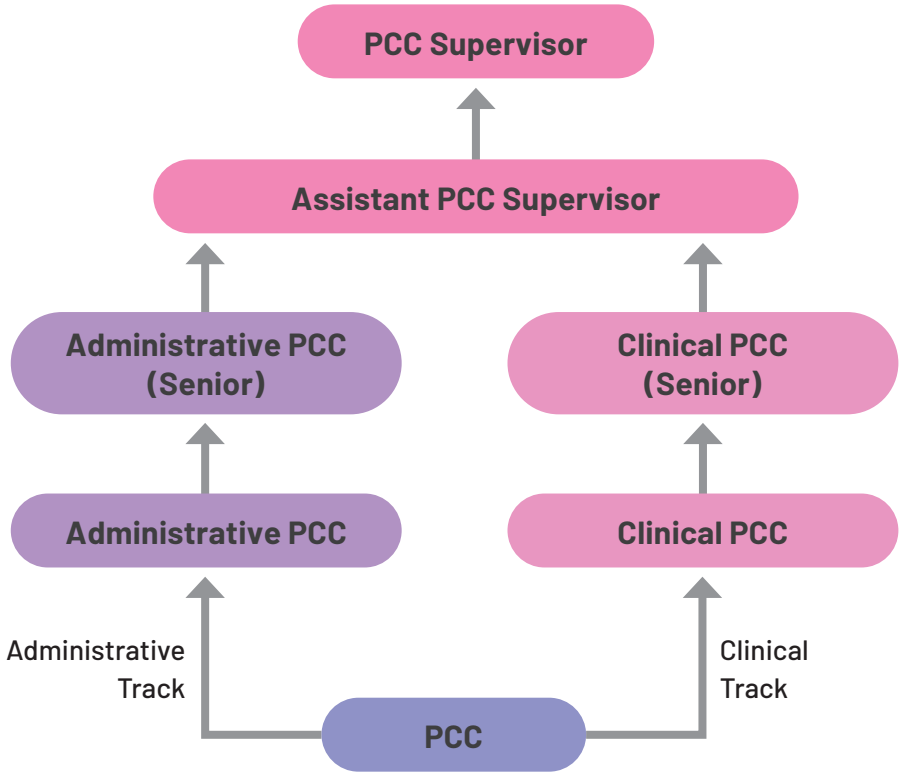


CAREER MAP | Primary Care Coordinators

The job role titles may be reviewed and adapted as necessary, in consideration of the unique context, culture and goals of each PCN.

PCCs from both administrative and clinical tracks may progress to take on roles of Assistant PCC Supervisor and PCC Supervisor. Having clinical support experience is not a pre-requisite but provides an added advantage for PCCs progressing to the advanced roles.





JOB ROLE PROFILES

7 groups of Job Role Profiles (JRPs) are provided to illustrate the possible roles of PCN nurses and PCCs.

For each JRP group, the Job Titles, Key Responsibility Areas (KRAs) and Key Activities are presented for reference, based on the relevant competencies from the **CNCF** & the **Competency Framework for PCN**.

Nursing Job Role Profile Group A

Job Title Examples: Enrolled Nurse / Senior Enrolled Nurse / Principal Enrolled Nurse

Nursing Job Role Profile Group B

Job Title Examples: Staff Nurse / Senior Staff Nurse / Assistant Nurse Clinician

Nursing Job Role Profile Group C

Job Title Examples: Nurse Clinician / Senior Nurse Clinician

PCC Job Role Profile Group A

Job Title Example: PCC

PCC Job Role Profile Group B

Job Title Examples: Administrative PCC / Administrative PCC (Senior)

PCC Job Role Profile Group C

Job Title Examples: Clinical PCC / Clinical PCC (Senior)

PCC Job Role Profile Group D

Job Title Examples: Assistant PCC Supervisor / PCC Supervisor

Note: JRPs are intended as general guidelines and may not be definitive or applicable to all organisations. These descriptions can be altered and customised to suit the specific needs and requirements of individual PCNs.

PROFICIENCY LEVEL MATRIX

The *Proficiency Level Matrix* on each JRP page describes the suggested proficiency levels for all the Professional Competencies in the **Competency Framework for PCN** and the **CNCF**.

An overview of the suggested proficiency levels for all job roles can be found on pages 24 and 25. A definition of proficiency levels can be found on page 27.

Note: While the matrix aims to provide a structured overview, it *should not be considered exhaustive or definitive* in assessing the capabilities of nurses in all contexts. Users are encouraged to exercise judgement when evaluating overall proficiency.

Nursing Job Role Profile Group A

Job Title Examples	**Enrolled Nurse / Senior Enrolled Nurse / Principal Enrolled Nurse**
Job Role Description	The Enrolled Nurse assists in helping patients achieve their health goals through delivery of basic patient education, supporting health promotion and screening activities. S/He supports the delivery of nursing interventions to manage patients' chronic conditions and empower them in managing their conditions. S/He participates in quality improvement activities. The Senior Enrolled Nurse / Principal Enrolled Nurse also supervises, teaches and assesses junior members of the team.

Key Responsibility Areas	Key Activities
Patient Care	• Assist in biopsychosocial assessment of patients contributing to formulation of individualised health plans • Support delivery of health plans to empower patients in self-management • Assist patients and/or caregivers in using home monitoring devices for blood pressure and glucose levels • Conduct screenings such as diabetic foot screening (DFS), diabetic retinal photography (DRP), and spirometry • Follow established escalation pathways in case of deteriorating symptoms or abnormal readings • **[Senior Enrolled Nurse / Principal Enrolled Nurse]** Involve in formulating person-centred health plans based on care needs
Patient Education and Health Promotion	• Provide basic patient education on chronic diseases • Provide information and guidance to patients on health promotion, screening and immunisation • Encourage and facilitate positive changes in patients' behaviours to promote health and prevent illness • Guide patients on accessing health educational resources • Educate patients on recognising red flags or warning signs, empowering them to take timely action or seek medical help when necessary
Communication and Team-Based Care	• Engage patients through active listening skills and shared agenda setting • Communicate and document assessments and interventions clearly and appropriately • Escalate when additional expertise or referral is necessary • Understand the roles of individuals within the PCN and communicate effectively • **[Senior Enrolled Nurse / Principal Enrolled Nurse]** Participate in engagements with GPs and clinic teams
Professional and Leadership Development	• Attend continuing professional development courses based on learning needs • Set personal development goals and plans for career progression • **[Principal Enrolled Nurse]** Provide supervision, teaching and assessment to junior staff

Key Responsibility Areas	Key Activities
Innovation and Quality Improvement	• Participate in quality improvement, evidence-based practice or research projects • Participate in quality assurance activities

Proficiency Level Matrix				
Source	**Competency Element / Domain**	**Suggested Proficiency Level^**		
		Enrolled Nurse	**Senior Enrolled Nurse**	**Principal Enrolled Nurse**
Competency Framework for PCN	E2.1. Chronic Disease Care Management	1	1	1
	E4.1. Patient and Caregiver Self-Management Support	1	2	2
	E6.1. Working with GPs and Clinic Teams	1	2	2
	E8.1. Health Promotion and Preventive Health	1	1	1
CNCF	E1. Client Assessment and Care Planning	1	1	2
	E2. Management of Individuals with Health Conditions	1	1	1
	E3. Medication Management	1	1	1
	E4. Client, Family and Caregiver Education and Empowerment	1	2	2
	E5. Care Transition Across Care Continuum	1	2	2
	E6. Communication, Collaboration and Teamwork	1	2	2
	E7. Client and Environment Safety and Risk Management	1	1	2
	E8. Population-based Practice	1	1	1
	E9. Develop and Lead Self	1	1	2
	E10. Develop and Lead Others	1	1	1
	E11. Innovation and Quality Improvement	1	2	2
	E12. Evidence-based Practice and Research	1	1	1

^ Refer to page 27 for 'Definition of Proficiency Levels'

Nursing Job Role Profile Group B

Job Title Examples	**Staff Nurse / Senior Staff Nurse / Assistant Nurse Clinician**
Job Role Description	The Staff Nurse assesses, plans and implements nursing interventions to manage patients' chronic conditions and to achieve their health goals. S/He empowers patients in self-management of their health. The Senior Staff Nurse / Assistant Nurse Clinician takes on more roles in quality improvement, planning of services and health promotion activities. The Senior Staff Nurse / Assistant Nurse Clinician also precepts junior nurses and contributes to continuing professional development activities.

Key Responsibility Areas	Key Activities
Patient Care	• Conduct comprehensive nursing assessments incorporating biological, psychological, and social factors • Assist patients in setting and achieving personalised health goals to manage chronic conditions effectively • Identify patient barriers to goal achievement and develop strategies to overcome identified gaps in the health plan • Deliver primary prevention interventions such as immunisation safely • Implement disease prevention activities such as screening, immunisations, and health promotion programmes • Evaluate nursing assessments and interventions to achieve planned health goals • **[Senior Staff Nurse / Assistant Nurse Clinician]** Assist to identify and implement frailty prevention strategies
Patient Education and Health Promotion	• Explain the development and progression of chronic diseases to patients • Educate patients on the proper administration of insulin and inhaled medications • Provide personalised lifestyle recommendations to patients based on assessment findings • Provide patients with tools and resources to enhance self-management skills
Communication and Team-Based Care	• Integrate motivational interviewing and behavioural change strategies to empower patients for self-management • Establish rapport with GPs and clinic teams through open communication and reliable follow-through on commitments • Participate in interdisciplinary team meetings and contribute valuable insights
Professional and Leadership Development	• Attend continuing professional development courses based on learning needs • Provide feedback to team members and promote a positive team learning culture • **[Senior Staff Nurse / Assistant Nurse Clinician]** Provide guidance, supervision and support to junior team members • **[Assistant Nurse Clinician]** Act as a team leader to anchor a shift or a service line at the clinic or PCN setting • **[Assistant Nurse Clinician]** Assist in the development and delivery of training programmes for junior team members

Key Responsibility Areas	Key Activities
Innovation and Quality Improvement	• Support quality audits to maintain and improve standards of care • Recommend initiatives and implement quality improvement, evidence-based practice or research projects • **[Assistant Nurse Clinician]** Facilitate quality audits within the organisation

Proficiency Level Matrix				
Source	**Competency Element / Domain**	**Suggested Proficiency Level^**		
		Staff Nurse	**Senior Staff Nurse**	**Assistant Nurse Clinician**
Competency Framework for PCN	E2.1. Chronic Disease Care Management	2	2	3
	E4.1. Patient and Caregiver Self-Management Support	2	2	3
	E6.1. Working with GPs and Clinic Teams	2	2	2
	E8.1. Health Promotion and Preventive Health	1	2	2
CNCF	E1. Client Assessment and Care Planning	2	3	3
	E2. Management of Individuals with Health Conditions	2	2	3
	E3. Medication Management	2	2	2
	E4. Client, Family and Caregiver Education and Empowerment	2	2	3
	E5. Care Transition Across Care Continuum	2	2	2
	E6. Communication, Collaboration and Teamwork	2	2	2
	E7. Client and Environment Safety and Risk Management	2	2	2
	E8. Population-based Practice	1	2	2
	E9. Develop and Lead Self	2	2	3
	E10. Develop and Lead Others	1	2	2
	E11. Innovation and Quality Improvement	2	2	2
	E12. Evidence-based Practice and Research	2	2	2

^ Refer to page 27 for 'Definition of Proficiency Levels'

Nursing Job Role Profile Group C

Job Title Examples	Nurse Clinician / Senior Nurse Clinician
Job Role Description	The Nurse Clinician plans and manages nursing care for patients with complex and specialised needs. S/He works closely with PCN leads to review and initiate effective team activities, shares best practices, supervises junior members of the team, and collaborates in developing health promotion and preventive services. S/He leads quality improvement initiatives, shares outcomes and drives changes and contributes to the development of service initiatives. The Senior Nurse Clinician proactively reviews, identifies and addresses care and service gaps. S/He advocates and develops innovative care interventions to meet the changing needs of individual patients and/or population groups. The Senior Nurse Clinician will engage the PCN Lead(s) to review and seek concurrence before implementation of care/service initiatives or interventions.

Key Responsibility Areas	Key Activities
Patient Care	• Provide comprehensive case management to patients with complex chronic conditions to achieve health goals • Evaluate nursing assessments and interventions to achieve planned health goals • Evaluate the effectiveness of health promotion activities, functional, and mental health recommendations • **[Senior Nurse Clinician]** Provide comprehensive case management to patients with complex chronic conditions and diverse care needs, coordinating multidisciplinary care and support services • **[Senior Nurse Clinician]** Critically analyse and integrate the latest research and guidelines into patient care practices to ensure evidence-based and up-to-date treatment approaches
Patient Education and Health Promotion	• Provide education and coaching on self-management strategies tailored to patient needs • Create targeted interventions to address identified barriers to goal achievement and track patient progress in overcoming barriers and achieving health goals
Communication and Team-Based Care	• Prepare presentations for interdisciplinary discussions and share information on patient care plans, progress, and outcomes with GPs • Offer coaching and support to junior staff in communication techniques • Observe and evaluate junior staff's communication interactions with GPs and clinic teams
Professional and Leadership Development	• Attend formal and informal continuing education and training based on learning and professional development needs • Identify and support the learning needs of individuals or the team in response to personal development needs or service needs • Lead the development and delivery of training programmes • Ensure working policies and practices reflect and remain aligned with latest evidence-based recommendations, guidelines & best practices • **[Senior Nurse Clinician]** Develop effective team systems for ongoing supervision and preceptorship • **[Senior Nurse Clinician]** Develop evidence-based guidelines and protocols for PCN nursing practice within the appropriate governance framework

Key Responsibility Areas	Key Activities
Innovation and Quality Improvement	• Lead quality audits, quality improvement and evidence-based projects • **[Senior Nurse Clinician]** Evaluate outcomes and develop outcome indicators for PCN nursing practice

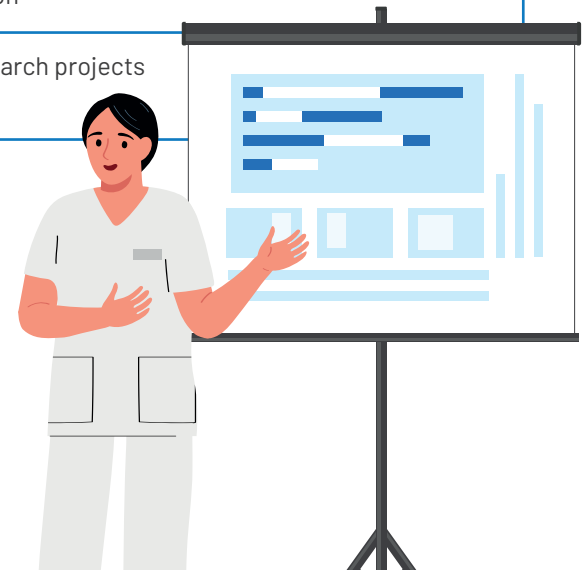
Proficiency Level Matrix			
Source	**Competency Element / Domain**	**Suggested Proficiency Level^**	
		Nurse Clinician	**Senior Nurse Clinician**
Competency Framework for PCN	E2.1. Chronic Disease Care Management	3	4
	E4.1. Patient and Caregiver Self-Management Support	3	3
	E6.1. Working with GPs and Clinic Teams	3	3
	E8.1. Health Promotion and Preventive Health	3	3
CNCF	E1. Client Assessment and Care Planning	3	4
	E2. Management of Individuals with Health Conditions	3	4
	E3. Medication Management	3	4
	E4. Client, Family and Caregiver Education and Empowerment	3	3
	E5. Care Transition Across Care Continuum	3	3
	E6. Communication, Collaboration and Teamwork	3	3
	E7. Client and Environment Safety and Risk Management	3	3
	E8. Population-based Practice	3	3
	E9. Develop and Lead Self	3	3
	E10. Develop and Lead Others	3	3
	E11. Innovation and Quality Improvement	3	3
	E12. Evidence-based Practice and Research	3	3

^ Refer to page 27 for 'Definition of Proficiency Levels'

PCC Job Role Profile Group A

Job Title Example	PCC
Job Role Description	The PCC executes essential administrative tasks to support patient care and facilitate smooth functioning of PCN services. S/He provides patients with information about community resources, subsidies, and schemes and coordinates PCN services and referrals. S/He also sets personal development goals and attends training courses for self-development and supports quality improvement activities.

Key Responsibility Areas	Key Activities
Patient Care and Care Coordination	• Provide information to patients regarding community programmes, services, available subsidies and schemes • Offer guidance and assistance to patients in accessing and navigating support services in the community • Coordinate and facilitate access to ancillary services and community programmes for patients based on care needs
Administrative Support	• Collate and organise required data • Participate in site visits to survey the clinic premises and ensure smooth operation of PCN services • Assist in conducting PCN briefings and with the onboarding process to newly enrolled clinics
Communication and Team-Based Care	• Ensure own work is within professional scope of practice and seek advice when appropriate • Recognise and understand the roles of individuals working within the PCN setting • Communicate effectively with stakeholders and work effectively within teams
Self-Development	• Attend continuing professional development courses based on learning needs • Set personal development goals and plans for career progression
Innovation and Quality Improvement	• Assist in quality improvement, evidence-based practice or research projects • Support quality assurance activities



Proficiency Level Matrix		
Source	Competency Element / Domain	Suggested Proficiency Level^
		PCC
Competency Framework for PCN	E2.1. Chronic Disease Care Management	–
	E4.1. Patient and Caregiver Self-Management Support	–
	E6.1. Working with GPs and Clinic Teams	1
	E8.1. Health Promotion and Preventive Health	–
	D5. Administration and Operations Support	1
CNCF	E1. Client Assessment and Care Planning	–
	E2. Management of Individuals with Health Conditions	–
	E3. Medication Management	–
	E4. Client, Family and Caregiver Education and Empowerment	–
	E5. Care Transition Across Care Continuum	1
	E6. Communication, Collaboration and Teamwork	1
	E7. Client and Environment Safety and Risk Management	–
	E8. Population-based Practice	–
	E9. Develop and Lead Self	–
	E10. Develop and Lead Others	–
	E11. Innovation and Quality Improvement	1
	E12. Evidence-based Practice and Research	–

^ Refer to page 27 for 'Definition of Proficiency Levels'

PCC Job Role Profile Group B

Job Title Examples	Administrative PCC / Administrative PCC (Senior)
Job Role Description	The Administrative PCC demonstrates a deeper understanding of community resources and referrals and is competent in data analysis and presentation. S/He engages in self-development to achieve personal development goals and participates in quality improvement and assurance activities. S/he also provides guidance and support to junior staff. The Administrative PCC (Senior) has advanced knowledge of data analytic and presentation tools, evaluates quality improvement and assurance activities and provides supervision to junior staff.

Key Responsibility Areas	Key Activities
Patient Care and Care Coordination	• Refer to Key Activities in PCC JRP Group A: Patient Care and Care Coordination • **[Administrative PCC (Senior)]** Provide tailored and relevant information to patients regarding community programmes, services, available subsidies and schemes • **[Administrative PCC (Senior)]** Determine patients' needs and offer guidance and assistance to them in accessing and navigating support services in the community
Administrative Support	• Collate and organise required data • Use data analytics tools to analyse and interpret data • Utilise visual aids to enhance presentation delivery • Organise site visits to recce the clinic premises and ensure smooth operation of PCN services • **[Administrative PCC (Senior)]** Present data in a structured and organised manner to convey data effectively • **[Administrative PCC (Senior)]** Conduct PCN briefings and facilitate the onboarding process to newly enrolled clinics
Communication and Team-Based Care	• Ensure own work is within professional and personal scope of practice and seek advice when appropriate • Understand the roles of individuals working within the PCN setting and work effectively within teams • Establish rapport with GPs and clinic teams through effective communication and reliable follow-through on commitments
Self-Development and Leadership	• Attend continuing professional development courses based on learning needs • Set personal development goals and plans for career progression • Provide guidance and support to junior staff • **[Administrative PCC (Senior)]** Provide supervision, teaching and assessment to junior staff

Key Responsibility Areas	Key Activities
Innovation and Quality Improvement	• Participate in quality improvement, evidence-based practice or research projects • Participate in quality assurance activities • **[Administrative PCC (Senior)]** Gather feedback from various stakeholders to identify opportunities for improvement • **[Administrative PCC (Senior)]** Evaluate quality improvement, evidence-based practice or research projects for follow-up and/or implementation

Proficiency Level Matrix			
Source	**Competency Element / Domain**	**Suggested Proficiency Level^**	
		Admin PCC	**Admin PCC (Senior)**
Competency Framework for PCN	E2.1. Chronic Disease Care Management	–	–
	E4.1. Patient and Caregiver Self-Management Support	–	–
	E6.1. Working with GPs and Clinic Teams	1	2
	E8.1. Health Promotion and Preventive Health	–	–
	D5. Administration and Operations Support	2	2
CNCF	E1. Client Assessment and Care Planning	–	–
	E2. Management of Individuals with Health Conditions	–	–
	E3. Medication Management	–	–
	E4. Client, Family and Caregiver Education and Empowerment	–	–
	E5. Care Transition Across Care Continuum	1	2
	E6. Communication, Collaboration and Teamwork	1	1
	E7. Client and Environment Safety and Risk Management	–	–
	E8. Population-based Practice	–	–
	E9. Develop and Lead Self	1	1
	E10. Develop and Lead Others	1	1
	E11. Innovation and Quality Improvement	1	2
	E12. Evidence-based Practice and Research	–	–

^ Refer to page 27 for 'Definition of Proficiency Levels'

PCC Job Role Profile Group C

Job Title Examples	Clinical PCC / Clinical PCC (Senior)
Job Role Description	The Clinical PCC supports patient care by providing basic education on chronic diseases and empowering well patients in their self-care journey through preventive health education and conducting basic health screenings. S/He supports patients in self-management and adherence to health plans. The Clinical PCC provides guidance to junior staff, ensures self-development and assists in quality improvement activities. The Clinical PCC (Senior) is adept at tailoring health education and resource provision to patients' needs and communicating with patients. S/he also supervises junior staff and participates in quality improvement and assurance activities.

Key Responsibility Areas	Key Activities
Patient Care and Care Coordination	• Assist in biopsychosocial assessment of patients contributing to formulation of individualised health plans • Support delivery of health plans to empower patients in self-management • Assist patients and/or caregivers in using home monitoring devices for blood pressure and glucose levels • Conduct screenings such as diabetic foot screening (DFS), diabetic retinal photography (DRP), and spirometry • Follow established escalation pathways in cases of deteriorating symptoms or abnormal readings • Also refer to Key Activities in PCC JRP Group B: Patient Care and Care Coordination
Patient Education and Health Promotion	• Provide basic patient education on chronic diseases • Provide information and guidance to patients on health promotion, screening and immunisation • Encourage and facilitate positive changes in patients' behaviours to promote health and prevent illness • Guide patients on accessing health educational resources • Educate patients on recognising red flags or warning signs, empowering them to take timely action or seek medical help when necessary • **[Clinical PCC (Senior)]** Identify appropriate resources that cater to patients' learning needs and guide them on accessing them
Administrative Support	• Refer to Key Activities in PCC JRP Group A: Administrative Support • **[Clinical PCC (Senior)]** Refer to Key Activities in PCC JRP Group B: Administrative Support
Communication and Team-Based Care	• Engage patients through active listening skills and shared agenda setting • Communicate and document assessments and interventions clearly and appropriately • Escalate when additional expertise or referral is necessary • Also refer to Key Activities in PCC JRP Group A: Communication and Team-Based Care • **[Clinical PCC (Senior)]** Also refer to Key Activities in PCC JRP Group B: Communication and Team-Based Care
Self-Development and Leadership	• Refer to Key Activities #1-3 in PCC JRP Group B: Self-Development and Leadership • **[Clinical PCC (Senior)]** Provide supervision, teaching and assessment to junior staff

Key Responsibility Areas	Key Activities
Innovation and Quality Improvement	• Refer to Key Activities in PCC JRP Group A: Innovation and Quality Improvement • **[Clinical PCC (Senior)]** Refer to Key Activities in PCC JRP Group B: Innovation and Quality Improvement

Proficiency Level Matrix			
Source	**Competency Element / Domain**	**Suggested Proficiency Level^**	
		Clinical PCC	**Clinical PCC (Senior)**
Competency Framework for PCN	E2.1. Chronic Disease Care Management	1	1
	E4.1. Patient and Caregiver Self-Management Support	1	1
	E6.1. Working with GPs and Clinic Teams	1	2
	E8.1. Health Promotion and Preventive Health	1	1
	D5. Administration and Operations Support	1	2
CNCF	E1. Client Assessment and Care Planning	1	1
	E2. Management of Individuals with Health Conditions	–	–
	E3. Medication Management	–	–
	E4. Client, Family and Caregiver Education and Empowerment	1	2
	E5. Care Transition Across Care Continuum	1	2
	E6. Communication, Collaboration and Teamwork	1	2
	E7. Client and Environment Safety and Risk Management	–	–
	E8. Population-based Practice	1	1
	E9. Develop and Lead Self	1	1
	E10. Develop and Lead Others	1	1
	E11. Innovation and Quality Improvement	1	2
	E12. Evidence-based Practice and Research	–	–

^ Refer to page 27 for 'Definition of Proficiency Levels'

PCC Job Role Profile Group D

Job Title Examples	Assistant PCC Supervisor / PCC Supervisor
Job Role Description	The Assistant PCC Supervisor holds leadership responsibilities such as training new staff, managing team rosters, and fostering professional growth within the team. S/He role-models effective communication and participates in collaboration with team members and other stakeholders. S/He stays updated about changes in healthcare policies, regulations, and best practices relevant to primary care coordination. S/He leads quality improvement and assurance projects. The PCC Supervisor addresses patient feedback in a timely and effective manner and builds relationships with key stakeholders to facilitate collaboration. S/he assesses junior staff on communication skills, manages conflict to improve team dynamics and implements change management strategies to improve service delivery. The Assistant PCC Supervisor and PCC Supervisor roles may be categorised under either the clinical or administrative track.

Key Responsibility Areas	Key Activities
Patient Care and Care Coordination	• Refer to Key Activities in PCC JRP Group B **(Administrative Track)** or PCC JRP Group C **(Clinical Track)** • **[PCC Supervisor]** Manage feedback from patients regarding patient care and care coordination effectively
Patient Education and Health Promotion	• Refer to Key Activities in PCC JRP Group C: Patient Education and Health Promotion **(Clinical Track)**
Administrative Support	• Monitor process and operation indicators to evaluate performance and progress towards goals • Also refer to Key Activities in PCC JRP Group B: Administrative Support
Communication and Team-Based Care	• Communicate effectively with team members and motivate them towards shared goals • Work effectively within and across teams • Collaborate within the multi-disciplinary team to optimise care for patients • **[PCC Supervisor]** Maintain partnerships with clusters to facilitate collaborative programmes
Self-Development and Leadership	• Develop and deliver structured training programmes for new PCCs • Ensure new PCCs are competent in on-site procedures, workflows, and organisational policies • Plan and manage the team roster • Provide coaching to junior staff on effective communication techniques • Stay updated on healthcare policies, regulations, and best practices that impact primary care coordination • Discuss with PCN Leads and implement best practices in primary care coordination to enhance patient outcomes • **[PCC Supervisor]** Observe and evaluate junior staff's communication interactions with GPs and clinic teams • **[PCC Supervisor]** Resolve conflicts within teams and other stakeholders

Key Responsibility Areas	Key Activities
Innovation and Quality Improvement	• Lead implementation of quality improvement and assurance projects • Guide team members in implementing quality improvement and assurance initiatives and evaluate the impact on service delivery • **[PCC Supervisor]** Implement change management principles to facilitate transitions in service delivery

Proficiency Level Matrix			
Source	**Competency Element / Domain**	**Suggested Proficiency Level^**	
		Assistant PCC Supervisor	**PCC Supervisor**
Competency Framework for PCN	E2.1. Chronic Disease Care Management	1*	1*
	E4.1. Patient and Caregiver Self-Management Support	1*	1*
	E6.1. Working with GPs and Clinic Teams	2	3
	E8.1. Health Promotion and Preventive Health	1*	1*
	D5. Administration and Operations Support	3	3
CNCF	E1. Client Assessment and Care Planning	1*	1*
	E2. Management of Individuals with Health Conditions	–	–
	E3. Medication Management	–	–
	E4. Client, Family and Caregiver Education and Empowerment	2*	2*
	E5. Care Transition Across Care Continuum	2	2
	E6. Communication, Collaboration and Teamwork	2	3
	E7. Client and Environment Safety and Risk Management	–	–
	E8. Population-based Practice	1*	1*
	E9. Develop and Lead Self	2	2
	E10. Develop and Lead Others	2	3
	E11. Innovation and Quality Improvement	3	3
	E12. Evidence-based Practice and Research	–	–

* Only for clinical track

^ Refer to page 27 for 'Definition of Proficiency Levels'

PROFICIENCY LEVEL MATRIX | Nurses

Source	Competency Element / Domain	Suggested Proficiency Level^							
		Enrolled Nurse	Senior Enrolled Nurse	Principal Enrolled Nurse	Staff Nurse	Senior Staff Nurse	Assistant Nurse Clinician	Nurse Clinician	Senior Nurse Clinician
Competency Framework for PCN	E2.1. Chronic Disease Care Management	1	1	1	2	2	3	3	4
	E4.1. Patient and Caregiver Self-Management Support	1	2	2	2	2	3	3	3
	E6.1. Working with GPs and Clinic Teams	1	2	2	2	2	2	3	3
	E8.1. Health Promotion and Preventive Health	1	1	1	1	2	2	3	3
CNCF	E1. Client Assessment and Care Planning	1	1	2	2	3	3	3	4
	E2. Management of Individuals with Health Conditions	1	1	1	2	2	3	3	4
	E3. Medication Management	1	1	1	2	2	2	3	4
	E4. Client, Family and Caregiver Education and Empowerment	1	2	2	2	2	3	3	3
	E5. Care Transition Across Care Continuum	1	2	2	2	2	2	3	3
	E6. Communication, Collaboration and Teamwork	1	2	2	2	2	2	3	3
	E7. Client and Environment Safety and Risk Management	1	1	2	2	2	2	3	3
	E8. Population-based Practice	1	1	1	1	2	2	3	3
	E9. Develop and Lead Self	1	1	2	2	2	3	3	3
	E10. Develop and Lead Others	1	1	1	1	2	2	3	3
	E11. Innovation and Quality Improvement	1	2	2	2	2	2	3	3
	E12. Evidence-based Practice and Research	1	1	1	2	2	2	3	3

^ Refer to page 27 for 'Definition of Proficiency Levels'

PROFICIENCY LEVEL MATRIX | Primary Care Coordinators

Source	Competency Element / Domain	Suggested Proficiency Level^						
		PCC	Admin PCC	Admin PCC (Senior)	Clinical PCC	Clinical PCC (Senior)	Assistant PCC Supervisor	PCC Supervisor
Competency Framework for PCN	E2.1. Chronic Disease Care Management	–	–	–	1	1	1*	1*
	E4.1. Patient and Caregiver Self-Management Support	–	–	–	1	1	1*	1*
	E6.1. Working with GPs and Clinic Teams	1	1	2	1	2	2	3
	E8.1. Health Promotion and Preventive Health	–	–	–	1	1	1*	1*
	D5. Administration and Operations Support	1	2	2	1	2	3	3
CNCF	E1. Client Assessment and Care Planning	–	–	–	1	1	1*	1*
	E2. Management of Individuals with Health Conditions	–	–	–	–	–	–	–
	E3. Medication Management	–	–	–	–	–	–	–
	E4. Client, Family and Caregiver Education and Empowerment	–	–	–	1	2	2*	2*
	E5. Care Transition Across Care Continuum	1	1	2	1	2	2	2
	E6. Communication, Collaboration and Teamwork	1	1	1	1	2	2	3
	E7. Client and Environment Safety and Risk Management	–	–	–	–	–	–	–
	E8. Population-based Practice	–	–	–	1	1	1*	1*
	E9. Develop and Lead Self	–	1	1	1	1	2	2
	E10. Develop and Lead Others	–	1	1	1	1	2	3
	E11. Innovation and Quality Improvement	1	1	2	1	2	3	3
	E12. Evidence-based Practice and Research	–	–	–	–	–	–	–

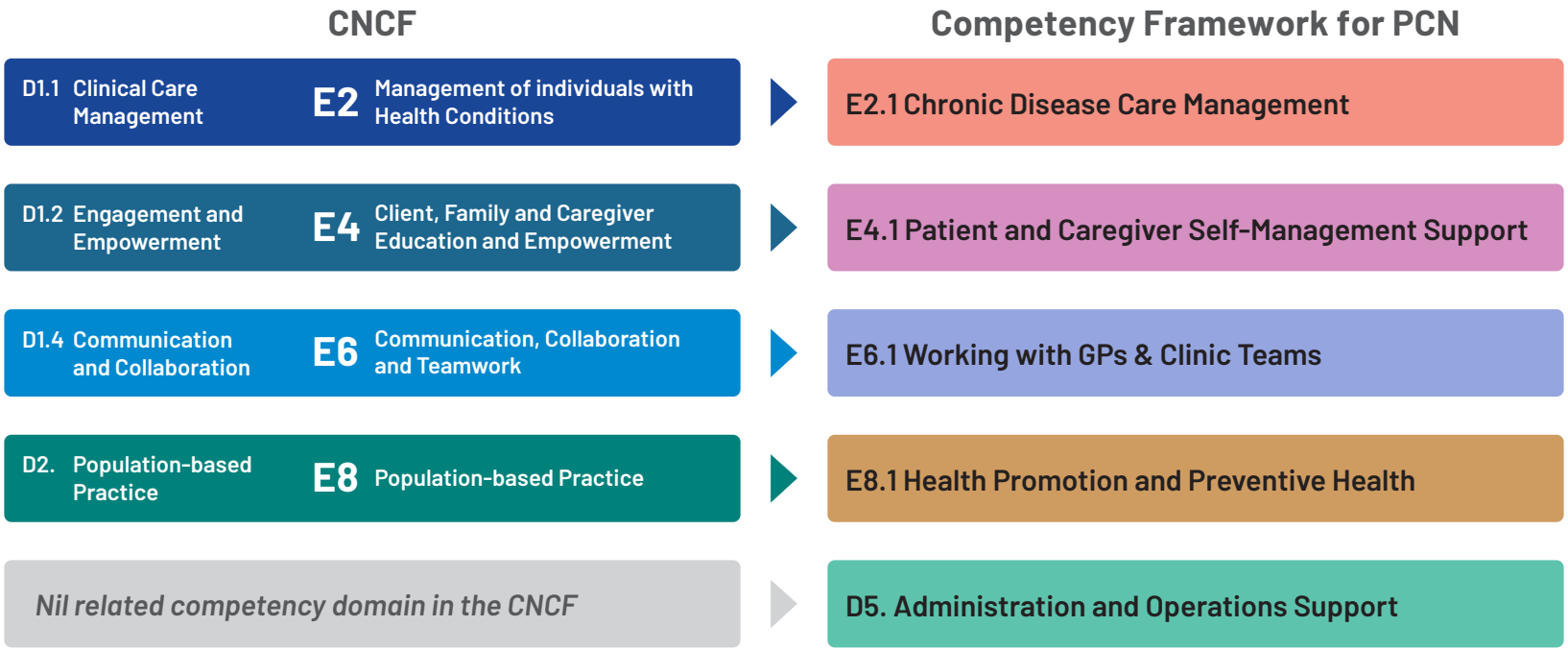
* Only for clinical track

^ Refer to page 27 for 'Definition of Proficiency Levels'

PROFESSIONAL COMPETENCIES

The **Competency Framework for PCN** builds on additional *4 competency elements* and *1 competency domain* to supplement the existing competency elements in the **CNCF**, in consideration of PCN nurses' and PCCs' unique attributes and practice settings.

For each competency element or domain, knowledge and abilities across different proficiency levels are described. The definition of the proficiency levels are adopted from the **CNCF** and may be found on Page 27.



Legend: **D** = Competency Domain **E** = Competency Element

DEFINITION OF PROFICIENCY LEVELS

Level	**Responsibility** (Degree of supervision & accountability)	**Autonomy** (Degree of decision-making)	**Complexity** (Degree of difficulty of situation & tasks)	**Knowledge and Abilities** (Required to support work as described under Responsibility, Autonomy & Complexity)
4	Accountable for significant area of work, strategy or overall direction	Empowered to chart direction and practices within and outside of work (including professional field/ community), to achieve/ exceed work results	Highly Complex	• Synthesise knowledge issues in a field of work and the interface between different fields, and create new forms of knowledge • Employ advanced skills, to solve critical problems and formulate new structures, and/or to redefine existing knowledge or professional practice • Demonstrate exemplary ability to innovate, and formulate ideas and structures
3	Accountable for achieving assigned objectives, decisions made by self and others	Provide leadership to achieve desired work results; manage resources, set milestones and drive work	Complex	• Evaluate factual and advanced conceptual knowledge within a field of work, involving a critical understanding of theories and principles • Select and apply an advanced range of cognitive and technical skills, demonstrating mastery and innovation, to devise solutions to solve complex and unpredictable problems in a specialised field of work • Manage and drive complex work activities
2	Work under broad direction May hold some accountability for performance of others, in addition to self	Use discretion in identifying and responding to issues, work with others and contribute to work performance	Non-routine (may not have precedence)	• Select and apply a range of cognitive and technical skills to solve non-routine/abstract problems • Apply relevant procedural and conceptual knowledge, and skills to perform differentiated work activities and manage changes • Able to collaborate with others to identify value-adding opportunities
1	Work with some supervision Accountable for tasks assigned	Use limited discretion in resolving issues or enquiries. Requires occasional to frequent guidance	Routine (has precedence)	• Understand and apply factual and procedural knowledge in a field of work • Apply basic skills to carry out defined tasks • Identify opportunities for minor adjustments to work tasks

Extracted from Page 31 of the **CNCF**

PCN Competency Element E2.1: Chronic Disease Care Management

Definition of Competency Element:
Assess, plan and implement interventions to manage patients' chronic conditions and optimise care outcomes.

	Level 1	Level 2*	Level 3*	Level 4*
Proficiency Level	(Applicable to nurses and PCCs) • **Support delivery of nursing interventions to manage patients' chronic conditions**	(Applicable to nurses) • **Perform and evaluate nursing interventions to manage patients' chronic conditions**	(Applicable to nurses) • **Plan and manage nursing care for patients with complex chronic conditions**	(Applicable to nurses) • **Review and steer the development and delivery of chronic disease management**
Knowledge	• Basic pathophysiology and clinical manifestations of common chronic diseases • Long-term complications of chronic diseases • Normal reference ranges for readings and laboratory results • Common medications used for common chronic diseases • Basic theories of DFS, DRP and spirometry • Lifestyle prescriptions • Basic nutritional and exercise assessments • Proper use of blood pressure set, glucometer • Healthier SG Care Protocols on chronic disease management • Red flags for escalation • Escalation pathways	• Common diagnostic criteria • Risk factors for chronic diseases • Development and progression of chronic diseases • Personalised treatment targets and normal ranges • Common side effects of medications • Proper insulin administration • Proper use of inhalers • Healthier SG Care Protocols and clinical guidelines relevant to chronic diseases	• Advanced pathophysiology of common chronic diseases • Interpretation of diagnostic tests for common chronic diseases • Mechanisms of action of common medications • Polypharmacy and associated risks	• Common differential diagnoses • Modifiable and non-modifiable risk factors • Monitoring parameters for common medications • Principles of medication titration • Management of polypharmacy • Latest evidence-based developments in clinical guidelines and research
Abilities	• Provide basic patient education on chronic diseases • Support patients in achieving set health goals • Emphasise importance of adhering to health plans and prescribed medications • Perform DFS, DRP and spirometry • Discuss lifestyle prescriptions • Assist patients in home blood pressure monitoring and glucose monitoring • Provide red-flag advice to patients • Apply escalation protocols when required	• Describe risk factors for chronic disease progression • Explain disease processes and complications • Support patients in setting personalised health goals • Provide counselling on common medications and associated side effects • Screen for medication non-adherence • Explain and demonstrate the correct technique for self-administration of insulin and inhalers	• Provide case management to patients with complex chronic conditions • Screen for co-morbidities • Assess patient-specific risk factors for chronic diseases • Assess need for medication adjustments and make suggestions to referring GPs for consideration	• Provide case management to patients with complex chronic conditions and care needs • Recommend and justify pharmacological adjustments to referring GPs for consideration • Critically analyse latest research and guidelines to incorporate into patient care • Ensure working policies reflect and remain up to date with latest evidence-based practices and guidelines

* Items from prior levels apply.

PCN Competency Element E4.1: Patient and Caregiver Self-Management Support

Definition of Competency Element:
Formulate and deliver health plans to empower patients and caregivers to take an active role in managing health conditions.

	Level 1	Level 2*	Level 3*	Level 4*
Proficiency Level	(Applicable to nurses and PCCs) • **Support delivery of health plans to empower patients in self-management**	(Applicable to nurses) • **Formulate and deliver health plans to empower patients in self-management**	(Applicable to nurses) • **Evaluate health plans and review resources available for patients in self-management**	(Applicable to nurses) • **Drive development and strategies in promoting self-management**
Knowledge	• Importance of good communication with patients • Basic principles and methods of patient education • Techniques of motivational interviewing • Time management strategies	• Effective communication techniques • Person-centred care • Types of social determinants • Biopsychosocial assessments • Therapeutic relationships • Strategies in facilitating self-management	• Principles of strategies in facilitating self-management • Principles of clinical reasoning	• Emerging patient counselling trends and best practices • Mentoring skills
Abilities	• Assist in implementation of person-centred health plans • Identify patients' barriers in achieving health goals • Practise good time management during patient counselling • Communicate information on health interventions to patients and/or caregivers • Enable effective counselling in different environments including face-to-face, phone and video consultation	• Elicit biopsychosocial history to provide context for counselling • Formulate and deliver person-centred health plans based on individualised care needs, preferences and goals • Address identified gaps in meeting health goals • Facilitate therapeutic relationships with patients to encourage them to take ownership of their health • Recommend strategies to facilitate self-management	• Evaluate person-centred health plans based on individualised care needs, preferences and goals • Develop strategies to facilitate self-management • Develop strategies to help patients overcome barriers and achieve health goals • Review provision of resources for patient counselling	• Drive development and implementation of resources for patient counselling • Act as a mentor to train junior colleagues on counselling techniques

* Items from prior levels apply.

PCN Competency Element E6.1: Working with General Practitioners (GPs) and Clinic Teams

Definition of Competency Element:
Effectively communicate, collaborate and build relationships with GPs and clinic teams to uphold high care standards.

	Level 1	Level 2*	Level 3*	Level 4*
Proficiency Level	(Applicable to nurses and PCCs) • **Support collaborative work with GPs and clinic teams through effective communication and relationship building**	(Applicable to nurses and PCCs) • **Build rapport with GPs and clinic teams through mutual understanding & open communication**	(Applicable to nurses and PCCs) • **Role model effective communication and teamwork**	(Applicable to nurses) • **Facilitate culture building and collaborative communication channels**
Knowledge	• Basic concepts of workplace communication • Common medical terminologies	• Inter-professional collaboration framework • Conflict resolution methods • Negotiation strategies	• Leadership in communication	• Organisational culture development strategies • Collaborative leadership
Abilities	• Communicate effectively with GPs and clinic teams to enhance care outcomes • Communicate and document updates on patient education, ancillary or care coordination services	• Build trust and confidence with GPs and clinic teams • Understand the cultures and challenges of the GPs • Present relevant information on patients and participate in patient care discussions with GPs • Participate in engagements with GPs and clinic teams • Guide junior staff to strengthen communication skills	• Promote a culture of open communication in the workplace • Facilitate interdisciplinary discussions with GPs • Serve as role models for effective communication practices with GPs and clinic teams • Provide supervision to junior staff in enabling effective communication with GPs and clinic teams	• Develop strategies to improve communication channels within the primary healthcare system and develop a culture of open communication • Keep up to date with new developments nationally and identify those that will enhance teamwork in the primary care setting • Identify and garner opportunities for collaboration to broaden and enhance the services delivered to patients

* Items from prior levels apply.

PCN Competency Element E8.1: Health Promotion and Preventive Health

Definition of Competency Element:
Advocate and enable strategies that enhance health promotion, wellness and disease prevention.

	Level 1	Level 2*	Level 3*	Level 4*
Proficiency Level	(Applicable to nurses and PCCs) • **Support health promotion, wellness and disease prevention activities**	(Applicable to nurses) • **Plan and deliver health promotion, wellness and disease prevention interventions**	(Applicable to nurses) • **Develop and manage delivery of health promotion, wellness and disease prevention interventions**	(Applicable to nurses) • **Develop strategies and direction to drive health promotion, wellness, and disease prevention**
Knowledge	• Fundamentals of health promotion and disease prevention • Health and disease screening, including basic functional and mental health screening • National Adult Immunisation Schedule (NAIS) • Appropriate physical activity and nutritional interventions • Community resources, support services and related referral pathways • Healthier SG Preventive Health Care Protocols • Escalation pathways	• Concepts of frailty and sarcopenia affecting older people • Assessment skills regarding patients' readiness to change • Evidence-based approaches to screening, immunisations, health promotion, and disease prevention	• Health promotion and disease prevention strategies • Evidence-based physical activity, nutritional and psychosocial interventions • Comprehensive health assessments to identify modifiable risk factors	• Best practices and strategies in the promotion of health and wellness • Emerging trends in health promotion and disease prevention • National health planning priorities
Abilities	• Obtain basic patient history related to health screening • Assist in basic functional and mental health screening • Provide basic lifestyle modification advice • Provide information and education on health promotion, disease screening and immunisation recommendations • Guide patients on accessing educational resources and tools • Apply escalation protocols when required	• Assist to identify and implement frailty prevention interventions • Perform nutritional, functional and mental health screening and recommend appropriate interventions • Implement evidence-based disease prevention activities such as screening, immunisations, and health promotion programmes • Deliver safely primary prevention interventions such as immunisation	• Develop personalised evidence-based wellness plans for patients • Evaluate the effectiveness of health promotion activities, functional and mental health screening recommendations • Stay updated on the latest research and evidence-based practices in health promotion and preventive health	• Incorporate evidence-based knowledge into health promotion and preventive health initiatives • Oversee the implementation of population-based interventions for health promotion and disease prevention • Develop strategies and drive new initiatives to address emerging health challenges and improve existing health promotion efforts

* Items from prior levels apply.

PCN Competency Domain D5: Administration and Operations Support

Definition of Competency Domain:
Manage and support administrative and operational functions to facilitate effective care coordination and functioning of PCN operations.

	Level 1	Level 2*	Level 3*
Proficiency Level	(Applicable to PCCs) • **Support administrative operations to facilitate effective coordination and ensure smooth functioning of primary care operations**	(Applicable to PCCs) • **Monitor and analyse administrative operations to facilitate seamless coordination and effective provision of quality patient care**	(Applicable to PCCs) • **Lead care coordinating-related initiatives and guide team of PCCs to perform administrative operations**
Knowledge	• Basic information technology applications • Organisational standards and guidelines for technologies, services and tools • Ancillary services, community programmes and referral services • Various subsidies and schemes available in the community • Importance of service orientation • Basic concepts of innovation and quality improvement	• Data analytics tools • Presentation techniques • Approach to critical thinking • Comprehensive concepts of innovation and quality improvement	• Leadership and supervisory skills • Roles and responsibilities related to implementation of new or improved services • Concepts of change management • Best practices and strategies in primary care coordination
Abilities	• Perform basic data collation and analysis • Coordinate and schedule patients for ancillary services • Communicate information on various subsidies, schemes and resources available in the community • Coordinate referrals to various programmes and schemes as appropriate within practice area • Support process improvement initiatives	• Present and communicate data clearly and coherently • Monitor and analyse process and outcome indicators • Collect feedback from various parties and articulate ideas on areas of improvement • Participate in innovation, quality improvement and assurance activities	• Liaise with clusters on collaborative programmes • Lead the team in improving the quality of services provided • Train new PCCs and ensure that they are familiar with on-site procedures and operations • Develop curriculum and execute training programmes for PCCs • Plan and manage the team roster • Lead implementation of innovation, quality improvement and assurance activities • Stay informed about changes in healthcare policies, regulations, and best practices relevant to primary care coordination

* Items from prior levels apply.

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2. Reynolds, R., Dennis, S., et al. (2018). A systemic review of chronic disease management intervention in primary care. *BMC Family Practice,* 19, 11.
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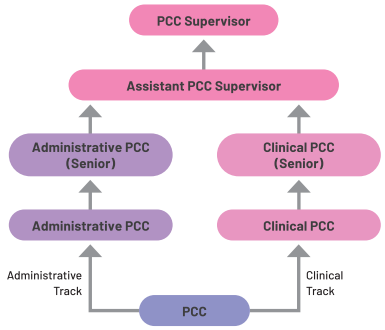
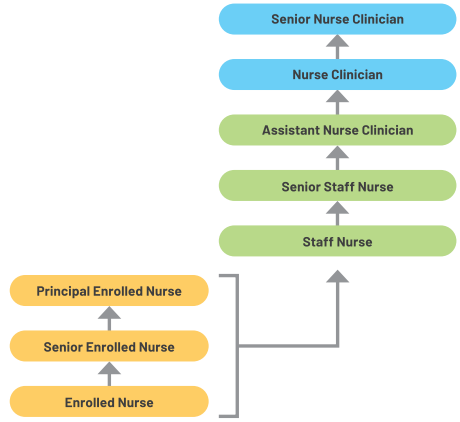
USER GUIDANCE

Application: Perform self-assessment to identify competency gaps.

STEP 1

Refer to the **Career Map** for an overview of possible career progressions.





STEP 2

Read the organisation's **Job Description (JD)** (or appropriate **JRP** from this framework) to understand key responsibility areas and key activities.

Nursing Job Role Profile Group B	
Job Title Examples	Staff Nurse / Senior Staff Nurse / Assistant Nurse Clinician
Job Role Description	The Staff Nurse assesses, plans and implements nursing interventions to manage patients' chronic conditions and to achieve their health goals. S/He empowers patients in self-management of their health. The Senior Staff Nurse and Assistant Nurse Clinician take on more roles in quality improvement, planning of services and health promotion activities. The Senior Staff Nurse and Assistant Nurse Clinician also precept junior nurses and contributes to continuing professional development activities.

Key Responsibility Areas	Key Activities
Patient Care	Conduct comprehensive nursing assessments incorporating biological, psychological, and social factors Assist patients in setting and achieving personalised health goals to manage chronic conditions effectively Identify patient barriers to goal achievement and develop strategies to overcome identified gaps in the health plan Deliver safety primary prevention interventions such as immunisation **[Senior Staff Nurse / Assistant Nurse Clinician]** Implement disease prevention activities such as screening, immunisations, and health promotion programmes **[Senior Staff Nurse / Assistant Nurse Clinician]** Assist to identify and implement frailty prevention strategies **[Assistant Nurse Clinician]** Evaluate nursing assessments and interventions to achieve planned health goals
Patient Education and Health Promotion	Explain the development and progression of chronic diseases to patients Educate patients on the proper administration of insulin and inhaled medications Provide personalised lifestyle recommendations to patients based on assessment findings Provide patients with tools and resources to enhance self-management skills
Communication and Team-Based Care	Integrate motivational interviewing and behavioural change strategies to empower patients for self-management Establish rapport with GPs and clinic teams through open communication and reliable follow-through on commitments Participate in interdisciplinary team meetings and contribute valuable insights
Professional and Leadership Development	Attend continuing professional development courses based on learning needs Provide feedback to team members and promote a positive team learning culture **[Senior Staff Nurse / Assistant Nurse Clinician]** Provide guidance, supervision and support to junior team members **[Assistant Nurse Clinician]** Act as a team leader to anchor a shift or a service line at the clinic or PCN setting **[Assistant Nurse Clinician]** Assist in the development and delivery of training programmes for junior team members

PCC Job Role Profile Group B	
Job Title Examples	Administrative PCC / Administrative PCC (Senior)
Job Role Description	The Administrative PCC demonstrates a deeper understanding of community resources and referrals and is competent in data analysis and presentation. S/He engages in self-development to achieve personal development goals and participates in quality improvement and assurance activities. S/He also provides guidance and support to junior staff. The Administrative PCC (Senior) has advanced knowledge of data analytic and presentation tools, evaluates quality improvement and assurance activities and provides supervision to junior staff.

Key Responsibility Areas	Key Activities
Patient Care and Care Coordination	Refer to Key Activities in PCC JRP Group A: Patient Care and Care Coordination **[Administrative PCC (Senior)]** Provide tailored and relevant information to patients regarding community programmes, services, available subsidies and schemes **[Administrative PCC (Senior)]** Determine patients' needs and offer guidance and assistance to them in accessing and navigating support services in the community
Administrative Support	Collate and organise required data Use data analytics tools to analyse and interpret data Utilise visual aids to enhance presentation delivery Organise site visits to recce the clinic premises and ensure smooth operation of PCN services **[Administrative PCC (Senior)]** Present data in a structured and organised manner to convey data effectively **[Administrative PCC (Senior)]** Conduct PCN briefings and facilitate the onboarding process to newly enrolled clinics
Communication and Team-Based Care	Ensure own work is within professional and personal scope of practice and seek advice when appropriate Understand the roles of individuals working within the PCN setting and work effectively within teams Establish rapport with GPs and clinic teams through effective communication and reliable follow-through on commitments
Self-Development and Leadership	Attend continuing professional development courses based on learning needs Set personal development goals and plans for career progression Provide guidance and support to junior staff **[Administrative PCC (Senior)]** Provide supervision, teaching and assessment to junior staff

STEP 3

Using the **Proficiency Level Matrix** as a reference, determine the proficiency level(s) required for each Professional Competency for current and desired job roles.

Source	Competency Element / Domain	Suggested Proficiency Level*							
		Enrolled Nurse	Senior Enrolled Nurse	Principal Enrolled Nurse	Staff Nurse	Senior Staff Nurse	Assistant Nurse Clinician	Nurse Clinician	Senior Nurse Clinician
Competency Framework for PCN	E2.1. Chronic Disease Care Management	1	1	1					
	E4.1. Patient and Caregiver Self-Management Support	1	2	2					
	E8.1. Working with GPs and Clinic Teams	1	2	2					
	E8.1. Health Promotion and Preventive Health	1	1	1					
CNCF	E1. Client Assessment and Care Planning	1	1	2					
	E2. Management of Individuals with Health Conditions	1	1	1					
	E3. Medication Management	1	1	1					
	E4. Client, Family and Caregiver Education and Empowerment	1	2	2					
	E5. Care Transition Across Care Continuum	1	2	2					
	E6. Communication, Collaboration and Teamwork	1	2	2					
	E7. Client and Environment Safety and Risk Management	1	1	2					
	E8. Population-based Practice	1	1	1					
	E9. Develop and Lead Self	1	1	2					
	E10. Develop and Lead Others	1	1	1					
	E11. Innovation and Quality Improvement	1	2	2					
	E12. Evidence-based Practice and Research	1	1	1					

Source	Competency Element / Domain	PCC	Admin PCC	Admin PCC (Senior)	Clinical PCC	Clinical PCC (Senior)	Assistant PCC Supervisor	PCC Supervisor
Competency Framework for PCN	E2.1. Chronic Disease Care Management	–	–	–	1	1	1*	1*
	E4.1. Patient and Caregiver Self-Management Support	–	–	–	1	1	1*	1*
	E8.1. Working with GPs and Clinic Teams	1	1	2	1	2	2	3
	E8.1. Health Promotion and Preventive Health	–	–	–	1	1	1*	1*
	O5. Administration and Operations Support	1	2	2	1	2	3	3
CNCF	E1. Client Assessment and Care Planning	–	–	–	1	1	1*	1*
	E2. Management of Individuals with Health Conditions	–	–	–	–	–	–	–
	E3. Medication Management	–	–	–	–	–	–	–
	E4. Client, Family and Caregiver Education and Empowerment	–	–	–	1	2	2*	2*
	E5. Care Transition Across Care Continuum	1	1	2	1	2	2	2
	E6. Communication, Collaboration and Teamwork	1	1	1	1	2	2	3
	E7. Client and Environment Safety and Risk Management	–	–	–	–	–	–	–
	E8. Population-based Practice	–	–	–	1	1	1*	1*
	E9. Develop and Lead Self	–	1	1	1	1	2	2
	E10. Develop and Lead Others	–	1	1	1	1	2	3
	E11. Innovation and Quality Improvement	1	1	2	1	2	3	3
	E12. Evidence-based Practice and Research	–	–	–	–	–	–	–

STEP 4

Refer to **Professional Competencies** in both the Competency Framework for PCN and the CNCF. Read the **knowledge** and **abilities** listed under the relevant proficiency levels.

Level	Responsibility (Degree of supervision & accountability)	Autonomy (Degree of decision-making)	Complexity (Degree of difficulty of situation & tasks)	Knowledge and Abilities (Required to support work as described under Responsibility, Autonomy & Complexity)
4	Accountable for significant area of work, strategy or overall direction	Empowered to chart direction and practices within and outside of work (including professional field/community), to achieve/exceed work results	Highly Complex	Synthesise knowledge issues in a field of work and the interface between different fields, and create new forms of knowledge Employ advanced skills, to solve critical problems and formulate new structures, and/or to redefine existing knowledge or professional practice Demonstrate exemplary ability to innovate, and formulate ideas and structures
3	Accountable for achieving assigned objectives, decisions made by self and others	Provide leadership to achieve desired work results; manage resources, set milestones and drive work	Complex	Evaluate factual and advanced conceptual knowledge within a field of work, involving a critical understanding of theories and principles Select and apply an advanced range of cognitive and technical skills, demonstrating mastery and innovation, to devise solutions to solve complex and unpredictable problems in a specialised field of work Manage and drive complex work activities
2	Work under broad direction May hold some accountability for performance of others, in addition to self	Use discretion in identifying and responding to issues, work with others and contribute to work performance	Non-routine (may not have precedence)	Select and apply a range of cognitive and technical skills to solve non-routine/abstract problems Apply relevant procedural and conceptual knowledge, and skills to perform differentiated work activities and manage changes Able to collaborate with others to identify value-adding opportunities
1	Work with some supervision Accountable for tasks assigned	Use limited discretion in resolving issues or enquiries. Requires occasional to frequent guidance	Routine (has precedence)	Understand and apply factual and procedural knowledge in a field of work Apply basic skills to carry out defined tasks Identify opportunities for minor adjustments to work tasks

PCN Competency Element E4.1: Patient and Caregiver Self-Management Support

Definition of Competency Element:
Formulate and deliver health plans to empower patients and caregivers to take an active role in managing health conditions.

	Level 1	Level 2*	Level 3*	Level 4*
Proficiency Level	(Applicable to nurses and PCCs) **Support delivery of health plans to empower patients in self-management**	(Applicable to nurses) **Formulate and deliver health plans in empowering patients in self-management**	(Applicable to nurses) **Evaluate health plans and review resources available for patients in self-management**	(Applicable to nurses) **Drive development and strategies in promoting self-management**
Knowledge	Importance of good communication with patients Basic principles and methods of patient education Techniques of motivational interviewing Time management strategies	Effective communication techniques Person-centred care Types of social determinants Biopsychosocial assessments Therapeutic relationships Strategies in facilitating self-management	Principles of strategies in facilitating self-management Principles of clinical reasoning	Emerging patient counselling trends and best practices Mentoring skills
Abilities	Assist in implementation of person-centred health plans Identify patients' barriers in achieving health goals Practise good time management during patient counselling Communicate information on health interventions to patients and/or caregivers Enable effective counselling in different environments including face-to-face, phone and video consultation	Elicit biopsychosocial history to provide context for counselling Formulate and prioritise person-centred care plan based on individualised care needs, preferences and goals Address identified gaps in meeting health goals Facilitate therapeutic relationships with patients to encourage them to take ownership of their health Recommend strategies to facilitate self-management	Evaluate person-centred health plans based on individualised care needs, preferences and goals Develop strategies to facilitate self-management Develop strategies to help patients overcome barriers and achieve health goals Review provision of resources for patient counselling	Drive development and implementation of resources for patient counselling Act as a mentor to train junior colleagues on counselling techniques

STEP 5

Self-assess the current proficiency level for each Professional Competency. **Identify the gaps**, in terms of Knowledge and Abilities, between current and desired proficiency levels.

STEP 6

Discuss with the supervisor on identified competency gaps. Co-formulate **professional developmental plans** to bridge the gaps.

Supervisors may use the competency framework to:

1. Adapt the JDs for recruiting nurses and PCCs with different job profiles based on the JRP groups and Proficiency Level Matrix in the framework
2. Engage nurses and PCCs in career conversations and co-formulate professional developmental plans to attain career goals
3. Shortlist trainings based on the nurses' and PCCs' identified competency gaps and enrol them in the appropriate trainings to bridge the gaps
4. Demonstrate availability of career growth opportunities to promote recognition and staff retention in the PCN

GLOSSARY

Behavioural change strategies	Techniques or interventions aimed at modifying individuals' behaviours to improve their health outcomes, such as motivational interviewing, goal-setting, and reinforcement strategies. Source: Miller, W. R., & Rollnick, S. (2012). *Motivational interviewing: Helping people change* (3rd ed.). Guilford Press.
Biopsychosocial	Holistic approach that considers biological, psychological, and social factors in understanding health, illness, and healthcare delivery. Source: Engel, G. L. (1977). The need for a new medical model: A challenge for biomedicine. *Science, 196*(4286), 129-136.
Clinical reasoning	Cognitive process to assess patient information, understand patient problems, and plan, implement, and evaluate patient care. Source: Levett-Jones, T. (Ed.). (2013). *Clinical reasoning: Learning to think like a nurse*. Pearson Australia.
Complex chronic conditions	Medical conditions that are persistent and multifaceted, often requiring comprehensive and coordinated care over long periods. Source: Van der Heide, I., Snoeijs, S., Melchiorre, M. G., Quattrini, S., Boerma, W., & Schellevis, F. (2015). Innovating care for people with multiple chronic conditions in Europe: *An overview. International Journal of Care Coordination, 18*(1-2), 39-52.
Conflict resolution methods	Strategies and techniques used to address and resolve disagreements or conflicts in a constructive manner. Source: Fisher, R., Ury, W., & Patton, B. (2011). *Getting to yes: Negotiating agreement without giving in* (3rd ed.). Penguin Books.
Differential diagnoses	Process of distinguishing a disease or condition from others that present similar clinical features. Source: Collins, R. D. (2011). *Differential diagnosis in primary care* (5th ed.). Lippincott Williams & Wilkins.
Effective communication techniques	Methods used to convey information clearly and effectively, including active listening, empathy, and clarity in verbal and non-verbal communication. Source: Balzer-Riley, J. W. (2021). *Communication in nursing* (9th ed.). Elsevier.
Frailty	Clinical syndrome in older adults characterised by a decrease in strength, endurance, and physiological function, which increases vulnerability to adverse health outcomes. Source: Clegg, A., Young, J., Iliffe, S., Rikkert, M. O., & Rockwood, K. (2013). Frailty in elderly people. *The Lancet, 381*(9868), 752-762.
Functional screening	Assessments used to evaluate a patient's ability to perform activities of daily living and instrumental activities of daily living. Source: Ministry of Health, Singapore. (2010). *Functional Screening for Older Adults in the Community*. HPB-MOH Clinical Practice Guidelines.

Lifestyle prescriptions	Assistance for clinicians in providing concise lifestyle advice to patients, such as diet and exercise, to improve health and prevent disease. Source: Primary Care Pages. (2023). *Lifestyle Prescriptions*. Retrieved from: www.primarycarepages.sg/healthier-sg/lifestyle-prescriptions
Organisational culture development strategies	Approaches used to shape and enhance the values, beliefs, and behaviours that define an organisation's culture, often to improve performance and patient care. Source: Scott, T., Mannion, R., Davies, H. T. O., & Marshall, M. N. (2003). Implementing culture change in health care: *Theory and practice. International Journal for Quality in Health Care, 15*(2), 111-118.
Person-centred care	Approach that creates or reinforces trust and mutual respect in the clinician-patient relationship, and where patients actively participate in the conversation and decision-making process. Source: Ministry of Health, Singapore. (2023). *CareTeam Education Playbook on Person-Centred Communication.*
Polypharmacy	Use of multiple medications by a patient, typically an elderly individual, often leading to increased risk of adverse drug events. Source: Khezrian, M., McNeil, C. J., Murray, A. D., & Myint, P. K. (2020). An overview of prevalence, determinants and health outcomes of polypharmacy. *Therapeutic Advances in Drug Safety, 11*, 2042098620933741.
Population-based interventions	Strategies and actions aimed at improving the health of an entire population or specific subgroups within it. Source: Frieden, T. R. (2010). A framework for public health action: *The health impact pyramid. American Journal of Public Health, 100*(4), 590-595.
Self-management	Ability of individuals to manage their own health conditions effectively through knowledge, skills, and confidence. Source: Bodenheimer, T., Lorig, K., Holman, H., & Grumbach, K. (2002). Patient self-management of chronic disease in primary care. *JAMA, 288*(19), 2469-2475.
Therapeutic relationships	Professional relationships between clinicians and patients that are based on trust, respect, and the goal of enhancing the patient's well-being. Source: Egan, G. (2018). *The skilled helper: A problem-management and opportunity-development approach to helping* (11th ed.). Cengage Learning.

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