Listening to our Stakeholders:
Analysis of interviews regarding competency-based education and training & competency-based career frameworks.

Report by the National Health Workforce Planning & Research Collaboration
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Project Background and Brief

The National Health Workforce Planning and Research Collaboration (NHWPRC) is a collaboration between HWA and a consortium comprising the Australian Health Workforce Institute (AHWI) and PricewaterhouseCoopers (PwC), and has included a substantial program of national health workforce planning and research projects to complete within a three year scope (2008-2011).

AHWI is a consortium of the University of Melbourne and the University of Queensland and for the purposes of this Collaboration has established links with the Australian National University, the University of Adelaide and Monash University.

In 2010 the University of Queensland Node of the Australian Health Workforce Institute (AWHI) undertook two competency related projects awarded under the NHWPRC partnership agreement and contracted as Projects 4 & 5 – the Competency Projects, namely:

- Mapping health workforce competencies with a view to developing a taxonomy (classification framework) for competency-based standards in health.
- Exploring evidence-based options for competency-based health career framework/s in Australia.

The competency projects were informed by two sources: 1) a review of the published and grey literature and 2) by formal semi-structured interviews and informal consultations with key informants across the health care sector.

As the projects proceeded, the extent of synergy and overlap between the projects became increasingly obvious. On this basis, the contracting organisation, Health Workforce Australia, requested a combined report covering both of the projects.

The initial report (Brownie, Bahnisch, & Thomas, 2011a) and the associated literature review (Brownie, Bahnisch, & Thomas, 2011b) were formally endorsed by the governing board of Health Workforce Australia on 5 December 2011 and released for publication in April 2012 and can be cited as follows:


Following receipt and formal endorsement of these reports, HWA requested further analysis and write-up of the semi-structured interview data, which had been obtained from members of HWA’s stakeholder community who had been interviewed during the course of the aforementioned research enquiries. The key messages from HWA stakeholders form the basis of this report.
As highlighted in previous reports, the research projects involved extensive work across a number of complex fields. This report is the combined effort of many contributors.

LISTENING TO OUR STAKEHOLDERS: Analysis of interviews regarding Competency-based Education and Training & Competency-Based Career Frameworks
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Introduction

The first Health Workforce Australia (HWA) strategy plan was endorsed by Australian Health Ministers in November 2011 (HWA, 2011). The plan includes a work stream related to exploration of the viability and utility of a whole-of-health workforce competency framework.

This report is the outcome of a request from HWA for a more detailed analysis of the semi-structured interviews undertaken as part of the 2010-2011 research process which resulted in two reports, specifically, the initial project report (Brownie, Bahnsch, et al., 2011a) and the associated literature review (Brownie, Bahnsch, et al., 2011b). These reports were formally endorsed by the governing board of Health Workforce Australia 5 December 2011 and released for publication in April 2012. A full PDF copy of the reports can be accessed from the HWA website http://www.hwa.gov.au/publications/hwa-reports under the following header:

National Common Health Competency Resource for the Australian Health Workforce

- Exploring the Literature: Competency-based Education and Training & Competency-Based Career Frameworks (.pdf) - report by the National Health Workforce Planning & Research Collaboration
- Competency-based Education and Competency-based Career Frameworks: Informing Australian health workforce development (.pdf) - report by the National Health Workforce Planning & Research Collaboration

This third report adds to the initial two project reports providing more detailed commentary regarding the views expressed by HWA stakeholders during the semi-structured interview process.

Prior to interviews, interviewees were forwarded a copy of the questions which would provide focus for the interview discussion (Annex 1). Informants included curriculum developers, employers, professional associations, unions and regulating bodies. A full list of participating groups/organisations is included in Annex 2.

As highlighted in the initial report (Brownie, Bahnsch, et al., 2011a), questions focussed on the understanding of informants in respect to concepts such as competence within education and training and of a competency-based career framework. Areas covered included competency-related benefits, challenges, language and descriptors along with matters pertaining to implementation and resourcing.

This report attempts to complement, rather than duplicate, material in the previous report. The information in this third report provides readers with additional rich data including many direct informants’ quotes. This provides HWA and other interested parties with the opportunity to access additional insights regarding the experiences, perceptions and views of those who were interviewed during the initial research project. While these views are not generalizable (due to the limitations of this study and the small cohort size), it is intended that the additional data presented in this report will be helpful to both HWA and the project advisory group which have been formed to consider the next steps in this important piece of work.
Seeking views from HWA Stakeholders: Method

Ethics approval

Following the development of the research plan and meeting with the reference group, a full proposal was submitted to the University of Queensland Ethics Committee. Approval to proceed was subsequently granted and collection of data commenced.

The ethics application was submitted to the University of Queensland Behavioral and Social Sciences Ethical Review Committee (UQBSSERC) on the 16th May, 2010 with approval for a period of 12 months granted on the 15th of June, 2010. A copy of the ethics approval certificate is included in Annex 4.

Identifying and classifying key stakeholder groups

In consultation with the National Health Workforce Planning and Research Collaboration (NHWPRC) reference group and with HWA, stakeholders were classified as belonging to one of six groups:

1. Education and training providers
2. Professions
3. Health service users
4. Employers
5. Regulatory bodies
6. International participants

Groups were selected on the basis of their ability to inform the development of a competency-based education and training & the proposed competency-based career framework.

The groups were identified as a sample exemplifying the breadth of the Australian health care sector, and comprised education and training providers, health professions, health service users, employer’s regulatory bodies and international participants. As interviews proceeded, a snowballing technique was used to identify other key informants within each of these groups, to source grey literature of relevance to the project.

The Interview Process

Interviews were digitally recorded. Interview audio files were edited to remove identifying information, and transcripts were classified according to the group from which the informants were drawn. Each transcript was given a numerical designation. In addition, a written submission and commentary was received from the Australian Peak Nursing and Midwifery Forum on behalf of their seven member organisations, representing their agreed upon position. Further, one jurisdictional health provider responded by providing a written response to the semi-structured interview questions.

Limitations

This study provides a sample of views about competency-based education and training & competency-based career frameworks gleaned via 59 interviews with individuals and groups within the Australian health sector community. Analysis of the data gathered provides useful insights to assist the thinking of Health Workforce Australia regarding options for the ongoing exploration of competency-based concepts. Equally, the information gathered provides useful information for consideration by the participant groups.
However, given the number and scale of groups within the HWA health stakeholder community (including health care professionals, educational providers of health workforce education plus health service providers, users and regulators), this study is limited by the comparatively small sample of the interviewed cohort against the size of the health community overall. As a result, views canvassed in this report may not represent views within the stakeholder community as a whole.

Data Analysis

In order to inform the initial report, the complete set of interview data was analysed by one member of the research team by two complete read-throughs, and by hand coding according to identified themes.

Largely, the themes which emerged were consistent with the questions explored such as 'enablers to competency-based education and training;' ‘barriers to competency-based education and training; and/or ‘key considerations in the implementation processes’. However, three other themes also emerged, specifically:

1. The espoused reductionist nature of competency-based approaches and long standing debate regarding the relevance of competency-based education and training to higher education,
2. the work that will need to occur to better align the VET and higher education sectors and,
3. the extent to which the envisaged project was a workforce project only versus a project with industrial implications and/or components.

Findings from the data were further validated through a process of peer review, involving a teleconference workshop and the opportunity for identified reviewers to make written comments.

For the purposes of this report, the complete set of interview data was further reviewed by the lead author with detailed hand coding undertaken to identify key themes requested by HWA in the work order pertaining to this report. A list of these themes is included in Annex 1.

Themes are reported accordingly and build on the commentary included in chapter nine of the original project report, which summarizes findings from key informants (Brownie, Bahnisch, et al., 2011a) pp. 40-47.
Analyzing views from the HWA Stakeholder Community: Results from the Data

The questions which formed the basis of the semi-structured interviews (Annex 2) included a series of questions against which the themes emerging from analysis of the interview data are now reported.

Stakeholder understanding of competency concepts

Consultations undertaken by the research team highlighted that, albeit varied, concepts related to competency-based education and training were much better understood than those relating to competency-based career frameworks.

Understanding also varied between the higher education and VET sectors.

Findings highlighted a significant need for further consultation followed by the development and confirmation of an agreed set of terms and definitions to reduce ambiguity and ensure maximum clarity of communication and meaning across HWA and its key stakeholders groups.

This is an important underpinning to successful progression of projects within HWA’s competency-related work stream.

Understanding of competency-based education & training concepts

The interview scripts revealed multiple slants, perspectives and insights into the complexities associated with competency related concepts and competency-based education and training and associated definitions and/or concepts.

When questioned about competency-based education and training concepts, and competency concepts in general, a number of informants immediately articulated an active working knowledge and/or familiarity with the Australian VET sector definition of competency along with their understanding of the TAFE use of competence-related terminology.

“Well basically, it’s when you’ve got the knowledge, skills and attributes which allow you to do a particular activity or task well.” Participant 8

“Competency-based training involves a set of competency standards (which are set by industry in collaboration with clients/patients) that each student is assessed against to ensure the stand of knowledge, skills and attributes have been achieved.” Participant 7

“In a nutshell, it’s the skills, knowledge and attitude that are needed for a profession and based on standards which the profession sets.” Participant 4

Others espoused a definition which they described as a ‘practical’ working definition of competence, for example:

“Well it generally requires you to have a reasonably good understanding of whatever the role is that the person is being trained for and to ensure that they can adequately fulfil their role once their training is complete.” Participant 36

“So generally speaking, I see competence as being able to do whatever it is that you do at a reasonable level.” Participant 49

Others specifically highlighted the view that competence within their discipline or service was much broader than the VET sector definition. Not infrequently, informants held a view that the TAFE definition was skills-based only and that the VET sector utilization of competency-based education and training related only to that which could be directly observed.
“Well my understanding of competence within education and training — actually we don’t use it in the TAFE terms of skills … it’s much broader … it’s the skills, knowledge, values, and our understanding of the competence at the end of training…” Participant 39

Others added additional definitional characteristics including the notion of competence being both skills-based (practical) and conceptually or theoretically-based (cognitive) – with competence including abilities able to be measured and quantified at a specifically designated time.

“Competence is the assessment at a point in time of the ability to undertake a particular skill, whether that be practical or cognitive … essentially an observable ability that is able to be quantified at a specific point in time” Participant 37

Responses also included reference to the idea that competence was context and profession specific:

“So it depends of course on what the field is, about what competence represents in that field.” Participant 50

Others highlighted links between theoretical understanding; clinical & workplace application; and, job performance, specifically:

“Competence is sort of bi-fold … It's really a demonstration of theoretical understanding and its clinical applications. … We are actually moving the paradigm away from years of practice being a measure to actually the demonstration of clinical contributions and competence.” Participant 6

Understanding of competency-based career frameworks

Conversely, the majority of participants admitted a lack of knowledge or understanding of concepts related to competency-based career frameworks.

“I don’t think I can help you much here but anyway … I've got a vague idea what it is, big public sector essentially” Participant 8

“No I am not really familiar with that sorry.” Participant 32

“No don’t know a great deal … I presume you are going to have a list of competencies as you move up the list. So your career fields and so if you are a junior doctor (cites other examples) has these. Once you've ticked them you reach those levels, you’re salary kind of reflects those … you’ve kind of go a bunch of things that you tick off and that determines the level at which you operate.” Participant 20

In respect to those participants who did have an understanding of the concepts associated with a competency-based career framework, this was obviously strongest amongst the UK-based informants working directly with the UK Skills Escalator project.

Australian-based understanding of the concept was strongest amongst employers, regulatory and accreditation bodies. Some of these articulated the view that a competency-based framework could be used solely as a workforce instrument; however, others immediately articulated the view that development of a competency-based career framework was both a workforce and an industrial concept/initiative.

“The legal structures that you have in the states/jurisdictions actually mitigate against having single nationally agreed terminology … so it would need to have the same kind of radical overhaul that you have done with the registration legislation in the sense that you would have
to have a single national piece of industrial legislation with all the categories etc that were there.” Participant 23

**Variance in understanding**

Participant responses also highlighted significant discrepancies in the use and understanding of terminology and definitions associated with competency concepts.

Areas of discrepancy or difference were greatest in respect to agreement or non-agreement with a specific definition, terminology and underlying philosophy.

“I think the language definitions are significant. I work in inter-professional education with eighteen different disciplines. The languages between the different health disciplines are almost foreign languages in many ways so there is a huge amount of work to get clarification on what everybody is talking about.” Participant 43

“I think there’s a range of understandings of competence, but when I consider competence within a health professional setting, at least it’s the ability for the professional to satisfactorily perform the task or activities or professional role that they’re assigned to.” Participant 22

“Re the question of what is your understanding of competency-based education and training … that’s a very good question because in the Australian context there’s a lot of, particularly in the health environment, there’s a lot of confusion.” Participant 21

In summary, considerable variances were identified in informants understanding and agreement about competency concepts. This finding informed and confirmed the recommendation that HWA consults, develops and confirms an agreed set of terms and definitions to reduce ambiguity and ensure maximum clarity of communication and meaning across its work portfolio and in its interactions with key stakeholders (Brownie, Bahnisch, et al., 2011a).

**Strengths, benefits and/or barriers for a national framework**

While there is considerable support and many perceived strengths for the development and implementation of national competency-based frameworks across the Australian health workforce, respondents also highlighted legitimate issues related to potential barriers such as the need to secure a common understanding and agreement across the VET and higher education sectors and the need to provide reassurance regarding a commitment to minimize the limitations associated with competency-based approaches. There is a clear need to work through these issues in any future project.

**Perceived strengths and benefits**

Perceived benefits included the envisaged promise of consistency of standards; transparency of training outcomes and professional practice; increased career flexibility; improved interprofessional communication; and, ultimately with these factors, the promise of improved health outcomes.

“… the competency approach which brings in the discipline of assessment of competency does have a value add in terms of consistency and ultimately quality of service delivery”. Participant 26

“Hopefully it will lead to better consistencies of standards … You know it is fairly daunting to realise that if you get a cancer in Australia and you are not in Sydney, Melbourne or Adelaide, you have a 20% higher chance of dying.” Participant 28
“The benefits of adopting a competency-based training approach is perhaps the transparency that’s clearly understood and the outcomes are very easily articulated.” Participant 31

“I guess the hypothesis is that it may lead to better communication in health care and that’s got to be good for outcomes.” Participant 35

“The benefits … it’s about how do we ensure people across a range of disciplines develop expertise, that sort of higher level clinical expertise.” Participant 32

“A national framework gives opportunity for side-ways advancement as well … not everyone wants to just go upwards…. There needs to be opportunity to broaden your skills as well.” Participant 12

Some expressed caution that while benefits could be perceived, care should be taken to not over specify a rigidly applied standard approach to education and training.

“The benefits are plentiful ……. but I would just worry that people would apply it too rigidly” Participant 33

**Perceived barriers**

A range of issues were cited as perceived or likely barriers to the implementation of a national framework. These included issues such as professional tribalism, the reality of human nature, pedagogical controversies, resourcing requirements and resistance of change.

“Given human nature, there’ll be a lot of nit-picking and all the reasons will come out why we can’t do it.” Participant 4

“Some of the concerns are around the risk of boxing people.” Participant 10

Some expressed fears that higher education would be subject to reductionist approaches while others expressed views that did not denote full understanding of VET sector roles and functions.

“Competency-based training … it’s based on a premise that everything can be reduced to a string of activities to get an outcome. In the health area in particular, that’s just not the case.” Participant 24

Various limitations of the competency approach were also raised as a perceived barrier to the implementation success of a national, whole-of-workforce framework. There was a clear need to undertake further consultation and systematically work through these issues in any future project.

“It is easy to design competencies around skills acquisition but other things are more difficult to define in terms of competencies. Initiation and induction are very difficult to write as competencies… these require assessment of thinking systems, thought processes, problem solving and these sorts of things. Initiation is learning the social and professional morays and the ethical basis of what you are doing…. These areas require complex judgement which is difficult to define in competency terms. ” Participant 20

The geographical and complex state-based jurisdictional differences were also highlighted as probable barriers to the development and implementation of national frameworks.

“While you have jurisdictional, state focussed processes that vary, that obviously going to be an impediment.” Participant 23

“There is a lot we can learn but we are not the UK and any-one who thinks a national model such as the UK model can be readily adoptable in the Australian system is ignoring
the diverse, the jigsaw nature of the Australian health care system compared to the NHS.” Participant 21

Finally, some of the pragmatics of what the envisaged project would actually involve taxed the mind of at least one participant.

“What competencies and what learning outcomes should be included in the framework? To me that would be the biggest challenge.” Participant 30

The envisaged project is obviously a large-scale undertaking and the issue of what to include and what not to include and how to gain agreement across an interrelated but diverse stakeholder community is a significant consideration.

Controversial considerations

Perhaps the biggest controversy rested around the pedagogical concerns and perceived limitations of the competency-based approach and the work that will need to occur to better align the VET and higher education sectors.

Concerns also emerged in regards to the extent to which the development and implementation of a competency-based career framework is an industrial rather than a workforce development initiative.

Another concern of significance included the tension between the concept of ‘autonomous’ versus ‘collaborative’ practice as highlighted by a range of key informant responses included in this section of the report.

The range of pedagogical concerns raised included fear of locking education into a defined set of competencies; the potential reductionist limitations that may ensue, and the difficulty of defining some attributes as defined competencies, for example, critical thinking.

“Once you go down a competency path … the risk is that can easily lock learning into a defined set of competencies but things are always changing. Evidence-based practice cannot be locked into static competencies.” Participant 24

“I think the major challenge is that the whole is much greater than the sum of the parts and it’s not being able to get over a set series of hurdles at a point in time, but it’s the way in which those competencies are melded together.” Participant 37

“If we try and reduce practice, which is what we’re doing, to a list of things that you can and can’t do, we somehow lose the complexity of what we’re doing.” Participant 33

“Teaching critical thinking in current VET training is generally not seen as being done well. The literature says outcomes-orientated programs are considered best educational practice.” Participant 7

“Competency is essential … but a lot of work we do is also focused determining someone’s capacity to perform within an environment rather than necessarily their competence alone.” Participant 23

Another theme commonly raised by participants related to the tension that exists between the nursing profession and other professional groupings. The tension was described as a tension based on the concepts of ‘autonomous’ versus ‘collaborative’ practice with nursing being seen as driving an ‘autonomous’ model which was not necessarily understood by other professions.
Some felt that nursing had placed too many boundaries around their practice with increasing articulation by nurses of ‘what we do and what we don’t do’ (participant 5) and that this had left gaps which had triggered a necessity to develop new categories of health workers.

“There are increasing gaps of stuff that nurses no longer do any more … Nursing is putting its own boundaries around it which is why we are getting other professional groupings to fill the gaps, physicians’ assistants, care assistants etc.” Participant 5

Some noted these new roles as viewed as ‘servant or subordinate roles’ in contrast to the moves towards ‘autonomous practice’ roles being developed within nursing including the roles for nurse practitioners. The well-known controversial issues between a medically-led health workforce versus other models of health leadership and health service delivery were entwined within these debates and controversies.

These controversies need to be fully considered in moving the competency-based discussion forward and it is very clear that HWA will need to undertake more discussion, consultation and consideration around the issue of new and emerging roles. Opportunity exists for nursing to contribute to these developments by increasing awareness raising effort regarding the role of nurse practitioners and the significant contributions that can be provided by these increasingly emerging roles within the nursing profession and how they fit within the broader health care team.

However, in highlighting these controversies it is equally important to note the widespread support, utilisation and acceptance of competency-based approaches that exists among professional groups in the Australia health sector.

Albeit the concerns and controversies, it is important to note the existing widespread use and support of a competency-based approach across every health discipline within the Australian context. Almost universally, standard setting activities are articulated within profession-specific competency frameworks. Within this context, competency approaches are accepted and widely used.

Irrespective of the concerns, every discipline has to varying extents found a way to make peace with the competency movement and utilise the approach to confirm standards of practice and increase accountability within the scope of their professional standards.

The key controversy that existed in respect to competency-based career frameworks versus competency-based education and training frameworks, was of an industrial nature and articulated by one participant as the “elephant in the room” Participant 2

The controversial issues highlighted by informants including pedagogical concerns about the limitations of competency-based education and training; the need for closer alignment between the VET and higher education sectors; and, clarification of the purpose of a competency-based career framework; workforce strategy versus industrial strategy and, autonomous versus collaborative practice emerged as the most controversial issues to be resolved in any future project initiative.

Identified generic/core competencies for health sector employment

The question of generic or core competencies received generic agreement in respect to several unarguable competencies such as communication, record keeping and assessment. However, the point was highlighted that the level of skills would vary in these areas depending upon the level of practice (for example, undergraduate, novice, expert) or the profession/health stakeholder group involved.
So, while a number of core competencies were identified (for example, communication), these were noted as requiring adaptation depending on the level of practice (beginning to experienced practitioner) or the health workforce group involved, for example, care givers, nurse practitioners, medical specialists.

“Core competencies could include things such as communication … that would be a uniform competence, I would think - also the ability to take a history but then there are various performance indicators around each of these that would vary between each profession.” Participant 27

One respondent put forward the view that there were five clear areas of commonality, specifically: “Interaction with the client; the health professional; the practice environment; interaction with professional colleagues; and, responsibilities to the community.” Participant 7

Other core or generic competencies highlighted included “an ability to practice health care in a professional manner that includes legal, ethical, and cultural competency; a willingness to share knowledge with other health professionals; an ability to assess patient/client health status and to formulate and implement a care plan in consultation with the patient/client/ carer involved; to provide promote, maintain and support patient/client health; … an ability to retrieve and evaluate evidence to inform healthcare practice; and, an ability to work in a team to deliver safe health care.” Participant 17

A significant number of respondents dismissed the topic of core or generic competencies as a controversial topic. The objection appeared to relate to issue of semantics with the term ‘core competencies’ currently being viewed by some as a dated or redundant terminology.

“We have found that there are some’ no-go words’ that it’s like’ wash your mouth-out words’ … At the moment we don’t talk to anybody about core or generic competencies because it is totally unacceptable … We find that we have to talk to them about shared competencies … This fits in well with the notion of interprofessional collaboration and increasingly accepted concepts of interprofessionalism.” Participant 23

Identified profession specific competencies

Profession-specific competencies were found to be plentiful and were presented to the research team via multiple frameworks which were either fully developed or endorsed by either professional or regulatory bodies, under review or under new development.

So many examples were either provided or sourced by the research team that it was impossible to map these. A representative list is detailed in Brownie, Bahnisch, et al. (2011a) Annex 4, page 93 and, for ease of access, repeated in Annex 6 of this report.

Perceptions regarding which professions may find it difficult to implement a framework

This question was largely by-passed with none of the respondents having any particular view that it would be more or less difficult for any particular professional group.

Interprofessional competencies – relevance to a national framework

Interprofessional competencies were noted as integral to the concept of a national competency-based education and training framework and a national competency-based career framework.
Respondents articulated clear rationale for the inclusion of interprofessional competencies in a national framework, including the increasingly collaborative and multidisciplinary nature of contemporary models of care; the desire of health professionals to be multi-skilled and have broader and more flexible career and employment opportunities, the teaching benefits and improved learning outcomes that could be achieved through integrated provision of some shared aspects of health professional education versus a more silo style educational model, and, the essential need for increased inter-professional competence and collaboration to underpin the ongoing development and re-design of health service delivery.

Albeit the relevance of developing and including interprofessional competencies within a national framework, a national career framework was not seen as the sole input to advance the development of interprofessional practice. The importance of significant investment in communication and clinical education and training was also highlighted.

“If you are looking at a business case to improve interprofessional practice, it’s not going to be solved by a career framework; it’s going to be solved by money going into appropriate clinical training … Interprofessional collaborative practice is not about role substitution and if you have a look at the literature it’s about learning with, from and about each other and understanding where the different roles are” Participant 23

To be effective, the implementation of interprofessional competence and interprofessional practice was noted as having to be promoted and enacted broadly across the practising health workforce rather than being taught at undergraduate level only.

“One of the gaps in interprofessional — has been now, is that even though you teach that with an institution, unless it’s happening in practice when they go to clinical placement then it doesn’t become embedded in their practice as well. So, we’ve still got to somehow move the workplace at the same time … Otherwise there’s that tension where the uni’s taught me this but I’ve not seen it working in the workplace so do I or don’t I actually do it?” Participant 33

Overall participants emphasised the necessity for increasing moves towards interprofessional competence and practice including inclusion of such competencies within a national framework. Additionally, interprofessional competence was noted as a core or generic competency that should be possessed by all participants within the health workforce and as including

“the ability to work in a team to deliver safe healthcare, so that’s demonstrative effective interpersonal relations and communication skills and an understanding of interprofessional practice and awareness of the importance of leadership delegation and supervision.”
Participant 17

However as highlighted, the effective advancement of collaborative practice was also noted as an issue requiring significant resourcing to support widespread communication and education across the entire sector.
Views from participating HWA Stakeholder Groups

In contrast to the more generic themes highlighted in the preceeding section, this section attempts to provide insight into various understandings and views expressed by the various informant/participating HWA stakeholder groups who participated in this study. Thus, the information in this section reports findings specific to the participating stakeholder groups, namely, education and training providers, accreditation and regulatory authorities, employers, health consumers, professions and international participants.

That is, the analysis of data also sought to distil understandings and beliefs specific to the Australian health sector that were included. While the insights gleaned from this process provide useful points for reflection, discussion and further project planning, it is essential that readers of this report understand and acknowledge the limitations of the reported data.

Specifically, the interview cohort represents a very small sample from the health sector overall. The cohorts are even smaller when broken down into the sub-groups which follow, and as such cannot be considered as either generalisable or fully representative of the group profiled.

Also, the findings outlined under each of the cohort groups in this section are not the only views expressed by that participant grouping. Rather, they constitute highlights or themes which appeared more predominant within the cohort responses than others.

Education and training providers

Some significant differences existed in the views expressed by representatives of educational and training providers. The differences were most widespread between higher education versus TAFE and Industry Skills training providers.

It was possibly within the sector of this cohort grouping that the most controversial and negative views were expressed within this study with both VET and higher education groupings holding some quite strong views about each other.

“There are schools, VET and higher education all with different language … knowledge skills and application as expressed in VET is actually very different … I’m not sure higher education really understand what competency-based is about” Participant 25

“In fact, higher education reacts quite negatively to that language … that’s VET stuff — that’s nothing to do with us, that’s VET.” Participant 51

“I think that there may be some lingoes that universities are about education and training and higher thinking and the VET sector is about competencies. I know that there would be a lot of people, particularly in the university sector, who think that the job of competency training should belong to the VET sector. I personally don’t subscribe to that.” Participant 24

Registered training entities and others aligned with the Industry Skills council articulated consistent views regarding the functionality of the existing systems across the VET and Industry Skills contexts. Detailed information and feedback was provided in respect to the historical background and strongly embedded presence of existing VET sector competency-based education and training packages including those specific to the health workforce.

In several instances, informants indicated that the response that they wanted to provide was of such importance that they also wished to table a written response either at the time of, or shortly after, the interview process, with an example as follows:
“The national vocational education and training (VET) competency standards and qualifications for the community services and health industries are nationally agreed and reflect roles of approximately 700,000 Australian workers. The qualifications and standards are located in the HLT07 Health and CHC08 Community Services Training Packages and are maintained by the Community Services and Health Industry Skills Council (CS&HISC). These packages house over 1000 competency standards and 170 qualifications. The packages have been in place since 1999 for community services and 2002 for health. The CS&HISC updates the qualifications and competency standards based on industry supply and demand drivers captured annually in an Environmental Scan.

The competency standards describe generic and specialist work, skills and knowledge across different roles and levels extending from Certificate I to Vocational Graduate Diploma. Domains or areas of work are used to group and cluster competency standards and include occupational (e.g. Enrolled Nurse), functional (e.g. case management) and sectoral (e.g. aged care) groupings.

The packages form the basis of VET qualifications and have influenced the formation of job roles and industry classifications across the range of different employer structures. A key feature of these packages is that they influence development of integrated skills and design of services and work driven by industry and client demand at a national level. In theory if such a model were applied across the whole of the workforce rather than the “VET” sector only then formation of new and changed work roles could more quickly respond to client and patient demand; and the innovation and reform objective of more integrated and interdisciplinary could be significantly realised.

The Training Packages qualifications and competency standards as positioned against the Australian Qualifications Framework deliver the same function as the skills escalator developed as part of the Agenda for Change in the United Kingdom over the last decade; albeit for the “VET” sector only. However the packages enable development of competency standards at the highest levels. For example the Vocational Graduate Diploma of Family Dispute Resolution reflects work undertaken by solicitors, lawyers, barristers, psychologists, mediators or welfare workers. Similarly the Vocational Graduate Diploma of Community Services (Statutory Child Protection) reflects work undertaken by a social work or psychology university graduate or a worker with VET qualification or on the job experience.

The VET sector of the workforce has not been historically organised and recognised in the way the regulated professions have been. Arguably the benefits of structural flexibility and integration achieved through the packages have been achieved due to the absence of strong professional silos.

The packages are now integral to ongoing discussion of a more integrated workforce and research in relation to potential whole-of-industry competency frameworks. We have reached a juncture where expansion of the VET competency standards (and their potential expansion) is influencing design of the broader health and community services team and service models. New delegation and substitution arrangements are enabled in key areas such as allied health and aged care through the Certificate IV in Allied Health Assistance and Certificate IV in Aged Care. The competency standards in these qualifications reflect functions previously recognised as within the domain of degree qualified professions but now undertaken as part of the broader team.

Future consideration and research in relation to all-of-industry competency frameworks and related policy development and reform should include detailed consideration of nomenclature and structure as well as the development and implementation contexts of the VET competency standards.” Participant 19
In considering responses around this topic, it is also essential to highlight that not all higher education providers articulated adverse views regarding the VET sector model of competency-based education and training. Supportive views were also articulated from representatives within the higher education sector.

“The benefits of adopting a competency-based training approach is perhaps the transparency that’s clearly understood and the outcomes are very clearly articulated. For the learner it is very clear what they are expected to do and be able to demonstrate at every level of their training. I mean it’s very clear, it’s very transparent and its very consistent and there are no ambiguities about what people are expected to know – I know that there are some criticisms about the reductionist side of it but I think that stems from a misunderstanding of what competency-based means.” Participant 30

**Professions**

Overall professional groups provided balanced responses to matters pertaining to competency-based education and training. Universally, each group participating in the research process acknowledged widespread use of competency frameworks as standard setting tools within their profession. Subsequently, professional groups were able to offer views based on direct experience that were both supportive of competency approaches while also providing very realistic commentary regarding limitations.

Typically, professional groups expressed the view that standards and competency requirements were set by the professions and that health professionals were the key drivers of the system.

Many acknowledged the voice of other groups such as consumers, service users, employers and regulators as increasingly important but remained firm in the view that the role of standard setting and definition of competency rested with the profession/s.

“So the standards are set by the profession then drive the curricula that we would then implement in Universities and TAFE’s and what-not and then the assessment drives ‘sic’ the assessment closes the loop on the curricular that’s developed.” Participant 4

Considerable understanding was evident among professional groups, in respect to the concepts of competency-based education and training including relevance and applicability beyond TAFE level right through to the highest levels of specialty training.

Understanding and support was particularly strong among health practitioners directly connected to professional Colleges with existing competency and standards based frameworks and among those involved in workplace education and in the provision of post graduate specialty medical education.

The presence of existing professional frameworks was often cited as evidence that the concepts were relevant, viable and implementable, however, a commonly expressed view related to how agreement could be reach among the various professions to merge and align the various frameworks.

“People have their own taxonomies and don’t really want to change them to a new one. They’ve put a lot and time and effort into what they already have …. It’s a bit like cutting a cake. You can cut it in many different ways so there are a whole lot of arguments there
….. how you design it, how you label your headings, whether you are going horizontally or vertically or in a matrix….these have been worked through within each profession. ” Participant 36

Another key message raised by professional groups related the need to avoid the risks of competency approaches trying to over-specify a role with countless checklists. An equally recurring theme related to the limitations of a competency approach in measuring some aspects of performance, particularly those aspects relating to clinical judgment, interpersonal interaction and professional insight.

“The other challenge is … that often times there are things that it is very difficult for us to even write the competency language for, but also the assessment and understanding of the certain elements of what people do in their jobs… sometimes it’s the unspoken, the unwritten and almost the unconscious parts of some of the performance that occurs- say in our case of being doctors.” Participant 37

Whilst acknowledging various limitations of the approach along with the challenges of navigating the ‘professional tribalism’ that would be encountered in attempting to seek agreement re the alignment of frameworks diverse professional groups, the task was not viewed as insurmountable.

As a solution, the CanMEDS model was cited as evidence of a framework widely accepted across more than sixty medical specialties and sub-specialties and of increasing global relevance beyond medical education alone.

“CanMEDs is the preferred taxonomy for us to all communicate about. So, if you want to talk about national taxonomy for competence-based training it is definitely the CanMEDs principal. I mean that’s an internationally recognised standard.” Participant 39

“ Consider CAnMEDs – I mean… if people are using it and finding it successful after a long period of time, why would you change it?” Participant 23

**Health service users**

Health service users articulated a very strong user focus as the issue of primary concern to any future project involving whole-of-workforce competency developments.

“It is all very well to have an academic and carefully considered dissertation around the concept of competency but at the end of the day, what we need is stuff (education and standards) that helps people deliver services and intervene to prevent the loss of life.” Participant 26

“The focus should be the patient. It’s the competency to care for patients in a particular way or perform a particular task. I think the focus should be the competency rather than the registered health profession and where they come from or what specific profession.” Participant 24
**Accreditation and regulatory authorities**

Due to their roles and function across the whole of the Australian health workforce, the accreditation and regulatory authorities possess detailed understanding and insights into the competency-based education and training and career framework implementation status, benefits barriers and issues. Thus, this participant group was able to provide comment from whole of workforce, sub-sector and profession specific basis.

The authors of this report suggest that the insights and active participation of the overarching accrediting and regulatory authorities would be essential partnerships to successfully moving this project forward.

Informants from the cohort of accreditation and regulatory authorities provide broad insights:

“The understanding of competence within education and training, their use of the terminology is a bit of a concern to us because it seems to be fairly variant between competency, competence, competencies and performance … so I think our view would be that there needs to be some clarification of terminology because without that I think we’re going to get misunderstandings and perhaps confusion and waste a bit of time to move these issues forward.” Participant 23

“Nursing is a really good example and they’ve embraced qualifications - regulated, competency based qualifications very early on which have enabled a clear career pathway. When we look at some of the other areas, we don’t see there is much of a flow in dentistry for example, where there are dental nurses and dental assistants but we can’t see a clear pathway for a dental nurse to become a dentist.” Participant 26

**Employers**

During the process of semi-structured interviews, employers added significant additional information to inform this project than that which was available in the published literature only. Whereas other informants confirmed things present in the literature, employers were able to contribute additional insights; however, some of this was then embargoed.

Employing agencies (including the major jurisdictions) tended to have a considerable amount of un-published grey literature. Some of this was shared with the research team but some material was embargoed with confidentiality constraints applied due to the potential industrial implications of competency-based career frameworks which could be linked with pay scales.

All employers were using competency-based training in one form or another including the almost universal use of this form of training within orientation and mandatory training programs.

Other involvement included partnership activities with the professional entities of clinicians within their employ such as the use of the CanMEDS models by medical colleges during registrar training rotations.

In contrast, most employers were actively exploring (rather than utilising) concepts associated with competency-based career frameworks. Universally, employers were exploring multiple mechanisms to enhance the flexibility, scope of practice and cost effectiveness of their health workforce. The development of competency-based career frameworks was included within the explorations described by employers.
Most frequently, this exploration included activities such as policy research; think tanks focused on health service re-design; and the development of discussion papers rather than active possession of confirmed plans for implementation of competency-based career frameworks.

Where models and documents existed under embargo, this was usually due to the timing of development of discussion papers. Intended next steps included consultation with staff and their representative unions prior to broader public release including any formal release within this research project.

All of the employers spoken to within this study were grappling with the challenge of finding more innovative and flexible ways to deliver health services to a demographically expanding and ageing population of health consumers. All highlighted the challenges of negotiating existing professional demarcations, award structures and state-based differences when exploring and implementing new/redesigned models of care. All highlighted the tensions in the potential and possibly need for the project to be an industrial project rather than workforce project alone.

“I think the big elephant in the room in all of – a lot of workforce reform in Australia is the underlying industrial context … I think the reality for health going forward; we need to have a consistent industrial framework to achieve reform.” Participants 2

It was noted that industrial issues have the potential to disrupt efforts to develop and effectively implement and realise the benefits of a national competency-based framework for both education and training and also career progression.

“We need to move to take the industrial argument out of the debate as soon as possible otherwise it’s got the power to just hijack the whole discussion, and the risk for this discussion is that it becomes an industrial debate and a bread and rations debate and it shouldn’t be. I do think we need to get the key industrial principles agreed to very quickly so this is off the table and we can really start to talk about the clinical competency rather than what you get paid to attain a certain level. Otherwise I think it has the potential to derail the whole discussion.” Participant 2

Industrial issues aside, employers were keen to explore the potential benefits that clear and consistent national education and training framework and career frameworks might deliver.

“With this project I think there is the potential for the interprofessional merging of current boundaries to appear and I think that’s a good thing - for patients and staff.” Participant 8

“a project of this nature will allow focus on the competent clinician providing appropriate care in a caring manner — care is more important than the professional badge.” Participant 2

International participants

The international participants in this study all had first-hand experience in the development of either competency-based education or training frameworks or a competency-based career framework. Subsequently, they were able to provide unique insights into the implementation challenges, realities and benefits of a whole of workforce or profession-wide approach within their country.

Interviews were conducted with informants directly involved in major competency-based developments within three countries offshore to Australia, specifically; informants involved in the development and implementation of:
1. the Canadian CanMEDS framework (J. R. Frank, 2005);  
2. the UK Skills Escalator (Agenda for Change Project Team, 2004) and,  
3. the Career Framework for the Health Workforce in NZ (Ministry of Health and District Health Boards New Zealand Workforce).

Whilst uniquely different, a number of common messages emerge when analysing transcripts associated within the three diverse international projects included in this study. Specifically:

- language and shared agreement regarding key terms and definitions is important; consultation and development takes time and must be adequately resourced;
- whole of workforce inclusion is essential;
- over specification of competencies is counter intuitive, impedes implementation and destroys the balance between education and the delivery of patient care; and
- finally strong leadership with whole of government buy-in and political support is essential to full realisation of the envisaged developments.

In addition to the common messages articulated by each of the international informants, a number of useful project specific insights were also offered. Key messages from each of the international projects profiled in this study are included in section 10 of the initial project report (Brownie, Bahnisch, et al., 2011a) pp 50-65. Similar to domestic informants, international informants articulated a high level of collegiality and willingness to continue to engage with HWA and share learning going forward.

CanMEDS

The CanMEDs team highlighted a number of pragmatic realities associated with the development and progression of their model. These included:

Language: Language is important and you just need to work with the reality of where your workforce is at the time. For example, when the CanMEDS project was started there was a lot of reaction of the use to the word ‘competency’ or related terminology. On this basis the project initially commenced as a ‘roles’ based framework as this as non-controversial at the time.

The lesson was that it is important of project implementers to understand the current views of workforce and to make the necessary adjustments to work within these to achieve the desired result.
“At the start there was a lot of reaction to the concept of competency so we used the term roles. It was non-controversial at the time but now the CanMEDS framework is so embedded we are re-badging it for what it is, i.e. a competency-based framework” Participant 16

Myths: The topic was raised of the need for framework developers to manage common myths such as the notion that competency-based training will automatically shorten training and the need for active management of political expectations of this nature.

“I think the politicians, at least in Canada, immediately assume that competency-based models will lead to shortened training but we try and emphasise that this is not necessarily the case. Perhaps for some of the fast learners this may be the case but for some it is also perceivable that training could lengthen. There is also the immeasurable maturity/maturation that occurs over the length of a training program.” Informant 15

Envisioning the future: Informants within the CanMEDS team also provided useful insights into the envisaged future of competency-based programs and the health workforce five years out. These included an emphasis on increased accountability and transparency of practice; increasing team based/collaborative models of care; and, shifts in role allocations across various members of the health workforce.

“Five years out – I think that at the individual practitioner level there will be much greater transparency and accountability on activities one engages in and how these are assessed and profiled in practice – both clinical and non-clinical” Participant 15

“There will also be increasing emphasis on team competencies and how we can actually foster and relate more collaboratively with other health professions around learning and change in practice improvement strategies.” Participant 15

“In contrast and parallel we are seeing an expansion upwards and extension sideways of scope of practice for other professions – particularly nursing and midwifery – re the autonomous models there are some real tensions to be worked through re how this fits with the team.” Participant 16

NZ Competency-based career framework

Figure 2 The New Zealand Health Workforce Career Framework (Ministry of Health & District Boards New Zealand Workforce Group 2007)
Key messages from New Zealand focused on the need to secure buy-in; engage in thoughtful and careful pre-planning; ensure adequate resourcing; and, to ensure adequate consideration of the economic, political and industrial context in which the project is being planned and implemented.

While the New Zealand framework had been designed but not yet been implemented at the time of the study, informants highlighted a number of benefits in support of the intended future move to implementation.

“Í think that having a national taxonomy that is overt and publicly available is very helpful. People do not necessarily know what we do as health professionals, what level of knowledge we have or what services various professionals can provide.” Participant 10

However, clear cautionary messages were emphasised in relation to the risks of implementing the framework in a manner which was too prescriptive and restrictive.

“It is essential that the framework remains competency based in a broad sense rather than prescriptively skills based. If you make it too restrictive, that is going to decrease our ability as health professionals to be proactive and meet the changing needs of people and the health care system. We know that things are going to change into the future including new discoveries, technologies, treatments etc so we must be able to respond within a clear competency framework that is not overly prescriptive or restrictive.” Participant 11

**UK Skills Escalator**

![Figure 3: The Skills Escalator](image_url)

A very important message from the UK Skills Escalator included the need for clearly articulated purpose statements and a value proposition that is talked about and understood by health stakeholders before the project is embarked upon. As highlighted in the main project report (Brownie, Bahnisch, et al., 2011a) p 63, the difficulties that the UK experienced in implementation stemmed primarily from the lack of upfront sector familiarisation and consultation.
“One of the things we would do differently is to consult more upfront. Our project rushed into it and we met so much resistance we had to stop the project entirely for six months and go out and engage in an extensive round of sector familiarisation.” Participant 14

Another interesting point which emerged in discussion with members of the UK project team was that the implementation was much, much more than developing the framework and then posting it on a national web-site.

“I must admit that we were very surprised that our people did just keep re-inventing their own things. The idea was that the developments would be posted on a national web-site that people could access to get ideas — they don’t.” Participant 14

Further discussion with the informants associated with the UK Skills Escalator project highlighted the realities and enormities of the costs involved in post implementation communication, promotion and continuing maintenance/update.

**Application of UK Skills Escalator Model to the Australian Context**

All of the overseas models explored within the context of this project highlighted valuable lessons for consideration to HWA as a pre-cursor to planning the next steps of the project. However, a number of informants also pointed out some of the unique complexities of the Australian context which would preclude direct application of the UK Skills Escalator model, in particular.

“Yes, we can learn a lot from it and there is much that we can usefully adopt from it. But, we are not the UK, and anybody who thinks that the UK model would be readily adoptable in the Australian system is ignoring the diversity, the jigsaw nature of the Australian health care system compared to the NHS.”

Repeatedly, informants pointed out desirable features and sound valuable lessons that could be gained from exploration of the overseas models.

Overall, the UK Skills Escalator project raised the most concerns as informants who were aware of this project had a tendency to be wary of the potential industrial implications of the model.

In contrast the CanMEDS model was more widely acknowledged as a globally transferable framework with the potential for whole-of-workforce application.
Implementation considerations

Identified resource implications for adoption of a national competency framework

Universally, respondents identified substantial implementation challenges, including the need to secure consistency of definitions and common understandings on which to base the initial projects discussions; change management issues; pedagogical paradigms shifts, resourcing issues in respect to both time and funding; and, boundary issues related to existing professional frameworks.

“The implementation challenges involve a substantial paradigm shift where that those ‘sic’ charged with supervising and assessing within a competency-based system haven’t gone through that system themselves. So they are used to a certain model of supervision and now need to move to workplace-based assessment with the role of supervisor, assessor and appraiser have much more of a job in quality assurance that just the training process.” Participant 34

“It requires a dialogue; it requires people sitting down together; it requires thinking. All of those have resource implications because that’s people’s time to actually work through that and then the hardest thing will be the time and resources to change practice.” Participant 33

“It is probably a more expensive system with a lot more training and a lot more assessment…… Also is the health system prepared to pay people at higher levels of remuneration if they can demonstrate greater expertise?” Participant 32

Stakeholders views regarding who should be responsible for development of a national framework

A broad range of responses were received in respect to this topic. Some participants thought a potential national project must be profession led, others emphasised the need for multi-party engagement; others focused on the issue of who should pay; and, some thought that the National Health Workforce Taskforce (HWA was just emerging at this point in time), should lead developments.

“Clearly each of your professional groups is going to have some form of engagement in that and provide some leadership to it - if you don’t it’s certainly not going to roll out into the field. Obviously the education providers will have to be involved as well and there obviously has to be some link between what the education providers are doing and what is required in the workplace or by the professional group.” Participant 23

“It would have to be government funded. I think that for the professions to have to come and do this all over again would require government support …… therefore, if there’s to be a net benefit back the community should have some sort of funding by government.” Participant 27

“I think it can and should be the National Health Workforce Taskforce.” Participant 28

Connecting the Professions, Higher Education and VET sector

Analysis of data revealed that significant work needs to occur to better align the disparate views and articulation pathways between VET and higher education sector. An approach recommended by several participants included endorsement of the strengths of very well established competency-based models within the VET sector systems while also reassuring higher education providers that a competency-based education system is capable of avoiding reductionist pitfalls.

“It needs champions, the right sort of leaders and there are people out there … I can name some who can make the connections and lead this through.” Participant 28
Recommended sign-off processes

A diversity of view existed as to as to who should be the actual leaders of who should sign-off on the end product. Again, responses highlighted the need for comprehensive consultation, broad sector buy-in and effective leadership.

“You won’t get ownership if it’s not profession-based.” Participant 38

“I don’t think there is any ideal body to do it. No matter who you give it to there is going to be a gap. Everyone will want their two bobs worth.” Participant 24

“If it is actually going to work, I think you need all the major stakeholders. Everybody will need to be responsible for it. So it would be the health practice areas where everyone is working, it would need to be education providers, it would need to be the professions; the accrediting bodies; all those players who have an interest in this.” Participant 33

Political and industrial considerations

As highlighted, both in this report and the preceding reports (Brownie, Bahnisch, et al., 2011a, 2011b) the majority and possibly all health professional groupings have already developed their own professional frameworks. In many instances, these are linked to industrial awards. Thus, alignment to develop a whole-of-workforce framework requires a future project team to successfully negotiate these sizeable political and industrial considerations. At least one participant put forward the view that movement to a national awards structure would be required.

“You have to make the awards national … different terms are used in different awards and different levels are contained within different awards …. So I think that will be a show-stopper in the final update of your terms.” Participant 38

Albeit this view, it is very clear that frameworks for both education and training and career progression can be developed without industrial and/pay links and that this is by far the most pragmatic and implementable approach to take this project forward.
The future: Development opportunities for the use of competency-based education and training and competency-based frameworks across the Australian Health Workforce

Significant opportunity exists for HWA to undertake further consultation and collaborate with its health workforce stakeholder community to develop a whole-of-workforce framework for education and training across the sector and for greater definition of career opportunities and progression.

Clear opportunity exists for HWA to establish and progress a project which could develop a CanMEDS type framework with broad competency categories of relevance to all groups within the Australian health workforce and with levels which are aligned to the Australian Qualifications framework.

Analysis of transcripts identified a range of benefits to HWA and its stakeholder community through the further progression of this project. The potential for significant benefit is clearly evident within the interview responses with development opportunities of benefit to all of the key groups talked with during the process of semi-structured interview.

Provision of common platforms for learning, along with clear articulation pathways for those seeking recognition of prior learning, is of particular benefit in supporting health workforce developments (Duckett, 2005; Ellis, Robinson, & Brooks, 2006). Common frameworks inclusive of these features are of value to most groups within the health community (Wright, M., & Walker, 2008), including:

**Health Consumers**

- Improved patient and consumer care through increased flexibility in utilising the health workforce, and clear articulation and maintenance of skills and competencies
- The potential for less fragmented care and for more patient-centred practice

**Health Professionals**

- An enhanced understanding among students of the contributions and knowledge base of different professions
- Clearer career pathways and opportunities for the health workforce
- Greater clarity and transparency regarding workforce roles and accountabilities
- Simplification of complex employment arrangements and control of burgeoning new worker categories
- Opportunities to further understanding and knowledge-sharing across different professions and workforce categories
- Increased job satisfaction as a result of working more fully to scope.

**Health Employers and Health Planners,**

- Greater flexibility in workforce utilisation
- Better alignment between education and the health sector
• Strong base for maintaining role and remuneration parity between workforce groupings (for frameworks with industrial links)

• Greater confidence in respect to certainty and comparability of standards

Health Educators

• The possibility of more seamless articulation and recognition of prior learning not just between VET and higher education, but also within higher education and post-graduate training

• Opportunity to work in closer partnership with the health sector and graduate health professionals who are better prepared for the workforce

Regulators and Registration Authorities

• The potential for skills migration within the existing workforce, and better preparation in meeting the new and emergent demands within the health system
Next Steps: Key Considerations

The stated intent of HWA in commissioning this report was to gain a fuller understanding of the views of the community as expressed in the initial key informant interviews with an intent to key input to guide future planning.

HWA’s current work plan includes competency-based initiatives. It may be quite challenging, however, to envisage how these concepts could be progressed to an implementable reality.

The informants to this study have emphasised the point that it is essential to ensure that initiatives do not increase existing confusion or unnecessarily ignite resistive reaction from professional groups or educational sectors that may either misunderstand or misconstrue the envisaged intent.

Analysis of the data confirms some important points requiring clarification by HWA in planning the next steps of the project. It is recommended that the first steps include clarification of the project purpose, underpinning rationale (evidence), descriptions (terminology) and support partners, specifically:

**Purpose** including why this project is needed, why it is being undertaken and what exactly is intended was a commonly raised question. Participants frequently asked questions regarding the purpose of expected outcome of the intended project. Clarification regarding this issue was regularly sought; therefore, preparation and communication of a ‘value statement’ would be an important consideration in moving the project forward. A draft value statement has been prepared by the research team and is attached in Annex 5 of this report.

**Evidence** to confirm the rationale and projected benefits of the intended project is a high expectation of a qualified workforce. Not surprisingly, educators, health professionals, and users of the health system wanted to discuss and view evidence regarding the effectiveness and enhanced health and educational comes that could be realised should a project of this nature be progressed.

“I’m not aware of evidence which shows there are major benefits, certainly when you come to healthcare for example … It seems more of an idea or a dream rather than something people have actually done studies on ‘sic’ – you know longitudinal studies. So we can only go with the theoretical benefits such as like, well understand ability I guess are the issues, transfer ability and those sort of things.” Participant 22

**Terminology** emerged as a major consideration in project progression. The need to reach common understanding and agreed terminology was a consistent theme expressed by almost every informant to the study.

**Partnership** was noted as an essential underpinning to success in a project of this nature. Informants pointed out that implementation of a project to develop a national framework for competency-based education and training and competency based career progression across the entire Australian health workforce is a major undertaking.

The authors of this report support the view that HWA would need partners in this process and that the invaluable whole-of-workforce insights and the active participation of the overarching accrediting and regulatory authorities would be essential partners to successfully move this project forward.
Having gained insight into the views of the sample of stakeholders who participated in this study, there is opportunity for HWA to progress competency-based initiatives including the concept of a whole-of-workforce competency framework in a pragmatic and constructive manner.

In the first instance, this project should be progressed via activities that include a clear communication and consultation exercise to enhance increased understanding of the rationale for and benefits of utilising competency-based models including development of a whole-of-workforce competency framework. A well-articulated value statement would be an essential component of the communication strategy moving forward.

It is suggested that the way forward could include:

- Profiling of recently published reports on the HWA web-site to increase discussion across the sector
- Utilisation of the literature review on the HWA web-site to engender discussion, better inform the sector and increase understanding of key issues associated with competency-based education and training developments and competency-based career frameworks
- Consideration of each of the initial project recommendations (see Annex 5) with a view to progressive implementation of these as appropriate
- Production and dissemination of a project ‘value statement’ (see example in Annex 6)
- Production and dissemination of information bites pertaining to key terms and concepts regarding which there is current debate, ambiguity and variance in understanding, for example, competence, competency, taxonomy, framework, horizontal integration, competency-based education and training framework and competency-based career framework
- Commencement of further consultation with the sector by development of a detailed discussion paper which adopts a workforce approach and confirms opportunities, options, benefits and implementation requirements associated with a whole-of-workforce approach to competency-based education and training and competency-based workforce utilisation and career progression
- Development of a detailed plan for progression of the envisaged project

All of the aforementioned resources are ready and available to allow HWA to quite promptly open discussion and move forward with the first steps in this particular work stream.
References


Annex 1  List of Themes: HWA Data Analysis Request

REQUESTED:
Further data analysis and reporting of key Informant Interviews to support HWA taking the next steps in developing a National Competency Framework

- **Specific data analysis requested** That data analysis and reporting be undertaken in the following categories:
  - Education and training (e.g. universities, VET, ALTC projects etc)
  - Professions
  - Future users (e.g. students and health insurers)
  - Accreditation
  - Employers
  - Government
  - Industrial
  - Feedback from International groups
  - Other (identification of feedback from other groups which were identified inclusive of those who were identified as part of the snowball effect)
- Request a review of the themes and questions provided below.
- **Survey question responses to the theme of mapping health workforce competencies and taxonomy**
  - Identification of the range of understanding of competencies
  - Identified major benefits or pitfalls
  - Identified resource implications for National adoption of a developed framework
  - Identified who should be responsible for framework
  - Identified critical signoff processes in gaining agreement
  - Any issues identified regarding relevance and connection required between professional and VET sector
- **Survey question responses to the theme of evidence based options for competency based health career frameworks**
  - Identified core generic capabilities for anyone working in health sector
  - Identified core capabilities for specific professions
  - Identified which professions would find it most difficult to implement a framework
  - Any comments on inter-professional competency as an informing principle
- In addition to the survey themes identified the following also need to be identified
  - Any key controversies and sensitivities regarding a national framework raised by the
different stakeholder groups interviewed

- Any strengths or benefits for a national framework raised by the different stakeholder groups
- Any perceived or likely barriers to a national framework
- Any comments made on the future of competencies in Australia
- Any comments or information on activities or projects conducted by stakeholder groups which were raised in the interviews
Annex 2  Interview Questions

Survey Questions National Health Workforce Taskforce
Mapping health workforce competencies and developing a taxonomy for competency-based standards in health

1. What is your understanding of competence within education and training?
2. What is the evidence for major benefits in adopting a competency-based training approach?
3. What is the evidence for major challenges in adopting a competency-based training approach?
4. What is your personal experience and perspective on the benefits and challenges?
5. If a national competence-based taxonomy was to be adopted would you find language a potential barrier?
6. If a national taxonomy was adopted what terms could be common across all of the Australian Health Sector?
7. What aspects would need to be specific to professions?
8. How could we achieve an agreement across professions for a national taxonomy?
9. How do you think a national taxonomy would benefit your particular professional group/employment setting?
10. In what ways do you think a national taxonomy would impact on interprofessional collaboration?
11. What are the resource implications for adopting a national taxonomy for competence-based training and education across the Australian Health Sector?
12. Who do you think would be responsible for implementing a national taxonomy?
13. Who are the bodies that need to agree to a national taxonomy for it to be implemented?

Evidence-based options for competency-based health career framework/s in Australia

1. What is your understanding of a competency-based career framework?
2. Do you know of any career frameworks in use either nationally or internationally that could have a national scope? (UK skills for health)
3. In what ways could these frameworks be suitable to the Australian health care sector at a national level?
4. Are there any apparent challenges in applying these frameworks nationally to the Australian health care sector?
5. If a national career framework was to be developed what would it look like?
6. What problems could a national framework solve or create?
7. What would be the scope of a national competence-based career framework? (training, pay linkage, career progression)
8. Could a national career framework make comparison of competency levels between professions easier?
9. Are there any particular professions that may benefit from a national career framework?
10. Are there any particular professions that may be disadvantaged by a national career framework?
11. What impact would a national career framework have on an individual practitioner in the Australian Health Care sector?
### Annex 3  Key Informants: Participating Organisations

- ACT Department of Health
- Allied Health Professions Australia
- Australasian College of Health Service Management
- Australian Association for Social Workers
- Australian College of Health Service Management
- Australian Institute of Radiography
- Australian Medical Association
- Australian Medical Council
- Australian Medical Student Association
- Australian Nurses Federation
- Australian Peak Nursing and Midwifery forum (comprising Australian Nursing and Midwifery Council, Congress of Australian and Torres Strait Islander Nurses, Australian Nurses Federation, Royal College of Nursing Australia, Council of Deans of Nursing and Midwifery, Australian College of Midwives, The Coalition of National Nursing Organisations)
- Australian Physiotherapy Council
- Australian Qualifications Framework Council
- Carers Australia
- Committee for Presidents of Medical Colleges
- Community Services & Health Industry Skills Council
- Department of Health & Human Services, Tasmania
- Department of Health, England, UK
- Department of Health, Victoria
- Department of Health, Western Australia
- Dieticians Association of Australia
- Faculty of Health Science, QUT
- Faculty of Health Sciences, Curtin University of Technology
- Faculty of Health Sciences, La Trobe University
- Faculty of Health Sciences, University of Sydney
- Faculty of Medicine, Health and Molecular Science, James Cook University
- Faculty of Science, Charles Sturt University
- Health Sciences Faculty, University of South Australia
• Health Sciences Faculty, University of Tasmania
• HealtheCare
• Lifeline
• Manchester Business School, UK
• Medical Board of Australia
• Medical Deans Australia and New Zealand
• National Rural Health Students Network
• New Zealand Nurses Organisation
• Northern Territory Mental Health Services
• NSW Department of Health
• Nursing & Midwifery Board of Australia
• Pharmacy Board of Australia
• Physiotherapy, Faculty of Science, Charles Sturt University
• Queensland Department of Health
• Ramsay Health Care
• Royal College of Physicians and Surgeons of Canada
• San College of Education
• School of Medicine, Flinders University
• Services for Australian Rural and Remote Allied Health
• Skills Australia
• Skin & Cancer Foundation
• Society of Hospital Pharmacists of Australia
• South Australian Department of Health
Annex 4 Ethics Approval

THE UNIVERSITY OF QUEENSLAND
Institutional Approval Form For Experiments On Humans
Including Behavioural Research

Chief Investigator: Professor Helen Chenery
Project Title: Project 4: Mapping Health Workforce Competencies,
Developing A Taxonomy For Competency-Based Standards In Health
Supervisor: None
Co-Investigator(s): A/Prof Sharon Brownie
Department(s): Faculty of Health Sciences
Project Number: 2010000637
Granting Agency/Degree: National Health Workforce Taskforce (NHWT)
Duration: 31st December 2010

Comments:

Name of responsible Committee: -
Behavioural & Social Sciences Ethical Review Committee
This project complies with the provisions contained in the National Statement on
Ethical Conduct in Human Research and complies with the regulations governing
experimentation on humans.

Name of Ethics Committee representative:-
Dr Jack Broerse
Chairperson
Behavioural & Social Sciences Ethical Review Committee

Date 15/06/10 Signature

15/06/10

Signature
Annex 5  Recommendations: National Health Planning Workforce Planning and Research Collaboration

Based on its findings, the research team (Brownie, Bahnisch, et al., 2011a) made a range of recommendations to Health Workforce Australia (HWA) as replicated below. A full copy of the report and associated literature review be accessed from the HWA website http://www.hwa.gov.au/publications/hwa-reports under the following header:

National Common Health Competency Resource for the Australian Health Workforce

- Exploring the Literature: Competency-based Education and Training & Competency-Based Career Frameworks (.pdf) — report by the National Health Workforce Planning & Research Collaboration
- Competency-based Education and Competency-based Career Frameworks: Informing Australian health workforce development (.pdf) — report by the National Health Workforce Planning & Research Collaboration

Australian health workforce

- That HWA further interrogates data describing the full profile of the Australian health workforce as per the categories identified in this report and disseminates information to further enhance whole-of-workforce understanding.
- That HWA undertakes further work to gauge the full extent of the emergent workforce categories, including consultation with key stakeholder groups regarding actual workforce and health service demand with a view to forming a strategic framework to guide increasingly emergent innovations and developments.
- That, at a national level, HWA adopts a whole-of-government coordination role on the allocation of funding and activities of direct relevance to the Australian health workforce.

Terms and definitions

- That HWA consults, develops and confirms an agreed set of terms and definitions to reduce ambiguity and ensure maximum clarity of communication and meaning across its work portfolio and in its interactions with key stakeholders. The glossary of terms included in this report could be a starting point for undertaking such consultation.

Competency-based education and training frameworks

- That HWA considers the requirements of competency-based education and training frameworks—for example, a clear communication and consultation exercise—to enhance increased understanding of, rationale for, and benefits of developing a whole-of-workforce competency framework. Vocational education and training (VET) sector informants indicated that an extensive communication strategy would not be required for the VET workforce, as the language of this sector is already one of competency.
- That HWA considers three options for a competency-based framework adaptable to a whole-of-workforce application within the Australian context. These options are to start afresh and develop a national workforce competency model; to adapt an existing model identified as having increasing acceptance and update across the workforce; or do nothing, and simply allow current unguided market developments to continue to unfold.
Competency-based career frameworks

- That HWA notes the potential benefits in developing and implementing a competency-based career framework for the Australian health workforce.
- That HWA notes the case studies and lessons profiled in this report.
- That HWA undertakes further analysis regarding the juncture between development of a competency-based career framework (a ‘workforce project’) and implementation of a competency-based career framework (an ‘industrial project’) and that these frameworks are fully explored and understood to optimise successful outcomes for any proposed development activity.
- That HWA notes the New Zealand Let’s Get Real case study as an example of a competency-based career framework that has been implemented as a health workforce project without industrial adjustments.
- That HWA notes the Australian experience in reform of the Engineering Industry Award as a possible example of a competency-based career reform project implemented through aligned industrial adjustments (see Annex 6).
- That HWA notes the concept of levels contained within the notion of a competency-based career framework and collaborates with other key national initiatives (for example, Australian Qualifications Authority) to ensure optimal whole-of-government coordination in any developments going forward, so as to avoid frameworks with varying number of levels that do not match.

Further research

A suite of supporting papers, and a literature review, is being prepared to supplement this report, which together will help to inform ongoing work in the Australian health workforce context. The research team maintains that further research is necessary to provide a stronger evidence base for this work, and recommends further work in the following focus areas.

- Work to develop and enhance common understanding and an agreed glossary of terms associated with competency-based education and training and competency-based career frameworks.
- Interrogation of data describing the full profile of the Australian health workforce as per the categories outlined in this report.
- Work to gauge the full extent of the emergent workforce categories, including consultation with key stakeholder groups regarding actual workforce and health service demand, with a view to forming a strategic framework to guide increasingly emergent innovations and developments.
- Analysis and exploration of the juncture between development and implementation of a competency-based career framework in order to optimise successful outcomes for any proposed development activity.

In addition, the research team believes that significant gaps exist in the contextual literature informing health workforce debates, and has suggested a series of additional research. These are detailed in section 11.6 (Brownie, Bahnisch, et al., 2011a).
The full citation for the report within which these recommendations are included is as follows:

Annex 6  Draft Value Statement: Competence, Competency & Frameworks - Advancing the Discussion

Understanding the Terms

Multiple definitions exist with little consensus and considerable controversy. Opportunity exists for HWA to take the lead and develop a set of shared definitions with common agreement across the health workforce. Definitions of relevance to health workforce settings include:

**Competence**: A generic term referring to a person’s overall capacity to perform a given role, including not only performance but capability. It involves both observable and unobservable attributes such as attitudes, values, and judgemental ability (Victoria Government Department of Human Services, 2009)

**Competency**: The ability to consistently perform work activities to agreed standards over a range of contexts and conditions (Knight & Nestor, 2000; Ridoutt, Dutneall, Hummel, & Smith, 2002)

**Competency in the clinical setting**: The ability to handle a complex professional task by integrating the relevant cognitive, psychomotor and affective skills (Carter & Jackson, 2009)

**Competency-based education and training frameworks**: Frameworks which are constructed to specify competencies relevant for registration, assessment of practice and curriculum design, and, education and training. UQ Research team (Brownie, Thomas, & Bahnisch, 2011)

**Is there a problem to be solved?**

Significant problems exist that are common across westernised countries and are increasingly being tackled by the development of cross professional, interprofessional and cross sectoral competency frameworks. Examples include the CanMEDS framework and the European Tuning Project (Jason R. Frank & Danoff, 2007; Tuning Educational Structures in Europe, 2011). Current problems within the Australian context include:

- Everyone is developing frameworks with little if any alignment and increasing disparity
- Frequently, frameworks are not aligned with the recently revised Australian Qualifications Framework. This exacerbates problems related to:
  - Variable standards/levels of competency within health qualifications & professions
  - Difficult transition between the VET and higher education sectors
  - Difficulties in recognition of prior learning for health workers wishing to build on their careers, change careers or migrate into Australia
  - Increasing professional demarcation and protection of professionally siloed roles
  - Difficulties for health employers wishing to increase workforce flexibility

**Value Proposition: What are the benefits?**

Provision of common platforms for learning along with clear articulation pathways for those seeking recognition of prior learning is of particular benefit in supporting health workforce developments (Duckett, 2005; Ellis, et al., 2006). Common frameworks inclusive of these features are of value to most groups within the health community (Wright, et al., 2008), including:
Health Consumers

- Improved patient and consumer care through increased flexibility in utilising the health workforce, and clear articulation and maintenance of skills and competencies
- The potential for less fragmented care and for more patient-centred practice

Health Professionals

- An enhanced understanding among students of the contributions and knowledge base of different professions
- Clearer career pathways and opportunities for the health workforce
- Greater clarity and transparency re workforce roles and accountabilities
- Simplification of complex employment arrangements and control of burgeoning new worker categories
- Opportunities to further understanding and knowledge sharing across different professions and workforce categories

Health Employers

- Greater flexibility in workforce utilisation
- Better alignment between education and the health sector
- Strong base for maintaining role and remuneration parity between workforce groupings (for frameworks with industrial links)
- Greater confidence in respect to certainty and comparability of standards

Health Educators

- The possibility of more seamless articulation and recognition of prior learning not just between VET and higher education, but also within higher education and post-graduate training
- Opportunity to work in closer partnership with the health sector and graduate health professionals who are better prepared for the workforce

Health Planners, Regulators and Registration Authorities

- The potential for skills migration within the existing workforce, and better preparation in meeting the new and emergent demands within the health system

A whole-of-workforce framework: Is this an option?

Understanding and defining the scope and breadth of the Australian Health Workforce is an essential precursor to any ‘whole-of-workforce’ considerations. Little if any literatures exist to comprehensively describe the entire workforce, however, reference to demographic health data by both government and health professional organisations, non-government entities such as Carers Australia, and the work of researchers exploring health workforce issues (Australian Qualifications Framework Council, 2011; Duckett, 2005; Ellis, et al., 2006; Nancarrow & Borthwick, 2005) lead to the conclusion that any ‘whole-of-workforce considerations should include the following groups:
• Specialist workforce, e.g., medical specialists, dental specialists (orthodontists)
• Regulated health workforce, e.g., allied health professionals, nurses, registered medical officers
• Unregulated health workforce, e.g., social workers, paramedics, indigenous health workers
• Emerging health workforce, e.g., physician assistants, nurse practitioners
• Support workforce, e.g., nursing, allied health assistants
• Voluntary unpaid and carer workforce

Opportunity exists for HWA to develop a whole-of-workforce framework with the following potential benefits:

• **Consumers**: Greater focus on integrated collaborative practice and patient centred care. Greater openness and transparency regarding the roles and responsibilities of those providing the care

• **Health Workforce**: Increased career flexibility, clearer processes for recognition of prior learning, maintenance of practice, maintenance of registration and articulated learning pathways. Greater certainty re standards and level of competency

• **Health Planners & Employers**: Clearer definition of health workforce roles and accountabilities against which health service planning can be undertaken. Greater flexibility in health workforce utilisation and deployment

• **Health Educators**: Clearer definition of health workforce roles and accountabilities against which curriculum development be undertaken
Annex 7  Sample of Competency-based Education and Training Frameworks

This annex provides a sample of the extensive range of frameworks in use or under development in the health sector. Those highlighted by an asterisk (*) were analysed in detail to identify their similarities and differences in structure and content. The summary of this analysis is as follows.

A very significant finding of this research has been twofold:

- there is a large number of competency frameworks in use and in development across the health sector
- this fact has not been previously apparent—the research team was unable to locate any substantive published literature highlighting this point in the Australian context.

Subsequently, the research team could not readily map all frameworks in use or in contemplation—the scenario involved an extensively moving target as frameworks are continually being developed, updated, expanded and/or retired.

The important implication of this finding is that frameworks are and have been proliferating across the sector. In the Australian health sector, numerous competency-based frameworks have been implemented or are under development, a sample of which is tabulated below in this annex.

In practical terms it was inadvisable, if not impossible, to harmonise every existent framework into a single taxonomy without substantive further research, consultation and additional resourcing. Given the large number of frameworks located and the constantly changing status of the frameworks, it was quickly agreed that the resources within this project were simply insufficient to attempt a mapping exercise as originally envisaged. Subsequently, discussion took place with the project funders, who agreed that a smaller scale mapping of selected frameworks was the optimal approach to inform this project.

The team analysed 10 frameworks (highlighted by an asterisk (*) in the list of frameworks in this annex) to identify their similarities and differences in structure and content. Purposeful sampling was used to select frameworks for analysis. Selection was made on the basis of the ability of the selected framework to illustrate salient points that had been identified in the research process regarding the nature of competency frameworks in the health sector and the way in which frameworks are developed for a number of purposes by differing stakeholders (for instance, professional bodies and jurisdictions).

All of the frameworks analysed used hierarchical structuring where first-level domains were identified as functional areas of the professions. Second-level elements covered units of competencies, which were then broken down into smaller, third-level units containing performance criteria, ranges of variables and evidence guides suited to assessment. Within the hierarchical structure, the frameworks varied considerably in the number of domains in each tier. Some frameworks contained as few as three domains within the first tier, with others comprising up to 12. Similarly, in lower levels of each hierarchy, the number of points or competencies numbered from as few as one and up to 12 in some cases.

Reference to the literature highlighted the fact that a hierarchical levelling structure can assist in the assessment of competencies and help individuals identify their strengths and weaknesses regarding their ability to perform in the profession or role (Hager and Gonczi 1991). Additionally, the hierarchical nature of a typical framework structure is useful for translating different languages characteristic of different professions for interprofessional practice and planning and deployment of skill-mix in varying workplace and clinical contexts.
A good example of a framework specifically designed for interprofessional practice has been provided in the case study of the British Columbia Competency Framework for Interprofessional Collaboration (see case study in section 10.2.3; College of Health Disciplines and Interprofessional Network of BC 2008). Similarly, CanMEDS (see case study in section 10.1.1) has been utilised to align a range of skill-based competencies under broad domains common to various scopes of practice and specialties, and this report has underlined its growing acceptance among a number of professions and internationally (Frank 2005).

While concern is often expressed that frameworks can be reductionist, this is not necessarily so. The team noted that for this reason some models and frameworks made it explicit that no single domain or unit of competencies is valid on its own.

The team noted that the frameworks vary considerably in terms of language or terminology, highlighting the fact that there is no nationally agreed format for competency standards, including the terminology used. For example, competencies are variably referred to as competencies, performance criteria statements, capabilities and standards.

It is also apparent that competency statements acquire their meaning in the context of specific professions, and are not necessarily meaningful across professions. That is, they need to be interpreted in context by the user, and only the individual profession can fully ‘decode’ profession-specific competencies.

In general, the themes of the domains of each framework could be loosely grouped into four categories: professional, technical, social and operational competencies.

All models contained some component of professional competencies, either in a single first-level domain, in several first-level domains, or integrated within technical task-based domains of the profession. They included areas such as accountability and responsibility, operation within scope of practice, reflective practice, maintaining standards and improvement of practice.

Most frameworks described a list of technical competencies undertaken by professions in the treatment of the patient/client. In addition to activity-based competencies, some frameworks listed knowledge and skills that are required for the job in the technical competency category. These lists are diverse and include descriptive tasks, outcomes (for example, patient safety, collaborative care), standards or management of practice (for example, adverse event, emergencies). Social competencies relate to ways in which health professionals collaborate and interact with people and their environment; hence, there is some degree of overlap between social and professional competencies. This overlap is evident in that some frameworks listing social competencies under professional attitudes and behaviours, while other frameworks integrated them with technical/functional competencies or listed them in separate single domains constituting overall competence. Operational competencies relate to how individuals operate in an effective, efficient and safe manner. They are context specific and dependent on settings of practice; hence, operational competencies vary greatly among frameworks. They include management of practice, use of information technology to enhance own practice, management of patient records, workplace safety and self-management of workload.

The conclusion that can be drawn from this analysis is that competency frameworks have exhibited a range of classificatory strategies depending on context. It is also notable that the process of mapping and aligning competency frameworks is rendered more complex by the variance in the number of domains and hierarchical tiers employed. The team is confident that this analysis of a sample of frameworks, while not statistically representative, does capture some key features and dynamics of frameworks as developed in the Australian health care context. A key implication of our analysis is that it is vital that any prospective national or interprofessional framework avoids overspecification of detail in subsidiary domains (that is, competencies) and has a top-level domain that is both broad enough and well conceptualised so as to enable the aim of harmonisation and alignment to occur.
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## Listening to our Stakeholders:
Analysis of interviews regarding competency-based education and training & competency-based career frameworks.

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Analysis of interviews regarding competency-based education and training & competency-based career frameworks.

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Faculty of Health Sciences and University of Queensland Centre for Clinical Research, University of Queensland, Australia

October 2012