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**Report on Shared Competencies for the Health
Workforce Workshop
Department of Human Services**

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Background

Introduction

In March 2009 the Department of Human Services (the Department) published a discussion paper about the concept of health workforce competency principles. In the discussion paper, the Department:

- noted that there is not a consistent concept of clinical competency across the Victorian health care system;
- signalled its intention to explore the idea of developing an industry-wide common language concerning competency standards and how it may contribute to a more effective health care system;
- noted that defining a concept of shared competencies is not an attempt to reduce the value of professional qualifications to a lowest common denominator - rather, it should enable a description of what aspects of competence and performance are most important in a particular field; and
- suggested that the outcome of this work may be a system-wide framework of healthcare competency principles, but that in order to develop such a framework, further engagement with stakeholder groups, including health service providers, health professional associations, educational institutions, regulatory authorities and health unions would need to occur.

The Department also noted that the interim report of the National Health and Hospitals Reform Commission included a reference to the importance of introducing a competency-based framework to allow a variety of entry points into health care careers, recognise prior learning and foster more flexible, multidisciplinary training across tertiary education programs. The Department signalled its willingness to participate in the national debate and use the consultation process to enable it to present the views of Victorian stakeholders as part of the national process.

Defining key concepts

The discussion paper defines key concepts as follows:

- Competency - specific capabilities (such as leadership) made up of knowledge, skills and attitudes;
- Competence - a generic term referring to a person's overall ability. Overall competence depends on the level of every specific competency.

The discussion paper also proposes, as a basis for consultation only, a set of principles under which competencies from different health workforce groups could be aggregated. There are four suggested core principles:

Core principle	Specific principles
<p>Client/patient service</p> <ul style="list-style-type: none"> • Collecting, obtaining, analysing and interpreting data such as the diagnostic or clinical decision-making activities • Patient centred care 	<p>1 Philosophy of care</p> <p>2 Service delivery</p> <p>3 Specialty</p> <p>4 Client/patient safety</p>
<p>Professionalism</p> <ul style="list-style-type: none"> • Working effectively with diverse populations and communities • Being a health advocate • Engagement in professional development and evidence based practice 	<p>5 Ethics</p> <p>6 Law</p> <p>7 Equity</p> <p>8 Performance improvement</p>
<p>Workplace and health systems</p> <ul style="list-style-type: none"> • Working in partnership and providing coaching/mentoring • Policy and planning, and occupational health and safety 	<p>9 Management</p> <p>10 Team player</p> <p>11 OH&S</p>
<p>Communication</p> <ul style="list-style-type: none"> • Effective interpersonal communication with clients and colleagues • Intra- and inter-disciplinary communication • Data presentation and information technology 	<p>12 Client/patient</p> <p>13 professional</p>

The 'Shared competencies for the health workforce' workshop

On Monday 6 April 2009 the Department hosted stakeholders from a wide range of backgrounds at a workshop.

The purpose of the workshop was to discuss the concept of shared competencies for the health workforce and, in particular, the principles presented in the discussion paper.

The workshop was held at the Rendezvous Hotel and was facilitated by Dr Heather Wellington. The workshop agenda is at **Attachment 1** and a list of attendees is at **Attachment 2**.

Senior representatives of the South Australian Department of Health and the National Health Workforce Taskforce (NHWT) attended and participated in the workshop, reflecting a commitment by Victoria and South Australia to collaborate in the area of national health workforce development and to inform the forthcoming national project.

This is the report of the proceedings and outcomes of the workshop.

Policy rationale and implications of a shared competency framework

Introduction

'Setting the scene' presentations were made by:

- Ms Kim Sykes, Director, Service and Workforce Planning, Department of Human Services;
- Dr Brendan Murphy, Chief Executive Officer, Austin Health; and
- Professor Karen Dodd, Associate Dean, Faculty of Health Sciences, La Trobe University.

Copies of the presentations are available at <http://www.health.vic.gov.au/workforce/competency>

Background and policy rationale

Ms Kim Sykes presented on the background to, and policy rationale for, exploring the concept of a shared competency framework.

The Department has received feedback indicating that there is significant interest in the concept of shared competencies, and now seeks a meaningful discussion and honest dialogue about the opportunities and risks associated with the concept and the way in which it should be progressed.

Ms Sykes noted that:

- concerns exist and will need to be addressed, but also that there are perceptions and opportunities that require exploration;
- the differences in language used within the educational and health care sectors may mask similarities in concepts;

- there is no intention to undermine disciplinary professionalism or develop a different type of health care worker - rather, there is an opportunity to identify what is special and unique about different professions and use this to inform the crafting of future roles to complement existing roles;
- some good examples exist where shared competency frameworks have informed innovation - for example, training packages in the Vocational Education and Training (VET) sector, the La Trobe University common first year program for health students and the development of a national common assessment tool in nursing;
- the discussion paper was released for the purpose of beginning a dialogue. It does not present final concepts; and
- a shared competency framework project will be led by the NHWT, but Victoria hopes to make a significant contribution to the national initiative.

Implications for the health industry

Dr Murphy's presentation highlighted the critical need to address health workforce issues, which he identifies as the biggest challenge facing the health care sector. While previously he believed that addressing workforce shortages by educating or attracting new workers was the key issue, increasingly he believes that assuring the professional satisfaction of health care workers, thereby assuring their retention in the system, is the greatest challenge. This will require workers who are well-trained and who are undertaking tasks that fit their expectations, knowledge and skills.

Dr Murphy proposed that:

- an apprenticeship model is not a safe way for health care professionals to gain new skills;
- some skills are very similar between professions;
- a shared competency framework may assist in the recognition of prior learning of overseas-trained doctors;
- we have not been strong at working with universities to ensure the needs of employers are addressed in undergraduate curricula, instead opting to tailor postgraduate training to address deficiencies in the graduate workforce. The health care system needs to work with universities more closely, within a shared framework, to ensure graduates are equipped to meet the needs of employers; and
- while there are risks of reducing professional identity and sense of 'who we are', and some professionals and industrial groups are anxious about the implications of a shared competency framework, these risks and anxieties can be recognised and addressed as the framework is developed.

Implications for the higher education sector

Professor Dodd reported the experience of La Trobe University, which has introduced a common first year education program and maintenance of a common competency framework over the ensuing three years of its undergraduate health care professional courses. The final two years of each course will also be delivered in a clinical school setting.

La Trobe University started from the perspective of considering the needs of employers as a basis for identifying necessary competencies. There are commonalities between professions but also specialty areas - the process has enabled the differences between and 'uniqueness' of professions to be identified.

The University is looking to increase its interdisciplinary focus in the final year.

A major benefit has been the ease of transferring between courses in undergraduate years.

Initial feedback about principles, benefits and limitations

Introduction

Following the presentations, participants engaged in table-based discussions about the concept of a competency framework. They were asked to address the following questions:

- **What do you think of the concept of a shared competency framework?**
- **How might a framework benefit you and the work you do?**
- **What might its limitations be? What are the risks involved?**

Participants then had an opportunity to continue their discussion with a panel comprising:

- Ms Kim Sykes.
- Mr Peter Carver (Executive Director, National Health Workforce Taskforce).
- Mr Etienne Scheepers (Executive Director, Workforce Development Division, Department of Health, South Australia).
- Ms Di Lawson (Chief Executive Officer, Community Services and Health Industry Skills Council).
- Professor Karen Dodd.

General comments

The large majority of participants reacted positively to the concept of a shared competency framework. Some participants suggested that the concept was 'obvious' and 'sensible'. Some considered that it is too early to form a view. There were many potential risks, limitations and uncertainties expressed and a small number of participants did not appear to support the concept.

There was concern that:

- there is no 'shared language' between sectors and professions - this would need to be established as a first step and the adopted language would need to be clear and simple to support change management;
- until the purpose of establishing a shared competency framework has been agreed it will be difficult to agree on the elements of the framework. There may be a number of purposes including improving patient outcomes; establishing an inter-disciplinary approach to the delivery of care; establishing a basis for workforce performance monitoring; developing a more flexible workforce and/or improving the efficiency of the workforce;
- there are multiple stakeholders and the development process will be complex;
- the unions need to be engaged in developing and implementing the concept;
- the framework needs to apply to the community sector as well as the hospital sector;
- the needs of the current workforce should be recognised - the focus should not solely be on the needs of the emerging workforce; and
- the concept could be used to reduce health care costs by expanding utilisation of a less qualified and less expensive worker - many participants see this as potentially problematic.

It was suggested that:

- shared competencies already exist but they are not formulated or articulated;
- it will be important to consider how much of the acquisition of a competency is context-specific;
- there is a difference between generic competencies and generic positions;
- it should not be assumed that professionals are seeking to discard less complex tasks from their professional responsibilities, nor may it be practicable for them to do so. There is a risk that the roles of the professions may become highly technical with less emphasis on human interaction. There may be a need to mix low- and high-complexity tasks to achieve overall job satisfaction and the efficient delivery of services;
- as well as defining competencies, levels of competence are of great importance and require greater definition;

- a shared competency framework will need to relate to other competency frameworks that are already in place including the Australian Council for Safety and Quality in Health Care's National Education Framework, frameworks addressing cultural responsiveness and various other frameworks in the health and education sectors. Frameworks that are already established need to be identified and evaluated;
- timing will be important - in particular the relationship between the establishment of a national system of course accreditation and registration of health care professionals and the development of a national shared competency framework will need to be considered;
- a shared competency framework may assist to resolve some workforce issues but will not be the only solution to health workforce challenges;
- consumers should be invited to participate in identifying the competencies required of health care professionals and should be engaged in development of the framework; and
- a shared competency framework, if adopted, should apply:
 - to course entry-level;
 - throughout an entire course; and
 - throughout a professional's career.

Overall, participants emphasised the need for a shared competency framework to be:

- | | |
|--|--|
| <ul style="list-style-type: none"> • Developed for an explicit, agreed purpose • Based on the needs of patients • Evidence based • Encompassing both theoretical and clinical aspects of professional practice | <ul style="list-style-type: none"> • Applied to defined health professional groups • Developed in the context of, amongst other things, the needs and aspirations of 'generation Y' practitioners and practitioners from different cultural backgrounds • Subject to evaluation |
|--|--|

Benefits

The following potential benefits were identified:

For patients

- The ultimate benefit should be better, more streamlined patient care
- Improved referral, handover, coordination and continuity of care
- A client-centred rather than a task- or practitioner-centred approach
- Reduced duplication of care
- Freedom from jargon, with benefits for patients

For healthcare organisations

- A more positive culture
- Defining a vision and destination for the health workforce
- A more flexible health workforce, particularly in regional areas
- Better matching of skills with tasks
- A better understanding of what is required of employees and what they are capable (or otherwise) of doing
- Building of bridges between the university and health sectors
- Combined or better integrated graduate programs
- Improved efficiency of service delivery
- A true interdisciplinary workforce
- Benefits for credentialing and quality processes

For professions

- Recognition of the common underpinnings of professional knowledge
- A more efficient and flexible way to achieve qualifications
- Easier recognition of prior learning
- Support for lifelong learning
- Better understanding between professions and disciplines about each others' role and improved inter-professional and inter-disciplinary respect
- Better capacity to work in teams
- More opportunities for health care professionals to further their education with double degrees
- An opportunity to improve health care professionals' understanding of the Australian health care system
- Removal of 'secret professional silos'
- Improved staff satisfaction by changing work structures
- Professionals more empowered by building their profession-specific skills

For education providers

- Easier to establish pathways for movement between the VET sector and the higher education sector
- More informed decision-making by undergraduates
- More mobility of undergraduates

Risks and limitations

The following potential risks and limitations were identified:

For patients

- Threats to holistic care (by segmenting roles currently assumed by a single profession)
- Fragmentation of care
- Confusion for consumers

Implementation/system issues

- Implementation costs (may be significant)
- Difficulty comparing a university capability framework with a clinical competency framework
- Resources required to assess competencies
- Failure to take account of the complexities of the system
- Different implementation outcomes because of different interpretations of terminology and intent
- Recruitment difficulties because roles are not well-defined
- Blurring of accountability for care
- Rigidity through 'over-engineering'
- Work-based assessment may emphasise practical competencies over academic competencies
- Continuing investment in ongoing education and professional development will be necessary
- There is a distinction between workforce and workplace reform

For professional practice

- Potential to 'dumb down' the professions
- Over-emphasis on generic competencies at the expense of discipline- and specialty-specific competencies
- Narrowing of practice in different professions and disciplines
- The production of a 'standardised' worker, with a consequent limitation on creativity and innovation
- Failure to incorporate 'lower level' competencies
- Fragmentation of professions and practices
- The needs of specialist practice may be overlooked
- Longer training times for professionals wishing to specialise
- Loss of essential philosophies of and/or value placed on different professions and disciplines
- Confusion around the identity of different disciplines
- Production of a 'generic' worker'
- Loss of professional 'ownership' of and commitment to professional education and training

Practical applications of a competency framework

Implications for clinical service delivery

In session 2, participants were asked to consider the implications of a competency framework for different stakeholders and in different contexts.

Participants were asked to consider:

- How might work teams be structured under a shared competency framework?
- How might shared competencies be used to improve the efficiency of service delivery?
- How might a competency framework affect the provision of clinical education?

Participants made the following points:

- Teams may:
 - be trans-disciplinary or inter-disciplinary; and
 - contain a lead practitioner and support practitioners.
- Referrals may occur within and between teams.
- The impact of a competency framework on team structures may vary between hospitals and primary care.
- Nevertheless, a framework will support flexibility in team structure, identification of the specialist skills necessary to streamline client care and clarity of roles and processes.
- There is existing duplication within teams, some of which is to support safety and some of which is unnecessary. A shared competency framework will support reduction in duplication of common competencies.
- A shared competency framework will aid in improving communication (facilitating adoption of the most effective methods and achievement of the most consistent outcomes).
- A shared competency framework presents a risk of limiting professional practice and may have ethical and trust implications. Privacy, patient record and confidentiality issues will need to be addressed early.
- There may be a tendency for people to refer more to what is in their position descriptions rather than taking a broad professional view.
- Shared competencies are more about informing professional practice and knowledge across disciplines (mapping).
- Shared competencies may devalue specific professions, as 'under qualified' people may be providing advice.

- The best value of a shared competency framework would be to help understand what is taught and provide a mechanism to support transparency and inter-professional understanding.

Implications for individual practitioners

Participants were asked to consider:

- How might a shared competency framework account for specialty competencies in a meaningful way?
- How can the integrity of individual health professions be maintained while still maintaining a commitment to improved workforce efficiency and workforce redesign?
- What impact(s) might a competency framework have on the way care is delivered to patients?

Participants made the following points:

- A base of generic skills may improve consistency in the delivery of care.
- Health care professionals should be mandated to complete continuous professional development and professional standards should be established and reviewed on a national basis.
- Specialty competencies are not synonymous with discipline-specific knowledge, skills and attitudes. The shared competency framework example in the Department's discussion paper focuses on underpinning generic competencies e.g. communication, leadership, ethical practice, legal practice etc. If specialty competencies are intended to be part of the framework, the scope would be significantly expanded and, potentially, impracticable. If, however, a framework is limited to generic competencies, it is difficult to see how it would meaningfully contribute to workplace efficiency or redesign. The impact on delivery of care would, therefore, be minimal.
- It may be preferable to start from a point of commonality rather than difference.
- Most practitioners now function in teams.
- There is a need to improve sharing of experiences between practitioners.
- If a narrower range of competencies could be defined it may be possible to shorten undergraduate training times to meet community need.
- Gatekeeper roles should be shared.
- It should not be assumed that competency is not already being demonstrated or that individual practitioners are not already demonstrating commitment to improving workforce efficiency and redesign. The system of healthcare needs to change.
- Professions need to maintain control of accreditation processes to ensure profession-specific educational needs are met.

- There is a need for a greater focus on primary health care in the framework.
- There may be a particular benefit of a shared competency framework for specific patient groups, e.g. people from CALD backgrounds.
- An evidence-based approach will be needed to demonstrate any impact of a shared competency framework on the way care is delivered.

Implications for health professions

Participants were asked to consider:

- **What impact might a competency framework have on the registration and accreditation of health professional groups?**
- **How might a competency framework affect the way the professions interact with each other?**

Participants made the following points:

- Some professions have existing competency frameworks which may change with the introduction of a shared competency framework - hopefully, this would be complementary. A shared competency framework may limit the use of currently individualised programs.
- A level of commonality already exists between disciplines at present - this should be taken into account.
- The aim should be to reduce complexity.
- A shared competency framework:
 - will help to develop a shared language;
 - may create opportunities for debate and discussion on clinical and specialist competencies;
 - may create pressure on some professions to be more flexible and interact more;
 - may open up professional roles outside the traditional medical model;
 - may improve teamwork resulting in better management of clients, including those with chronic disease;
 - may assist professionals and professional bodies to identify and respond to continuous professional development needs;
 - may assist overseas-trained professionals to overcome 'artificial barriers' to registration and practice; and
 - would increase transparency across the health care professions.

- The role of accrediting bodies in setting competency standards varies across disciplines - this needs to be understood and taken into account.
- Improved interaction between the professions and understanding of each others' work will result in better outcomes for patients.
- There is a need for individual employers to be more explicit about their needs and expectations of their employees - this will be supported by a shared competency framework.
- Different levels of competency will apply at university/VET, work readiness, workplace novice and workplace expert levels.
- Structural and legal barriers may override shared competencies; options that are theoretically possible are limited by existing systems.
- There would need to be effective communication to persuade professions that have existing frameworks of the benefits of an overarching framework across all health professions. Generally, a high level of stakeholder consultation will be needed, which will require time and resources.
- How would a shared competency framework be taken up - for example, by legislation, or by registering bodies?

Implications for the VET sector

Participants were asked to consider:

- **How are competencies currently used and assessed in VET?**
- **How might a competency framework aid transitions between VET and higher education?**
- **How might a competency framework influence teaching and learning in VET?**

Participants made the following points:

- Currently, a unit-based system of assessment is used, with assessment of a cluster of 5-6 units, moving to a graded assessment (i.e. level of competency).
- A shared competency framework would:
 - enable a more informed choice for new entrants to education. The concept should extend beyond the education setting to the patient experience in the clinical setting;
 - enable assessment across sectors (e.g. acute, aged care etc.);
 - aid in the recruitment of sessional specialist teachers;
 - enable better utilisation of infrastructure and resources including information technology;

- need to be sufficiently flexible to be applied locally. In addition, professional groups are at different levels of maturity and a framework may need to be applied differently in different professional settings.
- There are opportunities to better define curricula based on competencies, to provide multidisciplinary and interdisciplinary education at all levels of the education and training continuum and to articulate the pathways between the VET and higher education sectors more clearly.

Implications for the higher education sector

Participants were asked to consider:

- How is competency measured in higher education?
- How might a competency framework influence the development of learning outcomes?
- What might be some common learning outcomes across health disciplines?
- How might a competency framework aid transitions between VET and higher education?
- How might a shared competency framework affect the provision of clinical education?

Participants made the following points:

- There are a variety of techniques used to measure competency in higher education. Competency assessment tools used alone or in combination include examinations, case studies, clinical skills laboratory observation and practical observation.
- Some participants perceived that higher education assessment is based more on 'capability' than competency.
- Competency measurement requires the right contextualisation.
- Care needs to be taken to avoid measuring only what is easy to measure. Some important outcomes are not readily amenable to, or even appropriate for, strict measurement.
- There is a shared obligation between the higher education sector, the service delivery sector, professional associations and colleges and regulatory authorities to determine whether an individual has acquired all required competencies.
- Care needs to be taken not to reduce measurement of competency skills, knowledge and attributes with respect to a task-oriented, 'tick-box' approach.
- Competencies could include privacy, confidentiality, quality, safety and leadership.
- Key competencies should be universally recognised.

- The challenge is not defining the necessary competencies, but reliably measuring whether those competencies have been acquired and applied. There is a distinction between competence and performance - measuring performance requires constant monitoring, evaluation and review, especially in the context of a changing workforce.
- There is an opportunity to align core competencies with common learning outcomes.
- There is an existing pathway between the VET and higher education sectors, but its accessibility is limited and depends on specific institutional arrangements. There is an opportunity to enhance transition between the sectors but this should not be about compelling or requiring uni-directional entry to higher education.
- There are significant opportunities to provide combined clinical education in the areas of common competencies - e.g. cardio-pulmonary resuscitation.
- A shared competency framework will enable identification of skill deficits for educational purposes.
- Clarity will be required about what educational modules are recognised by each profession.
- There will be greater opportunities for inter-disciplinary and multi-disciplinary undergraduate courses and inter-professional learning. Educators may be used across the professions and students assessed based on a shared competency framework.

Implications for recruitment, retention and performance assessment

Participants were asked to consider:

- **How could a competency framework be used to measure professional performance?**
- **How might a competency framework be used to recruit appropriate staff?**
- **How might a competency framework influence employees' transitions between work roles and organisations as they change jobs?**
- **What impacts might a competency framework have upon staff retention/attrition rates?**

Participants made the following points:

- There is an assumption that there are mature performance management systems in the health care system - this is not necessarily the case.
- Employers recruit against a position description rather than a shared competency framework. Where is the intersection between professional competencies and a position description?
- There will be a need to translate common competencies to the clinical setting.

- A shared competency framework may enable health care professionals to gain additional skills and credentials.
- A shared competency framework may underpin a tool for self-assessment and assist to define what education and training are needed to transition between work roles.
- There may be benefits in community settings where clients currently may see multiple practitioners.
- Improved flexibility for health care workers may enhance retention.
- Professional elitism may diminish.
- The benefits are in both teaching and assessing competencies. A generic national board could achieve this.
- There are many existing models in place which are supporting recruitment and retention of health care professionals.

Implementation issues

Participants were asked to consider:

- Is the proposed framework adequate? What requires further consideration? How might a framework be implemented? What are the barriers, risks and opportunities going forward?
- What are the roles and responsibilities of health services, educational providers and professional groups in the implementation process? What are the roles and responsibilities of the government?

Adequacy of the framework

Some participants believe the specific principles look broadly satisfactory, while others suggested that the framework may be too generic to be adequate and could be enhanced by contextualisation.

There was agreement that:

- the purpose of the framework needs to be defined before implementation can be progressed; and
- the relationship between competencies, scope of clinical practice, license to practice and quality and resource management needs to be clarified.

It was suggested that the proposed framework is too hospital-centric, and that the framework should be developed from the patient's point of view.

It also was suggested that the framework overemphasises the importance of generic competencies to the detriment of specialty-specific competencies, which consume the majority of training effort and shape the professional role and responsibilities. In general, all competencies should not be portrayed as being of equal importance.

Participants suggested that certain issues deserve more adequate coverage. For instance, the concept of clinical quality needs to be highlighted. In addition, the delegation of tasks to other health care professionals is a specific competency which is of critical importance in a team environment but is not explicitly included in the framework. Other issues include:

- | | |
|------------------------------------|--------------------------------------|
| • diversity | • lifelong learning |
| • fitness to practice | • critical decision-making skills |
| • self-management | • cultural awareness and sensitivity |
| • resilience | • inter-professional respect |
| • self-direction | • research |
| • critical thinking and reflection | |
| • analytical skills | |

There is support for identifying different levels of competency, but some participants believe that table 6 (in the Department's discussion paper) requires greater explanation.

It was suggested that:

- the benefits of the framework will need to be articulated clearly to stimulate stakeholder engagement;
- the terminology used to describe the principles may need revision. The terminology 'competency principles' was challenged by some participants;
- the principles of the National Health Workforce Strategic Framework need to be reflected in the competency framework;
- 'specialty' as a principle is unclear;
- 'workplace' is not a competency principle;
- occupational health and safety is a different concept from client safety and should be addressed separately;
- it is unclear whether the proposed levels are designed to reflect entry-to-practice as the minimum; and
- competency standards and levels need to be flexible and adaptive to change.

Barriers, risks and opportunities going forward

Participants noted that the initiative represents a significant change and identified the following barriers to implementation:

- Entrenched workplace cultures.
- Established lines of demarcation.
- No common language.
- A large number of accrediting and registering bodies.
- Professional silos and jealousy.
- Inertia and failure to act.
- A fear that the initiative may signal an intention by authorities to assume responsibility for determining professional competencies.

In the interests of enhancing relevance and application to clients, it was suggested that the topic should be 'health workforce care delivery principles' or 'health workforce principles of care'.

It was reinforced that:

- there needs to be a common language including common definitions of 'competency', 'framework', 'skills' and 'tasks';
- stakeholder engagement will be critical to effective implementation;
- the context of service delivery will be important to the development and assessment of competencies;
- there is a distinction between service delivery frameworks and a shared competency framework;
- the shared competency framework should not establish additional barriers to entering practice;
- the shared competency framework should apply in the context of life-long learning;
- the shared competency framework is a high-level model. It should be an adjunct to discipline-specific competency standards which define the richness and complexity of the professional roles;
- care will need to be taken to ensure the approach is not reduced to a checklist; and
- resources will need to be provided to both educational and service providers to enable implementation, including reviewing current curricula against the framework and redeveloping curricula to meet the framework.

Roles and responsibilities

It was suggested that:

- governance responsibilities will need to be clarified;
- the initiative should be national, not state-based;
- the initiative needs to align with the VET sector;
- monitoring of unregulated workers need to be considered;
- educators and clinicians will need to be engaged and resourced to develop and implement the shared competency framework;
- the role of professional bodies and regulatory boards needs to be clarified. It is assumed that professional bodies will still set specialty standards. Regulatory boards will need to be engaged early;
- accreditation bodies will be the keepers of competency standards relevant to their discipline (some shared with other professionals);
- any type of performance assessment is a challenge when professionals are working alone; and

- government will need to mandate or facilitate compliance (depending on the preferred policy direction), monitor progress and evaluate outcomes on an ongoing basis.

Suggested next steps

It was suggested that:

- the purpose for developing the shared competency framework needs to be clearly explained;
- the evidence basis for the initiative, including the experience internationally, and the construct on which the principles are based need to be explained;
- the relationship with existing quality and workforce frameworks and policies (including credentialing and scope of clinical practice policies) needs to be explained;
- competencies should be mapped at a discipline-specific level;
- a meta-analysis of all professional competency frameworks needs to be undertaken to identify commonalities and an appropriate clinical framework that will engage clinicians, not just managers;
- engagement of educators and clinicians will be critical to success;
- implementation will need to span the public and private sectors in hospital and community settings; and
- an evaluation framework needs to be established early.

National initiatives

Mr Peter Carver presented on the current status of national initiatives. He advised that three current projects are being undertaken:

- core competencies for the interface between acute and aged care services;
- core competencies and an educational framework for maternity services;
- core competencies for the Australian health workforce.

It is clear that:

- not all professions have defined competencies;
- there is no common agreement on the purpose or function of competencies;
- inconsistent language and terminology is used; and
- there is a developing inter-professional learning agenda but there is a lack of clarity on competencies and how best to focus both inter-professional learning and practice.

A significant consultation and engagement process is proposed at a national level, involving professions, accreditation bodies and education and service providers. This will inform a future health workforce competencies framework.

Further information can be obtained from:

- www.nhwt.gov.au
- Teresa Valentine, Teresa.valentine@dhs.vic.gov.au (tel: 03 9092 2002)

Closing remarks

Ms Kim Sykes thanked everyone for their participation and advised that feedback from participants would be used to inform Victoria's input into the national process. The workshop report would be publicly released and broadly disseminated.

Mr Etienne Scheepers closed the workshop with thanks to participants and an expression of appreciation for the welcome accorded to the South Australian representatives. He noted that it is clear that the workshop was the start of a process of consultation and development and that Victoria and South Australia will continue to work collaboratively, with the National Health Workforce Taskforce, to explore the concept and inform the development of a proposed shared competency framework for the national health workforce.

Attachments

Attachment 1 - Workshop agenda

Shared Competencies for the Health Workforce Workshop Event

Monday 6 April 2009

Rendezvous Hotel, 328 Flinders Street, Melbourne

TIME	SEMINAR
9.00 am	Registration
9.30 am	Welcome: Dr Heather Wellington, Consultant, DLA Phillips Fox, Facilitator
9.35 am	Presentation: Ms Kim Sykes, Director, Service and Workforce Planning, Department of Human Services, Victoria <i>Why competencies? Background and policy rationale</i>
9.50 am	Presentation: Dr Brendan Murphy, Chief Executive Officer, Austin Health <i>Implications of shared competencies for the health industry</i>
10.05 am	Presentation: Professor Karen Dodd, Associate Dean, Faculty of Health Sciences, La Trobe University <i>Implications of shared competencies for the higher education sector</i>
10.20 am	Morning tea
10.40 am	Breakout session 1: Health workforce competency principles - group discussion around the concept of a competency framework. Exploration of associated benefits and limitations
11.15 am	Panel discussion Ms Kim Sykes, Department of Human Services Victoria Mr Peter Carver, Executive Director, National Health Workforce Taskforce Mr Etienne Scheepers, Executive Director, Workforce Development Division, Department of Health, South Australia Ms Di Lawson, Chief Executive Officer, Community Services and Health Industry Skills Council Professor Karen Dodd, La Trobe University
12.00 pm	Breakout session 2: Practical applications of a competency framework - discussion of the implications that a competency framework has for the sectors, professions, organisations and individuals
12.40 pm	Lunch
1.20 pm	Breakout session 3: Implementation issues - identifying the barriers to implementation; the risks, opportunities and ways forward from here
2.15 pm	Report back
3.00 pm	Presentation: Mr Peter Carver, National Health Workforce Taskforce <i>Next steps in the national process</i>
3.15 pm	Closing remarks: Ms Kim Sykes, Department of Human Services, Victoria and Mr Etienne Scheepers, Department of Health, South Australia
3.30 pm	Close

Attachment 2 - Workshop attendees

Name	Surname	Organisation
Martin	de Graaf	Swinburne University of TAFE
Sue	Reichstein	Swinburne University of TAFE
Angela	Hoare-Lippmann	Box Hill Institute of TAFE
Kerry	Kirk	Box Hill Institute of TAFE
Kem	Sedick	Box Hill Institute of TAFE
Madelyn	Lettieri	Chisholm Institute of TAFE
Mavis	Smith	Mayfield Education
Helen	Ryan	Goulburn Ovens Institute of TAFE
Keith	Hitchen	Hays International College
Megan	Gaskett	Goulburn Ovens Institute of TAFE
Adrian	Schoo	Greater Green Triangle University
Megan-Jane	Johnstone	Deakin University
Helen	Forbes	Deakin University
Chris	Browne	Monash University
Louise	McCall	Monash University
Meg	Morris	University of Melbourne
Justin	Kidgell	RMIT University
Kay	Stewart	Monash University
Joanne	Cameron	ACU National
Geoff	McColl	University of Melbourne
Debbie	Kras	La Trobe University
Kathleen	McLaughlin	Royal College of Nursing Australia
Tracey	Osmond	The College of Nursing
Tina	Ivanov	Ambulance Victoria
Kathleen	Hickey	Royal Australasian College of Surgeons
David	Ranson	Royal College of Pathologists of Australasia
Harvey	Newnham	Royal Australasian College of Physicians
Rachel	Adkins	Australian Pharmacy Council
Dianna	Kidgell	Australian Nursing and Midwifery Council

Name	Surname	Organisation
Karen	Cook	Australian Nursing and Midwifery Council
Robert	Broadbent	Australian Dental Council
Tom	Molyneaux	Council on Chiropractic Education Australasia
Ian	Frank	Australian Medical Council
Katrina	Hansen	Council of Ambulance Authorities
Jane	Gray	Australian Orthotic Prosthetic Association
Patricia	Kiely	Optometrists Association of Australia
Shirley	Loh	Optometrists Association of Australia
Gail	Mulcair	Speech Pathology Australia
Catherine	Itsiopolous	Dietitians Association of Australia
Damien	Guengerich	Australian Osteopathic Association, Victoria
Antony	Nicholas	Australian Osteopathic Association
Garry	Pearson	Australian Dental Association, Victoria
Glenda	Bawden	Australian Association of Social Workers, Victoria
Jo	Page	Australian Institute of Radiography
Krystina	Brown	Chiropractors Association of Australia
Paul	Fisher	Chiropractors Board of Victoria
Andries	Kleynhans	Chiropractors Board of Victoria
Peter	Gigante	Chinese Medicine Registration Board of Victoria
Mark	Gilheany	Podiatrists Board of Victoria
Margaret	Dawson	Podiatrists Board of Victoria
Nigel	Fidgeon	Nurses Board of Victoria
Petrina	Halloran	Nurses Board of Victoria
Mitchell	Anjou	Optometrists Board of Victoria
Joanne	Katsoris	Medical Practitioners Board of Victoria

Name	Surname	Organisation
Jonathan	McConnell	Medical Radiation Practitioners Board of Victoria
Geoff	O'Kearny	Australian Medical Association, Victoria
Marcia	Gleeson	Australian Nursing Federation
Catherine	Hutchings	Australian Nursing Federation
Denise	Guppy	Health and Community Services Union Victoria Number 2 Branch
Enid	Smith	Stawell Regional Health
Suzanne	Metcalf	The Alfred
Jenny	Tunbridge	Hepburn Health Service
Rodney	Fawcett	Barwon Health
Doris	Vella	Royal Melbourne Hospital
Graeme	Allan	Bendigo Health Care Group
Fiona	Lukaitis	Bendigo Health Care Group
Christos	Roussos	Royal Victorian Eye and Ear Hospital
Cheryl	Woollard	Eastern Health
Carol	Jewell	Melbourne Health
Sue	Bruce	Melbourne Health
Gayle	Sammut	Goulburn Valley Health
Deanne	Riddington	St Vincent's Hospital
Nip	Thomson	Alfred Hospital Monash University Clinical School
Geraldine	Webster	Ballarat Health Services
Fiona	Brew	Ballarat Health Services
Anthony	Ball	Alfred Health
Hilary	King	Western District Health Service
Nicole	King	Peter MacCallum Cancer Institute
Aldo	Rolfo	Peter MacCallum Cancer Institute
Peter	Taylor	Peninsula Health
Fiona	Whitecross	Alfred Health: Psychiatric Services
Amanda	Molyneaux	Western Health

Name	Surname	Organisation
Yvonne	Hewitt	Barwon Health
Christine	Mandrawa	University of Melbourne Medical Students' Society
Alison	Brown	Victorian Healthcare Association
Judy	Nichols	Rural Workforce Agency, Victoria
Jacque	O'Brien	Community Services and Health Industry Training Board
Geoff	Sheehan	Community Services and Health Industry Training Board
Connie	Koklanis	La Trobe University Royal Children's Hospital Orthoptic Association of Australia
Allan	Ward	Skills Victoria
Charlie	Xue	RMIT University
Di	Lawson	Community Services and Health Industry Skills Council
Karen	Dodd	La Trobe University
Brendan	Murphy	Austin Health
Teresa	Valentine	National Health Workforce Taskforce
Peter	Carver	National Health Workforce Taskforce
Etienne	Scheepers	Department of Health, South Australia
Kate	Hawke	Department of Health, South Australia
Sue	Stack	Department of Health, South Australia
Kim	Sykes	Department of Human Services
Belinda	Moyes	Department of Human Services
Margie	Powell	Department of Human Services
Penny	Tolhurst	Mental Health Workforce Advisory Committee
Maria	DeLeo	Department of Human Services

Name	Surname	Organisation
Allan	Donelly	Department of Human Services
Liz	Brooks	Department of Human Services
Sue	Davey	Department of Human Services
Heather	Wellington	(Facilitator)