Australian Healthcare and Hospitals Association

Background research and consultation to inform the review of pharmacy competency standards

CONSULTATION PAPER

For the Pharmacy Practitioner Development Committee

19 December 2014

Australian Healthcare and Hospitals Association

Unit 8, 2 Phipps Close
Deakin ACT 2600

PO Box 78
Deakin West ACT 2600

P: 02 6162 0780

F:02 6162 0779

E:admin@ahha.asn.au

W: ahha.asn.au

AusHealthcare

cebook.com/AusHealthcare

ABN: 49 008 528 470

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Introduction

Purpose of this consultation paper

This consultation paper has been prepared for the Pharmacy Practitioner Development Committee (PPDC), chaired by Dr Shane Jackson, by the Australian Healthcare and Hospitals Association (AHHA).

The PPDC is a profession-wide collaborative forum of eleven organisations established to focus on the development of pharmacist practitioners in Australia through consideration of competencies and scopes of practice. The PPDC has commenced a review of the *National competency standards framework for pharmacists in Australia* which is consistent with its regular review cycle.

The AHHA has been appointed to conduct the initial background research and consultation work which will inform the PPDC's subsequent stages of the review.

The AHHA team is shown below.

Team member	Project role
Alison Verhoeven	Executive oversight
Andrew McAuliffe	Consultation survey design, data analysis
Bryan Stevens	Project sponsor, stakeholder consultation, reporting
Kylie Woolcock	Literature review, research and data analysis, stakeholder consultation, reporting
Yasmin Birchall	Project management

The purpose of the consultation paper is to facilitate consideration of the value and appropriateness of different features of competency framework models in the current competency standards landscape, as they relate to the different purposes for which competency frameworks are used, and as they apply to the pharmacy profession in Australia.

The questions included within this consultation paper will be the basis for discussion and input through an online survey, telephone interviews, stakeholder forums and private independent written submissions.

Subsequent to consultation, a final report will be prepared on the findings of the background research, literature review, and consultation with stakeholders to inform the PPDCs review of the *National competency standards framework for pharmacists in Australia* (2010).

Overview

There are increasing efforts to define professional competence within all health professions including in areas of specialty, extended and advanced practice, and for interprofessional collaboration. Competency frameworks are being used for diverse purposes, such as for:

- Regulation of individual practitioners and health service provision
- The development and delivery of education
- The development and delivery of assessments and examinations (local and overseas trained practitioners)
- Facilitating continuing professional development
- Human resources and personnel development in the workplace
- Articulating community expectations and facilitating policy reform.

There are clear benefits to defining scope of practice and identifying appropriate indicators of performance. However, there are still concerns expressed in the literature that:

- The competency approach has a 'tendency to limit the reflection, intuition, experience and higher order competence necessary for expert, holistic or well developed practice'[1]
- The implementation of the numerous competency frameworks currently being produced across practice settings and from various sources raises a number of practical challenges,[2] including for the individual who is required to declare maintenance of competence for their scope of practice
- The creation of competency frameworks by professional experts and leaders can reinforce conventional discourses about professional norms, behaviours and attitudes, and perpetuate existing domains of professional legitimacy[2]
- Patient centred care and collaborative practice is adversely impacted when competency frameworks are used to limit activities and roles to certain professions.[2] Increased inter-sectoral alignment is recommended so that whole of health workforce developments maximise the potential for shared learning pathways, recognition of prior learning and articulation agreements.[3]

The topic is complex and dynamic, and the ongoing scale and validity of such concerns is unclear. It is important to be aware that there is substantial variation in the competency framework models that exist.

The existence of such variation is no surprise given the multiple contexts in which they are used. Various competency frameworks, underpinned by different definitions and concepts, have been developed to address the current and perceived future needs of the respective professions at the particular time, as well as those who are to use them. Multi-dimensional frameworks have been adopted by many professions in recent years, with features intended to address concerns raised.

Methodology

In preparing this consultation paper, a review of the competency frameworks developed for the professions listed in Appendix 1 was undertaken to compare and contrast their various features. This review was primarily based on grey literature sourced directly from the relevant organisations. Current versions of documents were reviewed; these were mostly developed in the past 5 years, although some were older.

Competency frameworks were reviewed for Australian professions regulated under the *Health Practitioner National Law Act*, as in force in each State and Territory, and for pharmacists in Canada, Ireland, New Zealand, the United Kingdom and the United States. The competency frameworks for other professions (health and non-health) were included in the review if the framework:

- Included unique features not apparent in other frameworks being reviewed and/or
- Was being used for a specific purpose or combination of purposes that was not apparent in other frameworks being reviewed.

A review of the literature for the concepts/rationale supporting different features within these frameworks, as well as for current trends was then undertaken.

Note: *The frameworks used for other professions that are discussed within this consultation paper have been included to reflect an example of a particular feature or approach, and should not be considered a recommended approach nor the only framework that has this feature or approach.*

Navigating the consultation paper

Given the diverse purposes for which competency frameworks are used, the consultation paper covers an extensive range of information. Feedback from a broad range of respondents is desired who will each have varied experience with the current competency framework for pharmacists in Australia, but will each bring a unique and important perspective.

Many respondents may want to respond to questions for only one or two sections, depending on their experience and expertise. To assist respondents access the sections most relevant to them, the consultation paper has been structured as follows:

Part A. Trends in competency frameworks

This part provides an overview of a number of features that appear in more recently developed competency frameworks, both in Australia and internationally.

This section does not include consultation questions. However, the features will be referenced in the sections that follow, with requests to provide specific feedback relating to their value and appropriateness.

Part B. Competencies to meet healthcare needs

This part prompts respondents to consider the competencies required by pharmacists to meet the current and future healthcare needs of the Australian community.

Consultation questions are posed at the end of this section, and feedback from all respondents (both within the pharmacy environment and the broader healthcare environment) will be appreciated.

Part C. Competencies in context

In this part, there are five sections, each focusing on a specific purpose for which the competency framework may be used. The findings of the background research and literature review are summarised, to provide some context and prompt consideration of the issues. The sections are as follows:

C.1 Competencies in regulation

C.2 Competencies in education leading to initial registration

C.3 Competencies in the assessment of overseas trained practitioners

C.4 Competencies for ongoing professional development of pharmacists

C.5 Competencies in the workplace

Consultation questions are posed at the end of each section. The questions are mostly common between sections, allowing respondents to consider the features of competency frameworks as they relate to a particular purpose.

How to provide input

1. Online survey

The online survey will be available online from Friday 19 December 2014 to Friday 30 January 2015, via a link on the Australian Healthcare and Hospitals Association website at ahha.asn.au.

There are three versions of the survey which have been developed towards three particular groups of stakeholders – individual pharmacists; pharmacy organisations; and non-pharmacy health organisations or individuals.

To streamline responses for those only wanting to answer questions relating to one or two sections, the online surveys have been designed to allow respondents to skip past sections that are not relevant to them.

2. Stakeholder consultation forums

The Australian Healthcare and Hospitals Association will facilitate two forums to allow key stakeholders to provide additional feedback to inform the project. Registration for the forums will open on Friday 19 December 2014, at ahha.asn.au/events

The details of the forums are as follows:

Stakeholder consultation forums		
	Forum 1	**Forum 2**
Location	Gold Coast	Canberra
Venue	Griffith University, Gold Coast Campus	Canberra Rex Hotel, Northbourne Avenue, Canberra City
Date	Thursday 29 January 2015	Friday 6 February 2015
Time	1:00pm to 4:30pm	10:00am to 3:00pm

3. Written submissions

The Australian Healthcare and Hospitals Association welcomes written submissions from those who wish to provide additional feedback during the consultation period.

Further details for providing a written submission may be found by clicking on the Pharmacy Survey slide at ahha.asn.au.

Part A. Trends in competency frameworks

Introduction

A review of the literature around competence, competencies and performance is complicated by the use of varied definitions and underlying concepts. The existence of such variation is no surprise given the multiple contexts in which the terms are used.

Consistent definitions are needed. However, detailed discussion covering the many philosophical arguments in the literature around definitions is unlikely to provide the profession with clarity in determining a way forward. It could be considered that the definitions should not drive the development of the competency framework, but, rather, be a reflection of the model that best addresses the current and perceived future needs of the profession at this time.

There is no single 'correct' competency framework model. However, there are a number of features apparent in (or being proposed for) more recently developed competency frameworks. These will be described in this section, and include:

1. Defining the relationship between competence and performance
2. Reducing the level of detail in frameworks
3. Including markers of poor behaviour
4. Grouping competencies within frameworks
5. Reflecting variations in scopes of practice within frameworks
6. Reflecting the performance continuum in frameworks
7. Supporting implementation of frameworks with entrustable professional activities.

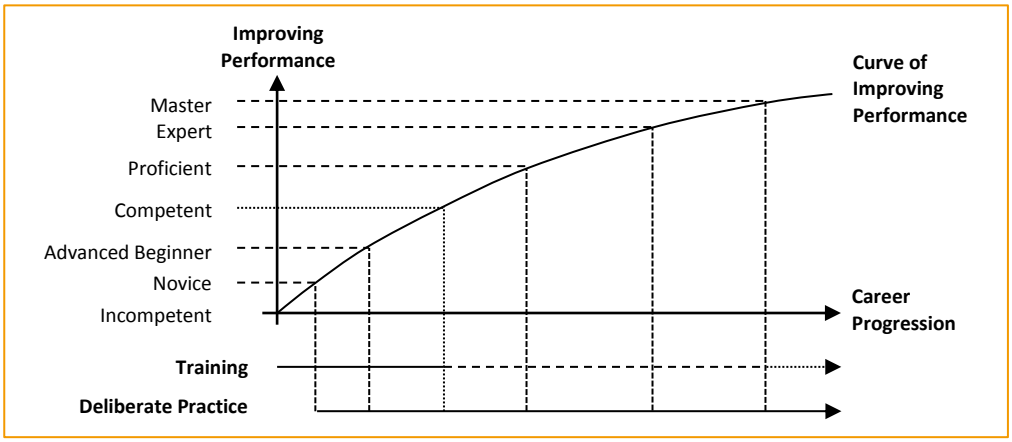
The value and appropriateness of these features for the diverse purposes for which frameworks are used will then be considered in the sections that follow.

A.1 The relationship between competence and performance

A current model for explaining the relationship between competence and performance is described in the literature by Khan and Ramachandran (2012), as modified from Dreyfus and Dreyfus (1980), Carrachio (2008) and ten Cate et al (2010).[4] This model will be referred to in this paper as the 'modified Dreyfus model'.

The modified Dreyfus model identifies seven levels of performance along a continuum (Incompetent, Novice, Advanced Beginner, Competent, Proficient, Expert, Mastery), as depicted in Figure 1.

Figure 1. Curve of improving performance adapted for health care – modified from Dreyfus and Dreyfus (1980) and ten Cate et al (2010)[4]



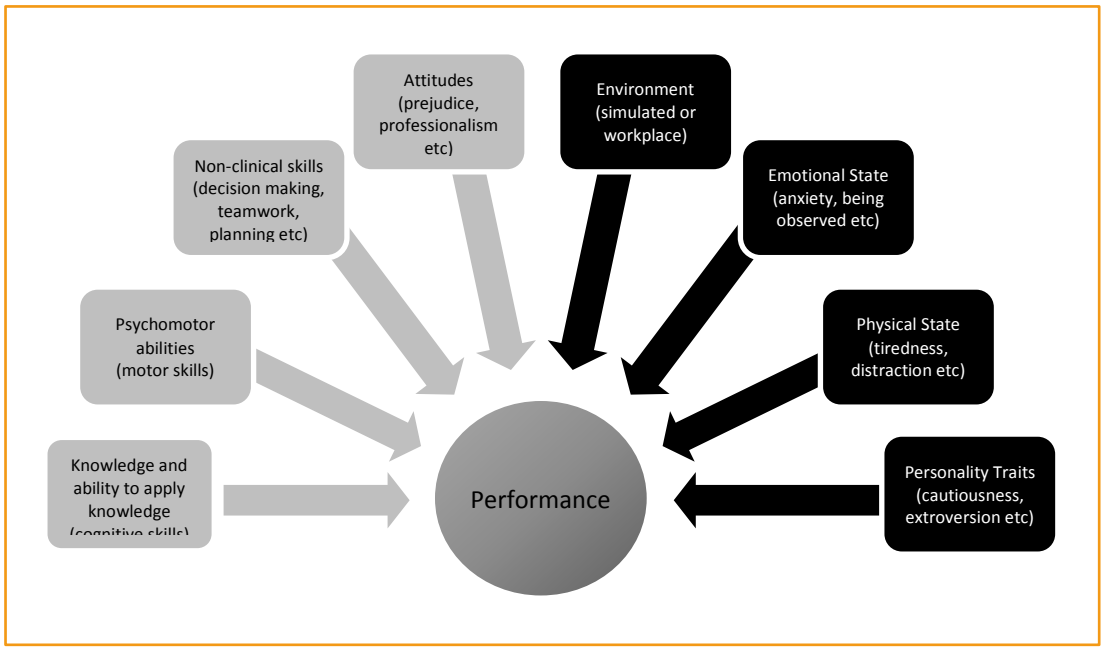
In this model, the relationship between performance and competence is described, where:[4]

- *Performance* is defined as 'the action or process of performing a task or a function'.[5] In a clinical environment, performance is a complex construct influenced by a multitude of factors (see Figure 2), and it is this combination of factors that makes it a variable trait. Further, the definition implies that every individual is able to perform every skill, even though not necessarily at a level sufficient to be deemed competent.

- *Competence* is defined as 'an ability to do something successfully or efficiently'.[5] It is a point on the spectrum of improving performance. While common in the English language to use the term 'competence' interchangeably with the term 'competency', this model reserves the term 'competency' to describe 'the skill', while 'competence' describes the person who is able to perform that competency at a certain level.

In this model, the points at which each level of performance intersects the X- and Y-axes in Figure 1 are arbitrary, varying from person to person and/or competency to competency. Also, the point at which mastery occurs should not be considered absolute, as individuals can continue to improve beyond this level.[4]

Figure 2. Factors that influence performance[4]



In this model, individuals reach the level of 'competence' on the spectrum of improving performance predominantly through *training* (defined as a process of acquisition of new skills or components of skills taught by others), while reaching the levels of proficiency, expertise and mastery predominantly through *deliberate practice* (defined as self-directed rehearsal, facilitated or un-facilitated by tutors, but leading to refinement of skills). However, there is no demarcation of a point at which further training would not be of benefit (or before which deliberate practice would not be of benefit) for a particularly competency.

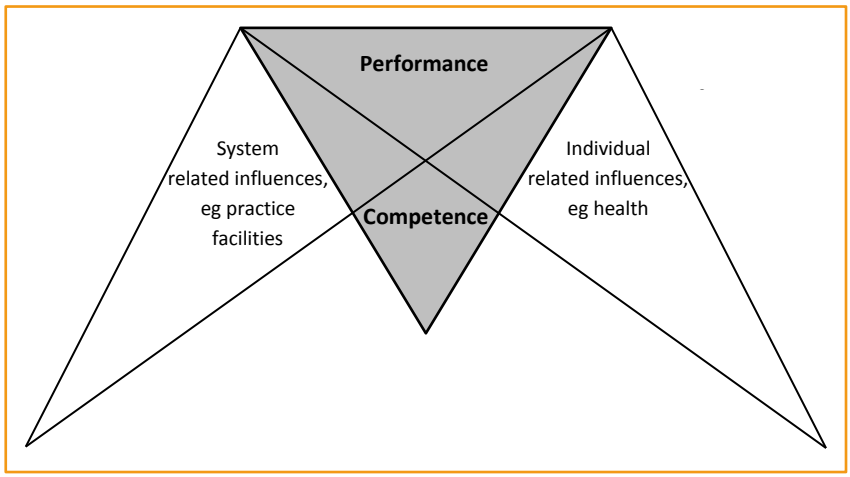
The model allows for attributes, supervision and training requirements, and the level of entrustment to be assigned for each level of performance. An example is provided by Khan and Ramachandran (see Table 1).

Table 1. Attributes of levels of performance in the context of healthcare – modified from professional standards for conservation, Institute of Conservation (London) 2003, websource[4]

Level of Performance	Attributes of performer (looking at overall performance encompassing simple tasks, and routine and non-routine complex tasks)	Supervision or training requirements	Relationship to the level of entrustment as described by ten Cate (2010)
Incompetent	Unable to perform	Training and supervision needed to move up to the novice level	Level I
Novice	Rules (protocol) based performance Unable to deal with complexity Task seen in isolation	Direct supervision needed at all times	Level I
Advanced beginner	Guidelines-based performance Able to achieve partial resolution of complex tasks Task seen as a series of steps	Able to perform routine tasks under indirect supervision Direct supervision needed for complex tasks only	Level II Level I
Competent	Performance not solely based on rules and guidelines but also on previous experience Able to deal with complexity with analysis and planning Task seen as one construct	Able to perform routine complex tasks Training and supervision needed for non-routine complex tasks	Level III for routine complex tasks Level II for non-routine complex tasks
Proficient	Performance mostly based on experience Able to perform on acceptable standards routinely Able to deal with complexity analytically Related options also seen beyond the given task	Still needing supervision for non-routine complex tasks Able to train and supervise others performing routine complex tasks	Level IV for routine complex tasks Levels III-IV for non-routine complex tasks
Expert	Performance based on experience and intuition Achieves excellent performance in complex situations moves easily between analytical and intuitive solutions All options related to the given task are considered	Able to train and supervise others performing routine and non-routine complex tasks	Level V
Master	Performance becomes a reflex in most common situations Sets new standards of performance Mostly deals with complex situations intuitively Has a unique vision of what may be possible related to the task	Able to train other experts at national or international level	Level V

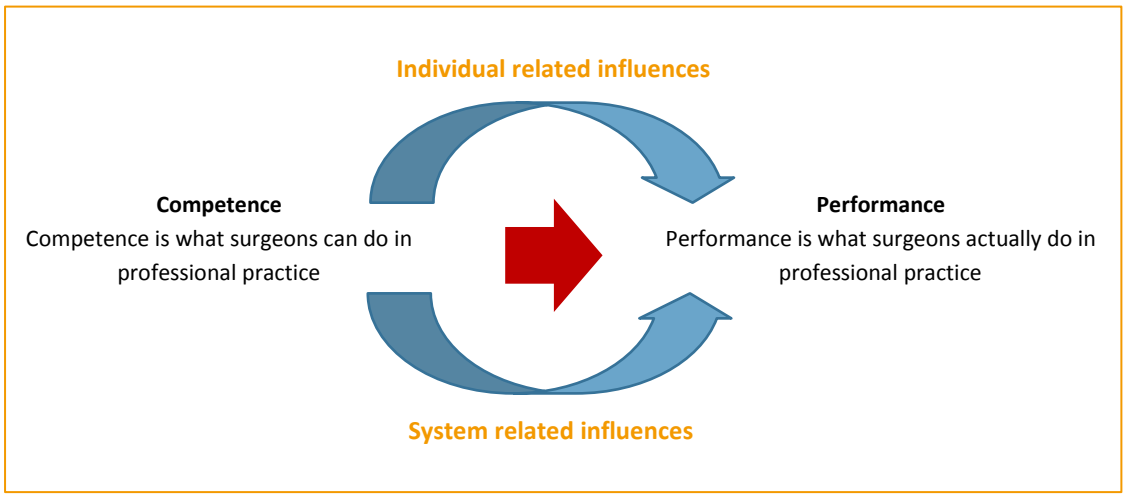
It is important to acknowledge, however, that this model contrasts with a large body of published literature that considers competence and performance as separate domains, e.g. the Cambridge model, where performance is identified as a product of competence combined with the influences of factors related to the individual (e.g. health, relationships) and factors related to the system (e.g. facilities, practice time) (see Figure 3).[6]

Figure 3. The Cambridge model for delineating performance and competence[6]



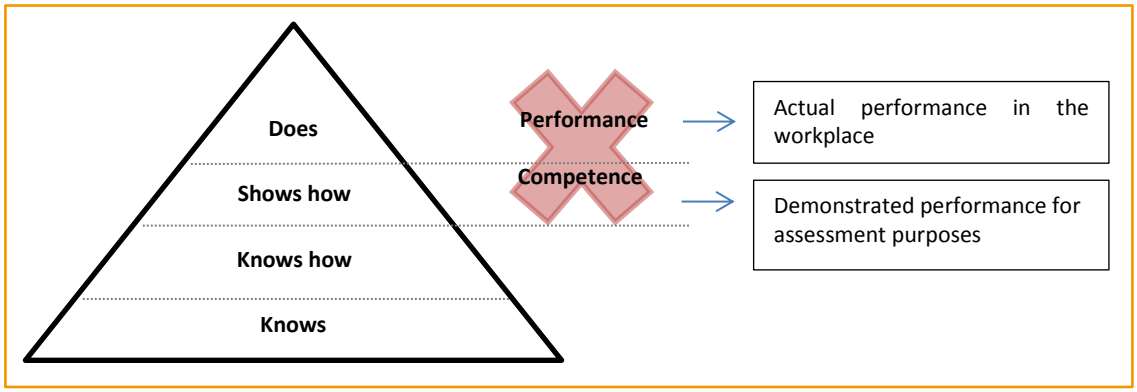
In some models, this has been explained as 'competence is what we have been trained to do', while 'performance is what we actually do in day to day practice' (see Figure 4).[7]

Figure 4. The distinction between competence and performance, as consistent with the Cambridge model[7]



Khan and Ramachandran report that the notion of competence and performance being two separate domains may have been partly created by an over-simplistic application of the principles described by Miller (see Figure 5) to complex assessment tools, where 'does' has become performance and 'shows how' competence.[4]

Figure 5. Miller's Pyramid, as reflected in the modified Dreyfus model



When considering Miller's pyramid, they argue that both 'does' and 'shows how' can be classified as performance, the former being *actual performance in the workplace* and the latter as *demonstrated performance for assessment purposes* (whether in the workplace or in simulated settings).

In the modified Dreyfus model (and in contrast with the Cambridge model), competence (as a point on the spectrum of improving performance) is also an interplay between the individual and the environment, and as such, will vary as the environment changes.[8]

The impact of this distinction may have greater impact when a competency framework is used for specific purposes (e.g. education and assessment), and will be discussed further in these contexts.

A.2 Reducing the level of detail

In more recently developed competency frameworks for professions, there is a trend to reduce the level of detail and complexity.

Historically, and consistent with the approach taken by many professions, the 2003 version of the competency standards for pharmacists in Australia relied heavily on the format adopted in the Australian National Training Authority (ANTA) Training Package guideline (developed for use in the vocational education and training setting). This approach described professional practice by breaking down complex professional functions into a series of related tasks (*Elements*), with associated *Performance Criteria* providing observable behaviours or results, and *Evidence Examples* provided to assist with interpretation and assessment of performance. The 2010 version of the competency standards built on past efforts, without substantial change to the format previously adopted.[9]

While such a structure has been reported as useful for supporting the description and measurement of practice,[9] it is an approach that has been criticised for understating the inherent integration of tasks and the complex conceptual, analytical and behavioural functions that underpin professional service delivery.

It has also been reported that describing general competencies in detail leads to bulky, fragmented documents that lose practical value.[8]

It has been reported that if a framework is too complex, '*it is highly expensive to develop, implement, maintain and assess. Further, it becomes a 'good tool used badly', in that it requires so much workplace assessment time that it detracts from time available for patient care*.'[3]

In recent times, a number of professions in Australia and internationally appear to have addressed such criticisms by no longer breaking down each competency into tasks or activities in their competency frameworks, and rather describing observable *Behaviours* for each competency (as indicators of the expected performance in the workplace). Recent examples include the frameworks for pharmacists in Ireland[10] and New Zealand[11] (see Figure 6).

Figure 6. Extract from *Competence Standards for the Pharmacy Profession in New Zealand* [11]

Competency	O3.1	Assess prescriptions
Behaviours	**O3.1.1**	Validates prescriptions ensuring they are authentic, meet all legal and professional requirements and are correctly interpreted
	O3.1.2	Uses a systematic approach to assess and review available patient medical history and medication record or notes
	O3.1.3	Applies knowledge in undertaking a clinical assessment of the prescription to ensure pharmaceutical and therapeutic appropriateness of the treatment and to determine whether any changes in prescribed medicines are warranted
	O3.1.4	Initiates action, in consultation with patient/carer and/or prescriber to address identified issues

A.3 Markers of poor behaviour

In competency frameworks where observable behaviours are included, it is markers of *good* behaviour that are most commonly described (e.g. frameworks for pharmacists in Ireland[10] and New Zealand[11]). However, there are also examples whereby markers of *poor* behaviour have been developed.

For example, behavioural markers have been developed for the surgical profession in Australia and New Zealand to provide examples of both good and poor behaviour (see Figure 7).[7] For each competency in the framework, a *Pattern of Behaviour* is identified. For each *Pattern of Behaviour*, markers of good behaviour are identified to provide guidance to surgeons whereby they may be seen as a role model for trainees or other surgeons. In contrast, markers of poor behaviour are identified as suggestive of underperformance and provide a basis for support and remediation of underperforming surgeons before patient safety or standards of care are compromised. This approach is promoted to support assessment of performance, including self-assessment, peer assessment, multi-source feedback and trainee assessment by supervisors.

Figure 7. Extract from *Surgical Competence and Performance* for the Competency 'Professionalism' and the Pattern of Behaviour 'Having awareness and insight'[7]

Professionalism

Demonstrating commitment to patients, the community and the profession through the ethical practice of surgery

Having awareness and insight

Reflecting upon one's surgical practice and having insight into its implications for patients, colleagues, trainees and the community

Examples of poor behaviours	Examples of good behaviours
■ Is difficult to contact post-operatively and admonishes staff for continued attempts to make contact ■ Blames registrars or others for poor outcomes ■ Books inappropriately long lists or is misleading with theatre staff/anaesthetists regarding the length of operations ■ Berates or humiliates subordinates	■ Adopts a courteous approach to other staff and patients ■ Responds positively to questioning, suggestion and objective criticism ■ Admits to errors ■ Acknowledges poor outcomes and takes opportunities to reflect and improve

Assessment Poor ☐ Marginal ☐ Good ☐ Excellent ☐ Unable to Rate ☐

A.4 Grouping competencies

Competency framework models typically group competencies into 'domains' relating to an area of responsibility or professional endeavour (e.g. Communication or Deliver primary and preventive health care). This is the model used in the current competency framework for pharmacists in Australia.

More recently, there has been a trend towards grouping competencies according to 'roles' (e.g. Communicator or Health Advocate).

This is the model used in the *CanMEDS Physician Competency Framework* (and the increasing trend may be associated with the uptake of this model in over 16 countries, including Denmark, the Netherlands, New Zealand and Australia).[12] Despite this trend, it has been argued that roles and competencies are not synonymous. *Roles* are a social construct, and *competencies* are a behavioural manifestation. Further, neither should be confused with *professional identity* which forms as an adaptive, developmental process at the level of the individual (through their psychological development) and at the collective level (through their socialisation into appropriate roles and participation in the community and work).[13]

Both the 'domains' and 'roles' models are now commonly used, and neither is unquestioningly accepted as the 'right' or 'best' approach. With either model, professional practice requires integration of competencies across the domains or roles, and both models have been criticised for such things as limiting attention to relational and situational factors, limiting the ability to capture the complex nature of expertise,[14] fragmenting elements of professional competence and imposing limitations on understandings of professional work.[12]

Where role-based competency models are used, the specific names chosen to describe roles are considered significant. The 'roles' should not be considered inherently 'natural' or 'self-evident', but decided in specific historical, cultural, social and national contexts. The language and imagery to describe, divide and reintegrate roles has been reported to affect how the roles are understood, valued and enacted.[14]

The CanMEDS Framework was developed for physicians in Canada and was released in 2005. It '*is based on the seven roles that all physicians need to have to be better doctors: Medical Expert, Communicator, Collaborator, Manager, Health Advocate, Scholar and Professional*'.[15] For each role, there are *key competencies* which are further described by *enabling competencies*.

The *Eight-Star Pharmacist* provides a comparable grouping of roles for pharmacists as CanMEDS does for physicians, with the concept first introduced in 2000 by the World Health Organization and adopted by the International Pharmacy Federation as the *Seven Star Pharmacist*.

The eight roles now reflected are *Caregiver, Decision-maker, Communicator, Manager, Life-long learner, Teacher, Leader, and Researcher*.[16]

A.5 Variations in scopes of practice

In Australia, of the professions regulated under the National Law, extended scopes of practice may be recognised as an 'endorsement' of registration, recognising that a person has additional qualifications and expertise in an approved area of practice and/or for scheduled medicines.[17] 38 Table 2 lists the current endorsements available and how competency frameworks have been used to reflect the competencies of the extended scope of practice.

Table 2: Current endorsements recognised under the National Law

Endorsements available under the National Law[17]	Profession	Reflection of additional expertise within the respective competency framework
Endorsement for scheduled medicines *Identifies registered practitioners within a profession who the National Board has determined are qualified to use (e.g. supply or prescribe) medicines that are otherwise restricted access because of State and Territory laws that regulate drugs and poisons*	Nursing: Registered Nurse[18]	No reference to a competency framework; specific programs specified for individuals to achieve endorsement are approved by the Nursing and Midwifery Board.
	Eligible Midwife[19]	Unique framework within registration guidelines defining the four components of prescribing, and which is not aligned with the competency framework for registered nurses
	Optometry[20]	Single competency framework with hierarchy of units, elements, performance criteria, and some suggested indicators.

		Indicators are identified as either 'universal' or 'therapeutic level'. Endorsement requires completion of accredited program that meets therapeutic level competencies.
	Podiatry	Single competency framework with hierarchy of competency standards, elements, performance criteria, and examples of evidence. *Supplementary elements* relevant to medicines prescribing are identified (and align with NPS framework[21]). Endorsement requires completion of accredited program, where accreditation standards link to these competency standards.
Endorsement as a nurse practitioner	Nurse Practitioner[22]	Unique competency framework for Nurse Practitioners that is not aligned with the competency framework for registered nurses
Endorsement for acupuncture	Any health profession (other than those registered by the Chinese Medicine Board of Australia)	No reference to a competency framework; specific programs approved by Board Note: the practice of acupuncture is not a protected practice; endorsement only required to use the title 'acupuncturist' or funding requirements (e.g. Medicare or health insurance).
Endorsement for approved areas of practice (clinical psychology, counselling psychology, forensic psychology, clinical neuropsychology, organisational psychology, sport and exercise psychology, educational and developmental psychology)	Psychology[23]	Guidelines issued by the Psychology Board of Australia list the competencies required for each area of practice. These are in addition to the 'generic competencies' to be demonstrated by all registered psychologists, as described within the respective accreditation standards.[24] There is no alignment between the two frameworks.
Endorsement for approved area of practice (conscious sedation)	Dentists[25]	No reference to a competency framework; specific programs specified for individuals to achieve endorsement are approved by the Dental Board.

Internationally, there are also examples of competency frameworks that reflect advanced, extended or different scopes of practice. However, where such frameworks exist, they tend to be separate to the framework for entry to practice and without alignment.

In the United Kingdom, the General Level Framework has been developed to support post-registration development for pharmacists delivering general pharmacy services working in hospital, community pharmacy and primary care.[26] Another framework has been developed to reflect the competencies required for specific advanced services (e.g. for the assessment of pharmacists providing the medicines use review (MUR) and prescription intervention service[27]), which does not align with the General Level Framework.

The Advanced and Consultant Level Framework (ACLF)[28] for pharmacists in the UK has also been developed to support post-registration development for all pharmacists progressing to advanced levels of practice. It is promoted as a generic framework that can be used across the profession for specialist and advanced practice.

In Canada, a competency framework for pharmacists at entry to practice exists.[29] In addition to this, Model Standards of Practice (MSOP) [30] exist primarily for pharmacy regulatory authorities. Like the competency framework for entry to practice, these are also competency-based standards.

However, they apply to all pharmacists (not just those at entry to practice), and have the goal of specifying the standards against which pharmacist's performance can be judged.

In developing the current version of the MSOP, the need to be able to reflect shifting and overlapping scopes of practice and emphasise accountability of professionals throughout their careers was explicitly noted. As such, for each 'General Standard' (which are grouped within four domains: *Expertise in medications and medication-use*; *Collaboration*; *Safety and Quality*; and *Professionalism and Ethics*), the MSOP that are required of all pharmacists regardless of the role they are fulfilling are identified, as well as those MSOP that are specifically associated with the five pharmacist roles identified in the entry-level competency framework (patient care, drug information, drug distribution, management, and education) (see Table 3). The regulators recognise that not all pharmacists perform each of the roles. However, it is their intention that when a pharmacist does perform a specific role, they meet all the MSOP associated with this role.

Table 3: Model Standards of Practice for Canadian Pharmacists – example of format[31]

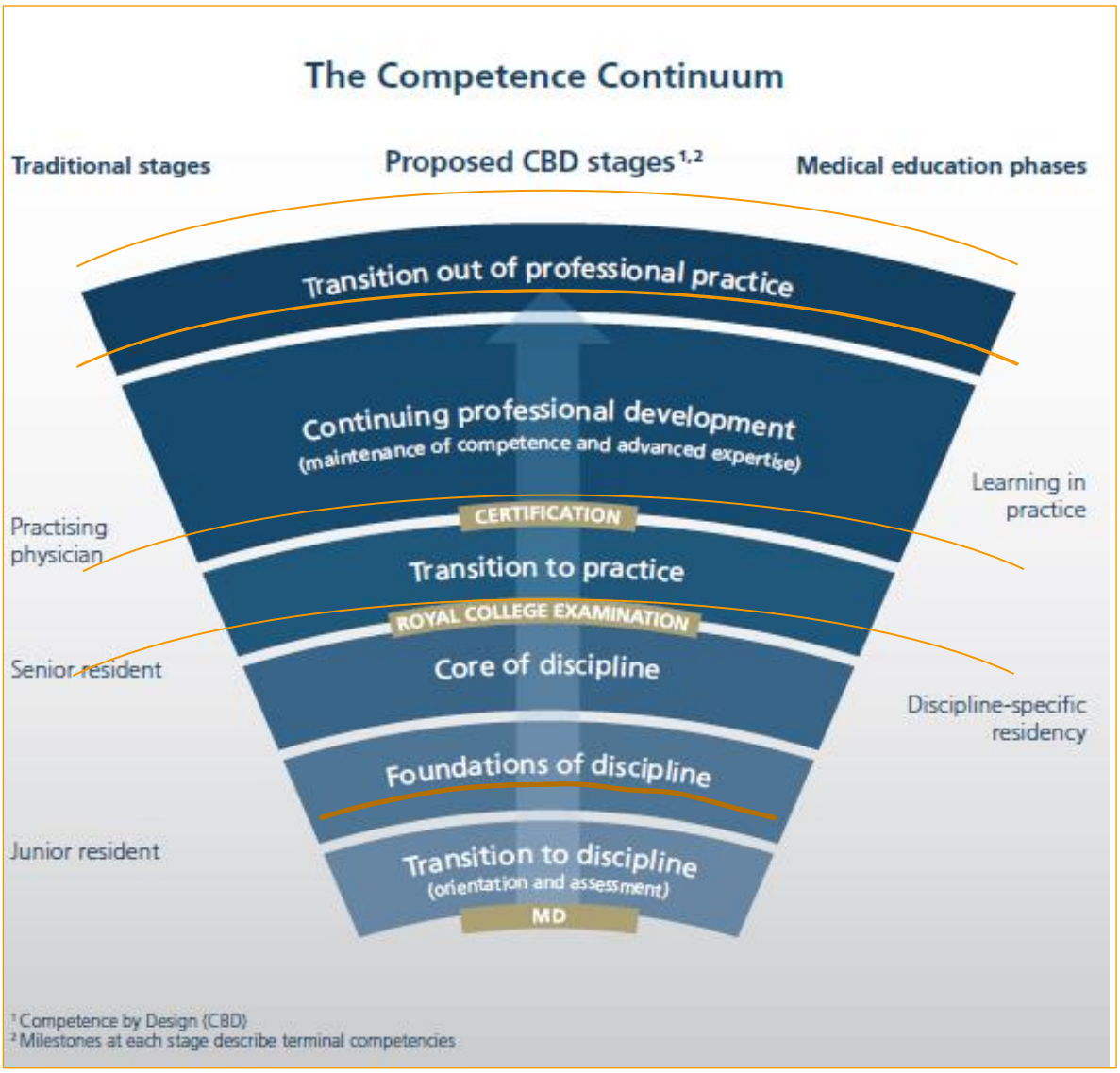
General Standard	Model Standards of Practice
Expertise in medications and medication-use	
• Pharmacists maintain their competence.	MSOP required of pharmacists regardless of the role they are fulfilling: • … MSOP required of pharmacists when providing patient care: • … MSOP required of pharmacists when providing drug information: • … MSOP required of pharmacists when responsible for drug distribution: • … MSOP required of pharmacists when managing a pharmacy: • … MSOP required of pharmacists when educating pharmacy students/interns: • …
• Pharmacists apply their medication and medication-use expertise while performing their daily activities.	MSOP required of pharmacists regardless of the role they are fulfilling: • … MSOP required of pharmacists when providing patient care: • … MSOP required of pharmacists when providing drug information: • … MSOP required of pharmacists when responsible for drug distribution: • … MSOP required of pharmacists when managing a pharmacy: • … MSOP required of pharmacists when educating pharmacy students/interns: • …

A.6 Reflecting the performance continuum

There are few examples of single competency standard frameworks that express the performance continuum from novice to expert (or equivalent) as a primary feature.

The current (2005) CanMEDS Framework describes the competencies expected of trainees at the end of their training (i.e. at the point when they are 'ready' to enter practice). However, an updated CanMEDS Framework is planned for release in 2015, with the most significant change being the introduction of milestones to '*describe the development of physician abilities across the continuum of their career starting at entry to residency, following them throughout practice, and finally into the transition out of professional practice'* (see Figure 8).[32]

Figure 8. The CanMEDS 2015 Competence Continuum[33]



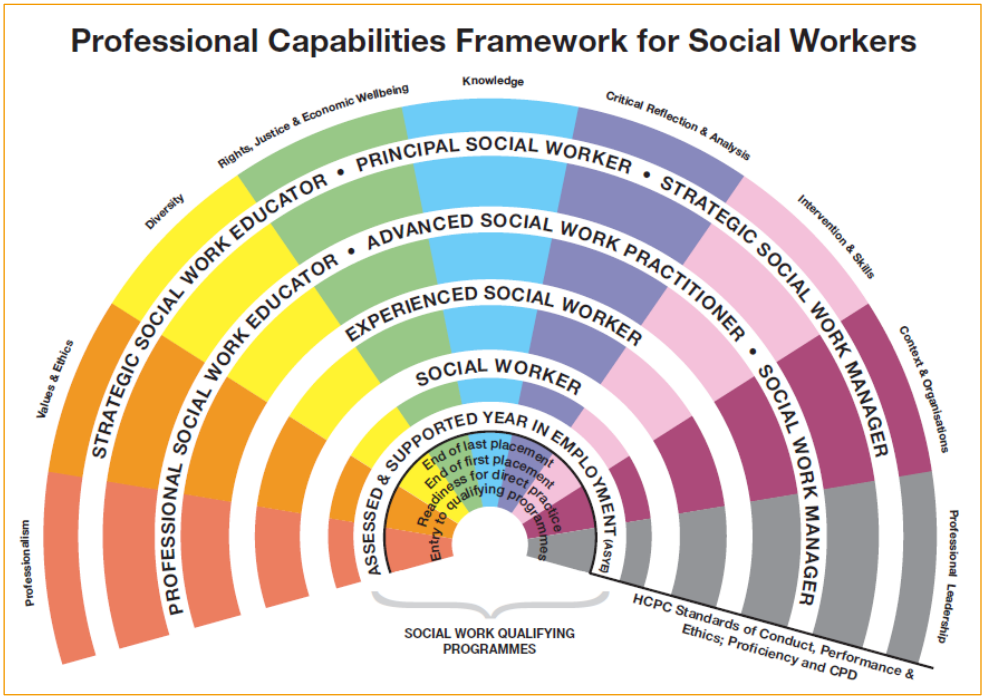
Both the competencies and milestones describe the abilities to be demonstrated in practice, as distinct from the information or content related to aspects of a 'Role'. There are milestones for each enabling competency, and between zero and four abilities listed for each milestone (see Figure 9 for an example). As each milestone builds on the previous one, where zero abilities are listed for one milestone, this reflects that there are no additional expectations for that competency as compared to the previous milestone. The milestones are included as a companion document, rather than integrated into the main document. In response to consultation feedback in the development of CanMEDS 2015, the recommendations to use 'plainer language' throughout and have fewer milestones have been addressed.

Figure 9. The CanMEDS 2015 Competence Continuum – extract for one enabling competency[33]

Key and enabling competencies	Requirements for residency	Transition to discipline	Foundations of discipline	Core of discipline	Transition to practice	Advanced expertise
SCHOLAR MILESTONES						
1 Engage in the continuous enhancement of their professional activities through ongoing learning						
1.1 Develop, implement, monitor, and revise a personal learning plan to enhance professional practice	Describe principles of effective learning relevant to medical education Describe learning opportunities, resources, and assessment and feedback opportunities relevant to learning in the clinical setting	Demonstrate a structured approach to monitoring progress of learning in the clinical setting Describe physicians' obligations for lifelong learning and ongoing enhancement of competence	Create a learning plan in collaboration with a designated supervisor and others as needed, identifying learning needs related to their own discipline and career goals Use technology to develop, record, monitor, revise, and report on learning in medicine	Review and update earlier learning plan(s) with input from others, identifying learning needs related to all CanMEDS Roles to generate immediate and longer-term career goals	Create a learning plan, incorporating all CanMEDS domains, targeting residency program completion and the transition to practice Discuss a learning plan and strategy for ongoing self-monitoring with a mentor, faculty advisor, or learning coach	Develop a plan to enhance competence across all CanMEDS domains for practice and update it regularly Coach others to enhance their own learning plans for practice

Another example of a competency framework that expresses the performance continuum in a single framework is that developed for social workers in England (see Figure 10). A number of resources support the framework to facilitate understanding, assessment and certification at the various levels, as well as progression between levels.

Figure 10. Professional capabilities framework for social workers[34]



A.7 Supporting implementation with entrustable professional activities

Within the literature, it is the implementation of competency frameworks that has been reported to raise the most concerns.[35]

Used inappropriately, any benefits can be negated. Implementation is reported to be of greatest concern where competency frameworks are 'atomised' into a large number of behaviours or performance criteria, and require evidence of competence to be assembled at this level. Such bureaucracy can reduce the assessment of complex behaviours to a tick-box exercise. [35]

The introduction of *entrustable professional activities* (EPA) has been proposed to address criticism that:[8]

- Current concepts of competence 'fail to account for the essential interplay between competencies and the contexts of practice'; and
- While workplace based assessments can be developed as valid assessments of specific competencies, they do not assess competence against an integrated set of competencies.

EPAs are defined as professional activities that should be entrusted only to those individuals who have adequate competence to carry them out.[8]

As such, they must:[8,36]

- Be essential professional work that can only be carried out by a qualified person;
- Require knowledge, skill and attitudes that are generally acquired through training;
- Lead to recognised output of professional work;
- Be independently executable within a specific timeframe;
- Be observable and measurable in process and outcome; and
- Reflect one or more competencies to be acquired.

The EPA concept is intended to be used in conjunction with competency frameworks. An example of a competency framework-EPA matrix is provided in Table 4. For a particular profession or training program, levels of entrustment are defined for the EPAs which formally acknowledge the level of supervision required (e.g. proactive, ongoing, full supervision required; reactive supervision required (i.e. supervision is readily available on request); may act independently; or may act as a supervisor and instructor).[8]

Table 4. Example of a competency framework-EPA matrix[8]

	CanMEDS roles						
Professional activities	Medical expert	Communicator	Collaborator	Scholar	Health advocate	Manager	Professional
Performing a venepuncture	●	●					
Performing an appendectomy	●	●	●				
Signover at morning report after a night shift	●	●	●	○		○	
Developing and implementing a patient management plan	●	○	●	●	●	●	
Chairing a multidisciplinary meeting		●	●			●	●
Requesting an organ donation	○	●			●	●	●

●= competency is absolutely needed. ○= competency is needed, but to a lesser extent.

EPAs have been introduced as part of the education requirements for a number of medical practitioner groups (general and specialist) in various countries, with the benefit appearing to be largely in supporting meaningful workplace-based assessment of competencies derived from a competency framework.[8,36]

It is still unresolved how best to assess entrustment levels for any given EPA, however the need to ground assessments of competence in authentic and complex tasks is a need supported across education more broadly.[37]

Assigning a level of entrustment is likely to at least depend on:[8]

- The competence of the learner
- The approach and skills of the supervisor
- The nature of the EPA
- Local circumstances or context (e.g. time of day, emergency situation).

An example of how competencies, as they relate to an EPA, can be used to support students and supervisors in workplace-based assessment is provided in Table 5.

Table 5: Example of competencies for the EPA 'Initiating medication' to support workplace based assessment of trainee psychiatrists[36]

		Indicative Questions
Medical expert	The trainee demonstrates the ability to make an accurate diagnosis, has conducted the appropriate assessments, can describe the evidence for the use of the medication, its dosage, interactions and side effects	*Has an appropriate assessment been completed?* *Is the use of this medication evidence-based?* *Are there any contraindications to the use of this medication (significant interactions etc.)?* *Is the dosing regime correct?* *Have appropriate investigations been performed?* *What plan is there to assess outcome?*
Communicator	The trainee shows the ability to explain to the patient the benefits and risks of the medication and how it should be taken and addresses the patients questions	*Have the reasons for the use of this medication been explained so that the patient is able to understand?* *Have the benefits of the medication been explained?* *Have the risks (major side-effects) of the medication been explained?* *Has the patient been explained about what to do should side effects emerge?* *Has the dosing regime been explained so that the patient understands?* *Has the need for further investigations been explained?* *Have the patient's questions been responded to appropriately?*

		Indicative Questions
Collaborator	The trainee ensures that members of the MDT (and GP) are aware of how the medication fits in with the management plan	*Has information about the medication been communicated with the MDT?* *Has information about the medication been communicated with significant others?* *Has the GP been informed?*
Professional	The trainee has obtained informed consent	*Has informed consent been obtained?* *Are there any conflicts of interest?*
Scholar	The trainee is able to apply the evidence from clinical practice guidelines	*What is the evidence base for the medication?* *What process will be used to evaluate outcome?* *Can the trainee explain the mechanism of action?*
Health advocate	The trainee ensures that the patient is able to access the medication	*Has there been a check on whether the patient can access the medication?* *Has there been a check on whether the patient can afford the medication?* *Has the appropriate authority form been used?*
Manager	Clear and accurate documentation is completed	*Is the documentation in the case note clear and accurate?* *Has the medication form (prescription) been completed correctly?* *Has the use of health resources been considered?*

Other features in frameworks for other professions

Features included in competency frameworks developed for some professions, which are worth noting, but will not be specifically explored in detail in this consultation paper, are listed below.

From competencies to capabilities:

The notion of capability is raised in the literature to be a more relevant approach for professions than competencies. Like with the term competency, a variety of definitions and concepts are used in association with the term.

In some contexts, capability appears to be viewed as a higher level of performance than competence (i.e. that demonstrated by advanced practitioners who embrace complexity as a mode of practice), along a continuum of familiar problems with familiar solutions to less familiar context or problems.[38]

In other contexts, a high level of capability is not synonymous with being comprehensively competent. Rather, intelligent judgement, ethical practice and self-efficacy allow an individual to know what level of competence is needed and to exercise it wisely.[39]

While the need for capability appears to be generally accepted, more recently developed competency frameworks appear to encompass the concept of capability to guide and define more advanced levels of practice. More current competency frameworks appear to be informed by capability concepts through:[39]

- The way activities are described. They are less limited in terms of context, assuming that the practitioner could be working in a variety of contexts (including unanticipated situations) and allow for evolving approaches to practice. Performance levels along a continuum are also described.
- Aspects of professionalism being embedded throughout the whole framework. While a single domain may focus on professional judgement and ethics, it is made clear that this applies across all areas of practice in the framework.

From competency standards to practice standards:

Some professions (e.g. nurse practitioners, physiotherapists) have removed the term 'competency' from their competency frameworks, without any apparent change from the typical structure or model.

For nurse practitioners, this is due to confusion that existed between the use of the term 'competency based assessment' in the vocational education and training (VET) sector and use of the term 'competency' in other settings.[40]

Part B. Competencies to meet healthcare needs

B.1 The health workforce

There is evidence that the current organisation of health professionals and their associated scopes of practice is not meeting the needs of the Australian public. The current organisation of roles is also reported to have no existing evidence base, and has not adapted to changes in the health needs of an ageing population and the clinical and technological responses that have altered the nature and location of care.[41]

Adapting the workforce faces challenges created by existing legislation and regulation, funding models for professional services and entrenched professional cultures.[41] Public interest is central to health policy reforms. If competency frameworks are to be used to facilitate changes in scopes of practice, it is important to ensure public and patient interest is central in their development. Further, the development process should be such that criticisms of competency frameworks reported in the literature, such as them serving the practitioner's economic interest; reinforcing professional norms, behaviours and attitudes; perpetuating existing domains of professional legitimacy; or protecting the profession from declining appreciation of its importance, are unfounded.[12]

B.2 The healthcare needs of the community

The National Registration and Accreditation Scheme (NRAS), established under the National Law, has a very strong focus on embedding and promoting responsiveness, flexibility, innovation, sustainability and access to services in accordance with public interest as key objectives surrounding the regulation of health professions. Every agency within NRAS is expected to contribute to these objectives and behave in a manner consistent with the objectives and guiding principles. However, preliminary feedback in the review of NRAS identified that better articulation of the workforce reform agenda and priorities would assist the agencies better fulfil responsibilities in this area.[42]

With the bill to abolish Health Workforce Australia (HWA) passed in September 2014, the strategic plan for the health workforce in Australia is currently unclear. It is reported that the HWA *Health Workforce 2025* study identified that productivity gains can be made through changing models of care, adjustments to practitioners' skills mix, health professionals working to their full or expanded scope of practice, and technological changes, such as utilising e-health or telehealth innovations. Other changes to health policy have shifted focus away from acute care and towards primary care and the prevention of chronic disease, and the treatment of chronic and aged related diseases in the community.[43]

From the 2013 review of Australian Government Health Workforce programs,[43] areas of public need being addressed by these programs, and that have a 'competence' requirement across all health professions, are listed in Table 6. Competency frameworks and other resources that have been developed in Australian in response to these needs, and that should be consulted in the review of the competency framework for pharmacists, are also listed. Ethics and professional autonomy have also been reported to be issues of vital importance to pharmacists, and all health professions, in ensuring top priority to serving the best interests of patients and society at large.[44]

Table 6: Areas of public need and competency frameworks and other resources that have been developed in response

Area of public need[43]	Australian competency frameworks and other resources developed in response to area of public need
Aboriginal and Torres Strait Islander health	■ Aboriginal and Torres Strait Islander Health Curriculum Framework (draft in development). Australian Government; 2014. ■ National Best Practice Framework for Cultural Competency in Australian Universities. Universities Australia; 2011. ■ Aboriginal Competence Framework. Victorian Government Department of Human Services; October 2008.
Allied health leadership	■ Health LEADS Australia: the Australian health leadership framework. HWA; 2013[45]
Clinical supervision and delegation	■ National clinical supervision competency resource. HWA; 2013. ■ National clinical supervision support framework. HWA; 2011. ■ Supervision and delegation framework for allied health assistants; State Government of Victoria; 2012.
Interprofessional collaboration	■ Interprofessional capability framework. Faculty of Health Sciences, Curtin University; 2011.[46] ■ National Common Health Capability Resource: shared activities and behaviours in the Australian health workforce. HWA; 2013.
Mental health care	■ Mental health care project: a framework for pharmacists as partners in mental health care. PSA; 2013.
Prescribing	■ Competencies required to prescribe medicines. National Prescribing Service; 2012.[47]
Rural and remote health	■ Rural and Remote Allied Health Competencies PROFESSIONAL. WA Country Health Service; October 2008.[48] ■ Rural and Remote Allied Health Competencies SENIOR PROFESSIONAL. WA Country Health Service; October 2008.[48]
Technological changes, e.g. eHealth or telehealth innovations	[None identified in Australia, but international e-health competency frameworks for health professionals exist as a reference point, e.g. Canada[49], Scotland[50]]

B.3 The healthcare needs of the community in competency frameworks

More often than not, the centrality of public and patient need in the development of competency frameworks for professions is assumed, but not explicitly stated, in frameworks. Where development processes are published, public consultation is often cited. However, the extent of the input or how such input has been incorporated is often not reported.

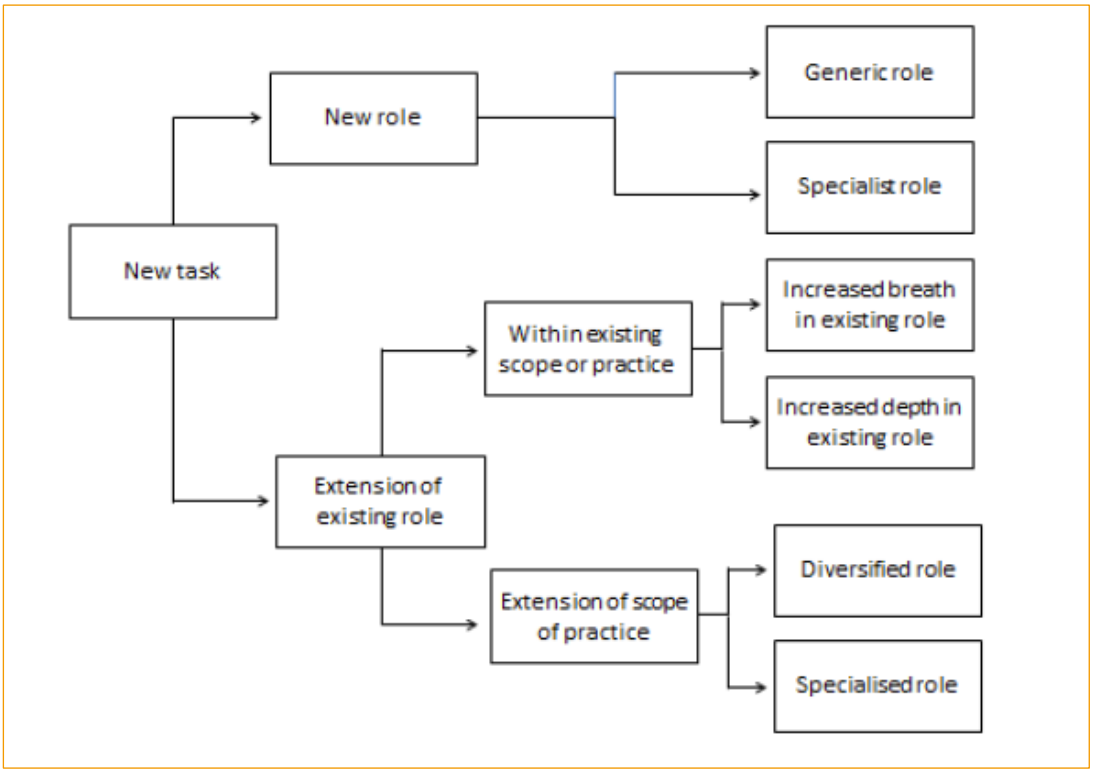
When developing the *Model Standards of Practice (MSOP) for Canadian Pharmacists*,[30] the rapidly changing scope of pharmacy practice in Canada was recognised. As such, pharmacist activities that related to emerging scope of practice activities (e.g. extending prescriptions, ordering laboratory tests, administration of medications by injection) were still included even though authorisation

varied between provinces and was changing substantially as legislation was being revised to meet public need.

B.4 Mechanisms for changing scope

The literature identifies six different ways of 'adding new tasks' to health professional roles (see Figure 11).

Figure 11. Ways of 'adding new tasks' to health professional roles[41]



Extending existing roles can be accommodated within the existing scope of practice by extending the *breadth* of the role (as experienced recently with pharmacist vaccination) or extending the *depth* of the role. Alternatively, the extension of existing roles can be accommodated with a change in scope of practice of the role, and this may be achieved by diversification (broadening professional practice to include new areas of practice) or specialisation with increased expertise.[41]

Achieving changes to scope of practice is reported to be achieved through three mechanisms: *interprofessional collaboration* (i.e. negotiated agreement among different health practitioners), *delegation* (i.e. where responsibility is assigned to another practitioner, but accountability remains with the delegator) or *substitution* (i.e. where both responsibility and accountability are transferred).[41] It has been suggested that the development of a whole-of-workforce competency framework for the Australian health workforce would facilitate such changes, increasing workforce flexibility to meet new and emerging demands on the health system.[3]

There is a relatively poor evidence base for the evaluation of scope of practice changes.[41] Some 'successful' changes to scopes and roles are reported. However, success is often related to implementation and acceptance, rather than impact. Where impact is measured, it is often short term rather than long term impact.

Scope of practice changes tend to be more widely accepted when the health profession transferring the scope have accepted that their profession does not have the capacity or interest in continuing to provide these tasks.[41] This means many scope of practice changes are proposed in a hostile environment.

With the many regulatory, financial, professional and behavioural changes required to effect such changes to scope, the extent that competency frameworks have a role in facilitating them is unclear.

Consultation questions: Competencies to meet healthcare needs

1. Would you like to provide a response to this section? (Yes or No)
2. What current and future healthcare needs of the community need to be considered in the review of the competency framework for pharmacists in Australia?
3. What future roles/activities for pharmacists need to be considered in the review of the competency framework for pharmacists in Australia?
4. Consider the current *National Competency Standards Framework for Pharmacists in Australia* outlined below. For each Standard, identify whether you agree it continues to be appropriate or whether it needs to change. Please explain your response.

Domain	Standards
1 Professional and ethical practice	1.1 Practise legally 1.2 Practise to accepted standards 1.3 Deliver 'patient-centred' care 1.4 Manage quality and safety 1.5 Maintain and extend professional competence
2 Communication, collaboration and self-management	2.1 Communicate effectively 2.2 Work to resolve problems 2.3 Collaborate with members of the health care team 2.4 Manage conflict 2.5 Commitment to work and the workplace 2.6 Plan and manage professional contribution 2.7 Supervise personnel
3 Leadership and management	3.1 Provide leadership and organisational planning 3.2 Manage and develop personnel 3.3 Manage pharmacy infrastructure and resources 3.4 Manage quality service delivery 3.5 Provide a safe and secure work environment
4 Review and supply prescribed medicines	4.1 Undertake initial prescription assessment 4.2 Consider the appropriateness of prescribed medicines 4.3 Dispense prescribed medicines
5 Prepare pharmaceutical products	5.1 Consider product requirements 5.2 Prepare non-sterile drug products
6 Delivery primary and preventive health care	6.1 Assess primary health care needs 6.2 Deliver primary health care 6.3 Contribute to public and preventive health
7 Promote and contribute to optimal use of medicines	7.1 Contribute to therapeutic decision-making 7.2 Provide ongoing medication management 7.3 Influence patterns of medicine use

8	Critical analysis, research and education	8.1 Retrieve, analyse and synthesise information 8.2 Engage in health, medicines or pharmacy practice research 8.3 Formally education and train students and health care colleagues

5. What other competencies need to be considered in the review of the competency framework to enable pharmacists to take up future roles/activities and best contribute to meeting the future healthcare needs of the community?
6. Would consistency in competency frameworks across different professions facilitate scope of practice changes, without impacting negatively on the purpose for which competency frameworks are used for individual professions? Why or why not? If yes, identify the professions you would recommend need to be aligned.
7. With consideration of the features of competency frameworks in Part A, to what extent do you support the following statements as they relate to facilitating scope of practice changes to meet the healthcare needs of the Australian community? (Please explain your rating where possible.) *[Likert scale: Strongly Disagree to Strongly Agree]*
    a. 'Competent' should be identified as one level of performance along a continuum from Incompetent through to Mastery (i.e. the modified Dreyfus model). *[Refer to Section A.1 – The relationship between competence and performance]*
    b. A reduction in the level of detail and specificity in the current competency framework would improve the framework's practical value without impacting negatively on the purpose for which it is used. *[Refer to Section A.2 – Reducing the level of detail]*
    c. The development of markers of poor behaviour would be useful in the assessment of performance, providing a basis for support and remediation, in meeting the healthcare needs of the Australian community. *[Refer to Section A.3 – Markers of poor behaviour]*
    d. The way in which competencies are grouped affects my use of the competency framework and the way a pharmacist's role is perceived. *[Refer to Section A.4 – Grouping competencies]*
    e. The development of competencies should be supplemented with a consideration of professional identity formation. *[Refer to Section A.4 – Grouping competencies]*
    f. A competency framework that provides a clear mechanism for demonstrating competence in, or capability for, extended scopes of practice should be pursued. *[Refer to Section A.5 – Variations in scope of practice]*
    g. The milestones in a performance continuum for pharmacist competencies should exist within one competency framework. *[Refer to Section A.6 – Reflecting the performance continuum]*
    h. Assessments of performance would benefit from the existence of performance rating scales that align with milestones in a performance continuum (rather than the dichotomous decision of competent or incompetent). *[Refer to Section A.6 – Reflecting the performance continuum]*
    i. Interpretation and implementation of the competency framework to facilitate scope of practice changes would be assisted by the development of entrustable professional activities and levels of entrustment. *[Refer to Section A.7 – Supporting implementation with entrustable professional activities]*
8. Please provide any other feedback you have about the competency framework as used to meet the healthcare needs of the Australian community.

Part C. Competencies in context

C.1 Competencies in regulation

C.1.1 Regulation through scopes of practice

To regulate is '*to control, govern or direct, especially by means of regulations or restrictions*'.[5]

Historically, laws to define scopes of practice for professions and the performance of defined functions were introduced to protect the public from potentially harmful health services being provided by unqualified people. As such, they:[51]

- Defined the practice of the profession in question
- Limited that practice to people who satisfactorily complete a specified training and examination requirements
- Restricted professional titles or credentials and the performance of defined functions to those licensed in that profession.

However, such laws can also limit a profession's ability to contribute positively to health care. These limitations may be a result of not only the defined scope of practice for one's own profession, but by the scopes defined for other professions or functions as well.

Approaches to regulating both professions and the performance of defined functions through defined scopes of practice vary (sometimes quite significantly) between different jurisdictions, between professions within jurisdictions, and with time.

C.1.2 Regulation of pharmacists and their scope of practice

Within Australia's health system, there is a complex network of governance and support mechanisms that enable the policy, legislation, coordination, regulation and funding aspects of delivering quality services. It is a joint responsibility of all levels of government, with the planning and delivery of services being shared between government and non-government sectors.[52] As such, regulation occurs at a number of levels and is influenced by a number of sources (including the individual's self-regulation), restricting a pharmacist's potential individual scope of practice.

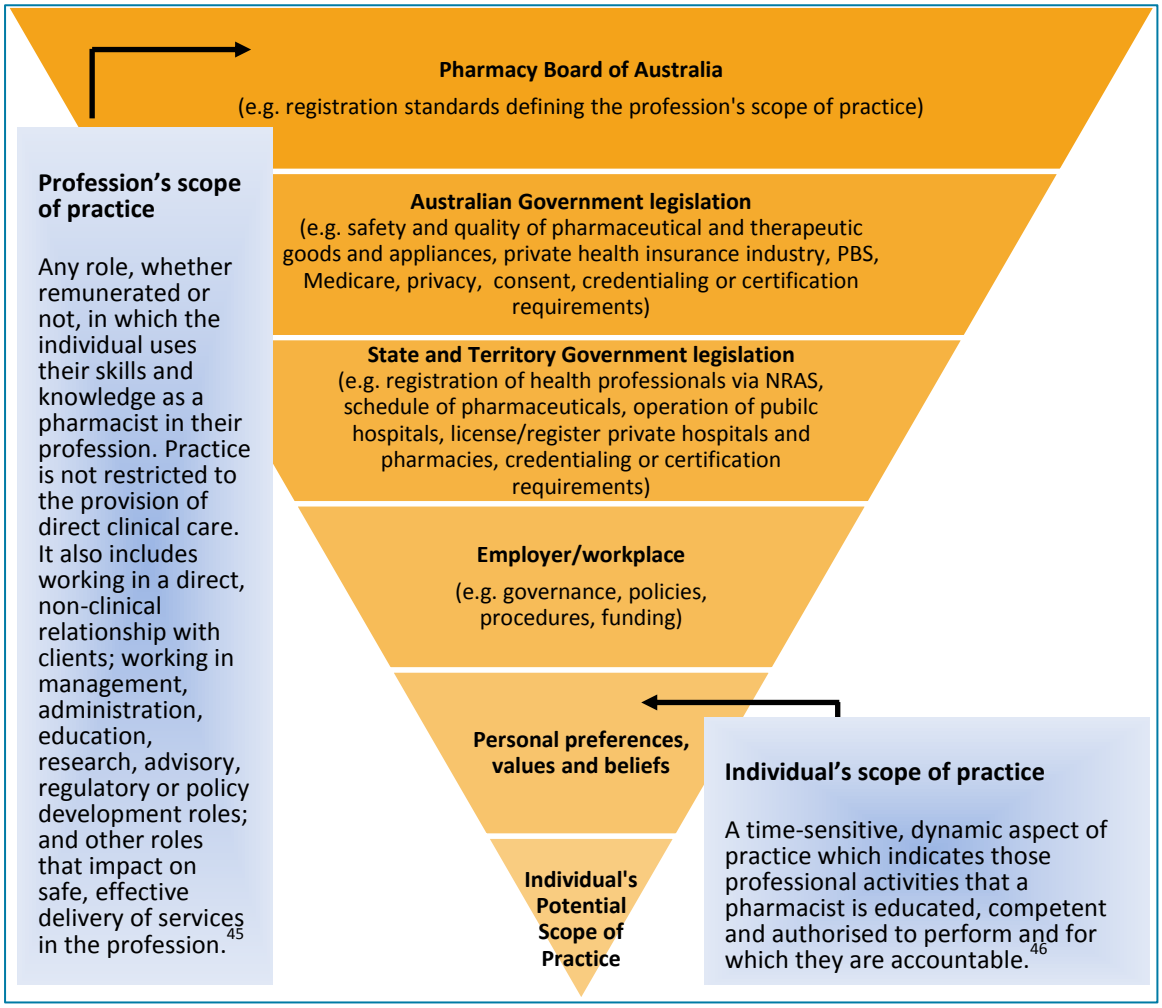
Figure 12 depicts in a simplified manner the regulation (or restriction) that occurs at a number of levels, from the pharmacy profession's scope of practice as reflected by the Pharmacy Board of Australia definition of practice, being:

> *'any role, whether remunerated or not, in which the individual uses their skills and knowledge as a health practitioner in their profession. … practice is not restricted to the provision of direct clinical care.*
>
> *It also includes working in a direct nonclinical relationship with clients, working in management, administration, education, research, advisory, regulatory or policy development roles, and any other roles that impact on safe, effective delivery of services in the profession and/or use their professional skills'*[53]

to the individual pharmacist's scope of practice:

'a time-sensitive, dynamic aspect of practice which indicates those professional activities that a pharmacist is educated, competent and authorised to perform and for which they are accountable'.[54]

Figure 12: Regulation of an individual pharmacist's scope of practice in Australia



C.1.3 Current use of competency frameworks to regulate individual scopes of practice

In Australia, pharmacists are regulated under the *Health Practitioner Regulation National Law Act*[55] (the National Law), as in force in each State and Territory. The Pharmacy Board of Australia (PBA) has been established for the pharmacy profession and has the functions defined in the National Law.

The Australian Pharmacy Council (APC) exercises the accreditation functions defined in the National Law for the pharmacy profession. The National Registration and Accreditation Scheme (NRAS), established as an object of this Law, has the objectives listed in Table 7. The *National Competency Standards Framework for Pharmacists in Australia* (the 'Competency Framework') for the pharmacy profession underpins activities that contribute to most of these objectives.

This Section will focus on those regulatory activities relating to objectives a. and e. (with the other activities being covered in later Sections).

Table 7. The application of the competency framework in achieving the objectives of the National Registration and Accreditation Scheme

Objectives of the National Registration and Accreditation Scheme[55]	Examples of the application of the competency framework towards achieving these objectives
a. To provide for the protection of the public by ensuring that only health practitioners who are suitably trained and qualified to practise in a competent and ethical manner are registered	■ While not explicitly stated (e.g. in a Registration Standard), the Competency Framework is used by the PBA to indicate the scope of practice for the profession ■ The PBA and the APC use the Competency Framework in the development of exams for determining eligibility for registration ■ The Competency Framework may be used as a reference point in investigating, assessing or responding to notifications/complaints about the performance or conduct of a pharmacist
b. To facilitate workforce mobility across Australia by reducing the administrative burden for health practitioners wishing to move between participating jurisdictions or to practise in more than one participating jurisdiction	■ None identified
c. To facilitate the provision of high quality education and training of health practitioners	■ Education providers (universities and intern training program providers) design and develop curriculum with regard to the Competency Framework ■ The APC accredits programs that (in meeting the relevant Accreditation Standards) can demonstrate students or interns achieve the required competencies in the Competency Framework
d. To facilitate the rigorous and responsive assessment of overseas-trained health practitioners	■ The APC designs and develops the assessments and examinations to determine whether overseas-trained pharmacists can demonstrate the required competencies in the Competency Framework
e. To facilitate access to services provided by health practitioners in accordance with the public interest	■ The Competency Framework has been used to demonstrate services that are within the pharmacy profession's scope of practice (i.e. pharmacist vaccination)
f. To enable the continuous development of a flexible, responsive and sustainable Australian health workforce and to enable innovation in the education of, and service delivery by, health practitioners	■ The Competency Framework can be used to guide continuing professional development (CPD) of individuals ■ The Competency Framework provides a mechanism for employers, the profession (collectively through associations and individually) and policy makers to consider how the pharmacy profession can meet the current and future health needs of the community

The National Law, however, is not the only legislation governing a pharmacist's scope of practice. The federal system of government in Australia involves six states, two territories and the federal government, each with law-making functions. Through federal and state/territory government there is regulation of other legal and professional obligations (e.g. privacy, confidentiality, consent, safe and quality pharmaceuticals and therapeutic goods, access to pharmaceuticals, funding of services, pharmacy ownership, employment practices), where the competency framework may also be applied.

One example involves the *National Health Act 1953* (the Act), which allows for payment of a claim for the supply of a pharmaceutical benefit only where the supply has been made at or from premises for which the pharmacist is approved under the Act. The *National Health (Pharmaceutical Benefits) (Conditions of approval for approved pharmacists) Amendment (Supply from Premises) Determination 2014* specifies that approved pharmacists must maintain currency of their pharmaceutical knowledge in accordance with the Competency Framework.[56]

Another example involves the requirements by which pharmacists participate as a service provider in the Home Medicines Review (HMR) program, funded by the Australian Government Department of Health as part of the Fifth Community Pharmacy Agreement, including abiding by the *5CPA General Terms and Conditions* and *HMR Program Specific Guidelines.*[57] The Accredited Pharmacist who is approved to conduct the HMR Service is required to be Medication Management Review accredited through the Australian Association of Consultant Pharmacy (AACP) or Society of Hospital Pharmacists of Australia (SHPA).

The AACP accreditation process has been designed to identify pharmacists with the required competencies to provide a particular professional service to the required level, and uses a Competency Map[58] that selects those competencies from the Competency Framework that are required to practice in the area of medication reviews.

State and Territory Health Departments also have governance frameworks to regulate advanced and extended scope of practice roles (including through credentialing) for health professionals employed by that department across a diverse range of sectors, contexts and settings. While these governance frameworks differ between states and territories; the concepts of assessing competence and/or performance (and frameworks to define these) are generally discussed.

However, some governance frameworks refer users to the relevant professional competency standards; others recommend the development of workplace-specific competency standards.

An example of a recently developed framework is the Victorian Department of Health *Allied health: credentialling, competency and capability framework*, [59] which is accompanied by a complementary 'kit' of competency resources (e.g. general tools, developers' resources, supervisors'/assessors' resources, learners' resources, evaluation and case studies) that support the development and implementation of competency-based programs in health service organisations.[60]

Case examples included in the kit cover medical practitioners, dentists, physiotherapists, nurses and midwives, and allied health assistants. The resources do not include any published examples of the framework being applied to pharmacists. However, through this mechanism, the competency framework may facilitate the integration of pharmacists in advanced or extended scope of practice roles.

Consultation questions: Competencies in regulation

9. Would you like to provide a response in this Section? (Yes or No)
10. In the past 5 years, how have you used the current competency framework in the context of regulating pharmacists and their scope of practice?
11. In considering how the current competency framework has *facilitated* a regulatory activity or desired outcome:
    a. Please describe an example(s).
    b. What features of the current competency framework were important in *facilitating* the regulatory activity or desired outcome?
    c. Would the incorporation of any of the features described in Part A of this consultation paper have *hindered* this regulatory activity or desired outcome?
12. In considering how the current competency framework has *hindered* a regulatory activity or desired outcome:
    a. Please describe an example(s).
    b. What features of the current competency framework *most hindered* the regulatory activity or desired outcome?
    c. Would the incorporation of any of the features described in Part A of this consultation paper have *better facilitated* this regulatory activity or desired outcome?
13. With consideration of the features of competency frameworks described in Part A, to what extent do you support the following statements as they relate to regulation of the pharmacy profession in Australia? (Please explain your rating where possible.)
    [Likert scale: Strongly Disagree to Strongly Agree]
    a. 'Competent' should be identified as one level of performance along a continuum from Incompetent through to Mastery (i.e. the modified Dreyfus model), *[Refer to Section A.1 – The relationship between competence and performance]*
    b. A reduction in the level of detail and specificity in the current competency framework would improve the framework's practical value without impacting negatively on the purpose for which it is used. *[Refer to Section A.2 – Reducing the level of detail]*
    c. The development of markers of poor behaviour would be useful in the assessment of performance, providing a basis for support and remediation, in the regulatory environment. *[Refer to Section A.3 – Markers of poor behaviour]*
    d. The way in which competencies are grouped affects my use of the competency framework and the way a pharmacist's role is perceived. *[Refer to Section A.4 – Grouping competencies]*
    e. The development of competencies should be supplemented with a consideration of professional identity formation. *[Refer to Section A.4 – Grouping competencies]*
    f. A competency framework that provides a clear mechanism for demonstrating competence in, or capability for, extended scopes of practice should be pursued. *[Refer to Section A.5 – Variations in scope of practice]*
    g. The milestones in a performance continuum for pharmacist competencies should exist within one competency framework model. *[Refer to Section A.6 – Reflecting the performance continuum]*

h. Assessments of performance would benefit from the existence of performance rating scales that align with milestones in a performance continuum (rather than a dichotomous decision of competent or incompetent). *[Refer to Section A.6 – Reflecting the performance continuum]*

i. Interpretation and implementation of the competency framework for regulation would be assisted by the development of entrustable professional activities and levels of entrustment. *[Refer to Section A.7 – Supporting implementation with entrustable professional activities]*

14. Would consistent workforce competency frameworks across different professions facilitate cross-profession regulation, without impacting negatively on the purpose for which competency frameworks are used for individual professions? Why or why not? If yes, identify the professions for whom it would be most appropriate to align in such a competency framework.

15. Please provide any other feedback you have about the competency framework as used in regulation of the pharmacy profession in Australia.

C.2 Competencies in education leading to initial registration

C.2.1 Quality assurance of education leading to initial registration

Accreditation is an important quality assurance and quality improvement mechanism for health practitioner education and training.[61] For professions regulated under the *Health Practitioner Regulation National Law Act*[55] (the National Law), as in force in each State and Territory, the National Registration and Accreditation Scheme (NRAS) established a common statutory framework for accreditation bodies that had previously operated within a diversity of profession-specific models.[61] For professions not regulated under the National Law (both health and non-health), accreditation occurs under other regulatory models (including self-regulatory or co-regulatory).

Accreditation Standards are used to assess whether a program of study, and the education provider that provides the program of study, provides graduates of the program with the knowledge, skills and professional attributes to practise the relevant profession in that jurisdiction. [61]

In terms of curriculum development, the Accreditation Standards for every profession make reference to educational outcomes, be they competencies, graduate/learning outcomes and/or graduate/professional attributes. These outcomes may be integrated within the Accreditation Standards document, included as an appendix to the document, or referred to but only available as a separate document.

Variation in how educational outcomes are defined for professions appears to be largely influenced by whether graduates of the program are immediately eligible to register/practise in the relevant profession or whether there are additional requirements before being eligible for general registration. In Australia, most professions regulated under the National Law are eligible to register on graduation. As such, the outcome measure for graduation can be performance of the specified competencies. However, for some professions there are various 'milestones' occurring post-graduation along a trajectory towards competence, e.g. professional/workplace experience, professional/workplace assessments, portfolios and examinations. At each 'milestone', there may be different outcome measures, which may or may not be explicitly linked to the competencies or each other.

C.2.2 Defining outcome milestones to qualify as 'competent'

Where graduates of a program are eligible to register and practice immediately following registration, the learning outcomes for the program should at least be equivalent to the competencies defined for an entry level practitioner.[62]

Minimum threshold learning outcomes (TLOs) common across healthcare graduates at professional entry-level have been developed, and are also a key document in this regard.[63]

However, of the health professions regulated under the National Law in Australia, medicine and pharmacy have additional education and training requirements after graduation from an approved program of study in order for graduates to be eligible to register. As such, the determination of outcome milestones along the pathway towards being deemed competent needs broader and coordinated consideration.

For medicine, a number of frameworks exist to support the pathway towards a student being deemed competent and eligible for registration, as described in Table 8. While these do not exist within a single framework, there is clearly interest in the frameworks aligning:

- The same four domains are used for the graduate and intern outcome statements
- Mapping was undertaken between the competencies for clinical placements and (former) graduate outcomes (see Table 9)
- The domains for intern outcome statements align with the *Australian Curriculum Framework for Junior Doctors* at intern level.

For medical degree programs, in addition to graduate outcome statements, a need for a level of clarity and precision around the training that occurs in a clinical environment was identified. To address this need, the competencies that rely on clinical placements were determined, and to complement this, the common diagnostic and procedural skills and the level of achievement expected of a medical graduate were identified (see Table 10). This framework provides an example of how the model of *entrustable professional activities* (see Section 1) can be used in practice, and the levels of achievement for this framework were adapted from the Dreyfus model as:[64]

1. Observes
2. Performs in a simulated environment (Novice)
3. Performs in the clinical environment under structured supervision (Competent)
4. Performs routinely in the clinical environment under minimal supervision (Proficient).

Initiatives to state the level of achievement expected of interns (PGY1 and PGY2) is now anticipated to provide an understanding of the individual junior doctor's progression of skill level from the level achieved at the end of their undergraduate training.[64]

Table 8: Frameworks used in medical practitioner education and training in Australia

Performance milestone	Framework	Developed by	Framework components
Graduation from medical degree program	Graduate outcome statements	Australian Medical Council	Domains Graduate outcome statements
	Competencies which rely on clinical placements[65]	Medical Deans Australia and New Zealand	Competencies (mapped to former AMC graduate outcomes and attributes)
	Procedural and diagnostic skills for competencies which rely on clinical placements[64]	Medical Deans Australia and New Zealand	Skills with specified level of achievement: ■ Observes ■ Performs in a simulated environment (Novice) ■ Performs in the clinical environment under structured supervision (Competent) ■ Performs routinely in the clinical environment under minimal supervision (Proficient)
End of intern training program	Intern outcome statements	Australian Medical Council	Domains Graduate outcome statements
	Australian curriculum framework for junior doctors (PGY1, PGY2 and above)	Postgraduate Medical Education Councils of Australia	Learning areas Categories Learning topics Competencies or capabilities

Table 9: Mapping of graduate attributes, learning outcomes and competencies that rely on clinical placements for medical graduates - extract[65]

Attribute	Student Learning Outcomes	Competencies
(26) Recognition that the doctor's primary professional responsibilities are the health interests of the patient and the community.	1. The student has the ability to recognise that the doctor's primary professional responsibilities are the health interests of the patient and the community.	1. Makes patient care his/her primary professional responsibility. 2. Understands the professional responsibility of the doctor extends from the individual patient to the health interests of the community.

Table 10: Procedural and diagnostic skills for competencies which rely on clinical placements - extract[64]

Procedural Skill	1. Observes	2. Performs in a simulated environment (Novice)	3. Performs in the clinical environment under structured supervision (Competent)	4. Performs routinely in the clinical environment under minimal supervision (Proficient)
Men's health				
Male catheterisation	✓	✓		
Musculoskeletal injury and anaesthesia				
Simple wound repair including skin suture	✓	✓		
Plastering of the upper limb and lower limb	✓	✓		
Injection of a local anaesthetic	✓	✓	✓	
Subcutaneous injections	✓	✓	✓	

For pharmacists:

- the *Accreditation Standards for Pharmacy Programs* require pharmacy degree programs to produce 'graduates who have the graduate attributes of the University and the knowledge, skills and attitudes necessary to commence supervised practice as an intern pharmacist'.[66]
- the *Accreditation Standards for Australian Pharmacy Intern Training Programs* (ITP) require ITP providers to 'provide learning opportunities that enable interns to integrate and apply the defined functional areas, not including supplementary elements, of the current *Competency Standards for Pharmacists in Australia'*.[67]

While the entry-level competencies are to be met at entry to professional practice, they can serve as a source of guidance to the teaching and learning expected across both the pharmacy degree program and the intern training program. In this regard, the *Customised Entry-level Competency Tool for Pharmacists*[68] was developed to assist with identifying the contributions of pharmacy programs and intern training programs to the learning and development of students and intern pharmacists, respectively.[66]

Most recently, a collaborative initiative with representatives from pharmacy schools in Australia has developed nationally agreed Pharmacy Learning Outcomes (PhLOs) for students graduating from entry-level pharmacy programs, clarifying expectations of both standards and levels of achievements across programs in Australia.[69] The potential for mapping curricula to PhLOs in accreditation requirements is currently under consideration by APC.

C.2.3 Competency-based education and assessment

Although 'competence' has always been the implicit goal of more traditional educational frameworks, it is reported that 'competency based education' (CBE) makes this explicit by establishing observable and measurable performance metrics that learners must attain to be deemed competent. [70] In CBE, *'the critical issue is that the learner reaches the specified level of performance in a competency; how he or she reaches that point (the educational process) is secondary'*.[70]

However, while there is much focus on CBE in the health professions, its definition is highly variable in the literature,[71] and there appears to be little agreement on many aspects of the model.

Benefits of CBE that are advocated include a focus on outcomes, thereby providing greater accountability to the public; an emphasis on abilities and a de-emphasis on time-based training; and promotion of greater learner-centredness.[71]

However, CBE brings challenges and criticism, including that:[8,62,71]

- Current concepts of competence 'fail to account for the essential interplay between competencies and the contexts of practice'
- Breaking competencies into the smallest observable units of behaviour, creating endless lists of abilities, can frustrate learners and teachers;
- CBE promotes the lowest common denominator, with learners pursuing milestones and not excellence;
- The rationale for adopting CBE is almost entirely expressed in terms of assessment and accountability to society, with little direct link to teaching and learning;

- Valuable content and experiences are removed from the curriculum when they do not directly contribute to defined program outcomes; and
- There is logistical chaos with managing the scheduling of students all progressing at their own pace.

As such, various models appear to exist that incorporate CBE to varying extents. By definition, however, CBE necessitates a robust and multifaceted assessment system.[72] 133

If the modified Dreyfus model (see Section A.1) is accepted as the model to underpin a competency framework, then it would follow that all assessments of competence are assessments of performance. Assessments may then be differentiated by the different settings or environments and the influence of different factors (rather than whether they are assessing competence or performance), e.g.:[4]

- A workplace based assessment (e.g. DOPS, MiniCEX) would be considered 'Observed Performance in Workplace Settings'
- An OSCE would be considered 'Observed Performance in Simulated Setting'.

Both reflect 'Shows how' in Miller's pyramid (see Figure 5), and for the same competency, an individual may have different levels of performance in different environments. Actual performance (reflecting 'Does' in Miller's pyramid), however, can only be assessed when the individual is unaware of being observed or assessed, e.g. 'mystery/incognito patients'.[4]

With such an approach, it is proposed that assessment be more continuous and frequent (emphasising formative over summative assessment).[72] Assessment tools used by training programs should be required to meet minimum standards of quality, and assessment (especially for summative decisions) should draw upon the wisdom of a group and involve active engagement by the student/intern.[72] Assessments must be criterion-based, using a developmental perspective.[72] *Performance rating scales* should be developed; that is, holistic scales that would allow the level of performance to be recorded, rather than just a dichotomous decision of being competent or incompetent, and could allow individuals to track their performance over the years of training leading up to registration, and also post-registration.[4]

As such, CBE would not seek 'competence' as an ultimate state, but rather recognise 'mastery' as the end goal.[72]

Consultation questions: Competencies in education leading to registration

16. Would you like to provide a response relating to this Section? (Yes or No)
17. In the past 5 years, how have you used the current competency framework in the context of educating pharmacists?
18. Consider an example(s) of how the current competency framework has *facilitated* an activity or desired outcome:
    a. Please describe an example(s).
    b. What features of the current competency framework were important in *facilitating* the activity or desired outcome?
    c. Would the incorporation of any of the features described in Part A of this consultation paper have *hindered* the activity or desired outcome?

19. In considering how the current competency framework has *hindered* an activity or desired outcome:
    a. Please describe an example(s).
    b. What features of the current competency framework *most hindered* the activity or desired outcome?
    c. Would the incorporation of any of the features described in Part A of this consultation paper have *better facilitated* the activity or desired outcome?
20. Have you used the *Customised Entry-level Competency Tool for Pharmacists*? *[Refer to Section 2.2, p.45]* If yes:
    a. Please describe how you have used it. *[Including indicating if this was for a degree program, intern training, assessment of overseas pharmacists, or other]*
    b. How effective did you find it? (Please explain your rating.)
    [*Likert scale: Ineffective; Somewhat effective; Effective; Very effective*]
    c. What problems (if any) did you encounter when using it?
21. With consideration of the features of competency frameworks in Part A, to what extent do you support the following statements as they relate to education (degree program and/or intern training) for the pharmacy profession in Australia? (Please explain your rating where possible.) *[Likert scale: Strongly Disagree to Strongly Agree]*
    a. 'Competent' should be identified as one level of performance along a continuum from Incompetent through to Mastery (i.e. the modified Dreyfus model). *[Refer to Section A.1 – The relationship between competence and performance]*
    b. A reduction in the level of detail and specificity in the current competency framework would improve the framework's practical value without impacting negatively on the purpose for which it is used. *[Refer to Section A.2 – Reducing the level of detail]*
    c. The development of markers of poor behaviour would be useful in the assessment of performance, providing a basis for support and remediation, in education. *[Refer to Section A.3 – Markers of poor behaviour]*
    d. The way in which competencies are grouped affects my use of the competency framework and the way a pharmacist's role is perceived. *[Refer to Section A.4 – Grouping competencies]*
    e. The development of competencies should be supplemented with a consideration of professional identity formation. *[Refer to Section A.4 – Grouping competencies]*
    f. A competency framework that provides a clear mechanism for demonstrating competence in, or capability for, extended scopes of practice should be pursued. *[Refer to Section A.5 – Variations in scope of practice]*
    g. The milestones in a performance continuum for pharmacist competencies should exist within one competency framework. *[Refer to Section A.6 – Reflecting the performance continuum]*
    h. Assessments of performance would benefit from the existence of performance rating scales that align with milestones in a performance continuum (rather than the dichotomous decision of competent or incompetent). *[Refer to Section A.6 – Reflecting the performance continuum]*
    i. Interpretation and implementation of the competency framework for education (university and intern training) would be assisted by the development of entrustable professional activities and levels of entrustment. *[Refer to Section A.7 – Supporting implementation with entrustable professional activities]*

22. Would consistent workforce competency frameworks across different professions facilitate inter-profession education, without impacting negatively on the purpose for which competency frameworks are used for individual professions? Why or why not? If yes, identify the professions for whom it would be most appropriate to align in such a competency framework.
23. Please provide any other feedback you have about the competency framework as used in education for the pharmacy profession in Australia.

C.3 Competencies in the assessment of overseas trained practitioners

C.3.1 Pathways for assessment of overseas trained practitioners

The assessment of overseas trained health professionals who wish to practise in Australia is undertaken by the accreditation authority or professional association for that profession. For registration purposes, this function is assigned by the respective National Board under the National Law. For migration purposes (e.g. Skilled Migration and Temporary Activity visa programs), this function is specified by the Minister for Immigration and Border Protection.

The assessments undertaken by these bodies vary depending on:[73]

- The competencies or capabilities specified for that profession
- The methods of assessment chosen.

C.3.2 Competency frameworks that support the assessment of overseas trained practitioners

Competency frameworks are reported to be used to support the assessment of overseas trained practitioners by facilitating such things as:

- Consideration of equivalence of qualifications awarded by overseas institutions with those awarded by accredited Australian programs;
- Consideration of equivalence of accrediting bodies in overseas jurisdictions with those in Australia; and
- Development of assessment blueprints and tools/exams for assessing overseas trained practitioners.

For the health professions regulated under the National Law, some competency frameworks explicitly state that supporting the assessment of overseas trained practitioners is a key function. However, it is often not specifically identified within the competency framework how they have been (or are being) used.

The Australia and New Zealand Osteopathic Council and Osteopathic Council of New Zealand published a report following a review of their assessment process for overseas osteopaths to practice in Australasia. One aspect of the report considers a map of the osteopathic capabilities against the assessment tools in all stages of their overseas assessment process, to consider the appropriateness of each assessment tool for assessing the particular capabilities, the frequency that capabilities were assessed across the tools, and adequate coverage by the assessment as a whole.[74]

To inform an accelerated process for assessing overseas qualified pharmacists ('Stream B'), the Australian Pharmacy Council uses a comparison of competencies (or equivalent) required for pharmacy practice in other countries.

In addition to competencies, the accreditation standards, examinations and clinical placement activity; registration standards; pharmacy practice standards and practice environment are also compared. Standards to underpin this process have been developed and approved by the Pharmacy Board of Australia.

For some professions, guidance material has been developed to support the use of the respective competency framework for assessment of competence, e.g. the Nursing and Midwifery Board of Australia has published a *Framework for assessing national competency standards*.[75]

Consultation questions: Competencies in the assessment of overseas trained practitioners

24. Would you like to provide a response relating to this Section? (Yes or No)
25. In the past 5 years, how have you used the current competency framework in the context of assessing overseas trained practitioners?
26. Consider an example(s) of how the current competency framework has *facilitated* (or can facilitate) an activity or desired outcome:
    a. Please describe an example(s).
    b. What features of the current competency framework were (or are) important in *facilitating* the activity or desired outcome?
    c. Would the incorporation of any of the features described in Part A of this consultation paper have *hindered* the activity or desired outcome?
27. In considering how the current competency framework has *hindered* (or may hinder) an activity or desired outcome:
    a. Please describe an example(s).
    b. What features of the current competency framework *most hindered* (or were most likely to hinder) the activity or desired outcome?
    c. Would the incorporation of any of the features described in Part A of this consultation paper have *better facilitated* the activity or desired outcome?
28. With consideration of the features of competency frameworks in Part A, to what extent do you support the following statements as they relate to the assessment of overseas trained pharmacists for eligibility to practise in Australia? (Please explain your rating where possible.) *[Likert scale: Strongly Disagree to Strongly Agree]*
    a. 'Competent' should be identified as one level of performance along a continuum from Incompetent through to Mastery (i.e. the modified Dreyfus model). *[Refer to Section A.1 – The relationship between competence and performance]*
    b. A reduction in the level of detail and specificity in the current competency framework would improve the framework's practical value without impacting negatively on the purpose for which it is used. *[Refer to Section A.2 – Reducing the level of detail]*
    c. The development of markers of poor behaviour would be useful in the assessment of performance, providing a basis for support and remediation, in the assessment of overseas trained practitioners.
    [Refer to Section A.3 – Markers of poor behaviour]
    d. The way in which competencies are grouped affects my use of the competency framework and the way a pharmacist's role is perceived. *[Refer to Section A.4 – Grouping competencies]*
    e. The development of competencies should be supplemented with a consideration of professional identity formation. *[Refer to Section A.4 – Grouping competencies]*
    f. A competency framework that provides a clear mechanism for demonstrating competence in, or capability for, extended scopes of practice should be pursued. *[Refer to Section A.5 – Variations in scope of practice]*

g. The milestones in a performance continuum for pharmacist competencies should exist within one competency framework. *[Refer to Section A.6 – Reflecting the performance continuum]*

h. Assessments of performance would benefit from the existence of performance rating scales that align with milestones in a performance continuum (rather than the dichotomous decision of competent or incompetent). *[Refer to Section A.6 – Reflecting the performance continuum]*

i. Interpretation and implementation of the competency framework for the assessment of overseas trained pharmacists would be assisted by the development of entrustable professional activities and levels of entrustment. *[Refer to Section A.7 – Supporting implementation with entrustable professional activities]*

29. Please provide any other feedback you have about the competency framework as used for the assessment of overseas trained pharmacists for eligibility to practice in Australia.

C.4 Competencies for ongoing professional development of pharmacists

C.4.1 CPD registration requirements

Competency frameworks are reported to be commonly used for the continuing professional development (CPD) of health care professionals, introduced largely due to little formal structure to development post-registration.[35]

For the health professions regulated under the National Law, registration standards have been developed by each National Board that specify requirements for CPD. For most professions this involves completing a set number of hours of CPD activities, and for some, reflective elements including descriptions of how the activities relate to professional practice and whether desired outcomes have been achieved. However, reference to the respective competency framework in registration standards is only made by:

- The Nurse and Midwifery Board of Australia, with a requirement that for self-directed CPD, learning needs are identified and prioritised based on an evaluation of their practice against the relevant competency or professional practice standards;[76] and
- The Pharmacy Board of Australia, with a requirement that pharmacists are expected to self-assess their individual needs with reference to the Competency Standards for Pharmacists in Australia.[77]

The limited reference to competency frameworks for the purpose of CPD appears consistent with the stated purpose of competency frameworks that exist for the respective professions, with professional development generally not an explicit purpose for frameworks developed for the professions regulated under the National Law. Most of these frameworks focus on the competencies of entry level practitioners only.

C.4.2 Accreditation of CPD

As specified in the Pharmacy Board of Australia (PBA)'s CPD registration standard, CPD can be either accredited or non-accredited. The accreditation of CPD activities provides assurance to pharmacists that an activity has been reviewed for its educational quality and for its relevant to a pharmacist's practice. However, at this time, the PBA has not stipulated that a proportion of CPD activities must be accredited.

The Australian Pharmacy Council (APC) has been authorised by the PBA to accredit providers of pharmacy CPD activities. The APC does this by accrediting organisations that meet strict criteria to accredit CPD on APC's behalf. CPD accrediting organisations assess CPD activities against the *Accreditation Standards for Continuing Professional Development Activities*.[78]

These Standards specify that the *National Competency Standards Framework for Pharmacists in Australia* must be appropriately considered in the development of content and materials for CPD activities, and they must have a statement of specific learning objectives that are mapped to these competency standards. Organisations currently accredited to accredit CPD for pharmacists are the Australian College of Pharmacy, Pharmacy Guild of Australia, Pharmaceutical Society of Australia, and the Society of Hospital Pharmacists of Australia.[79]

C.4.3 Competency frameworks that support CPD

Internationally, there are examples of competency frameworks that have been developed with professional development as a key purpose, e.g. CanMEDS 2015 for medical practitioners in Canada, Competence Standards for the Pharmacy Profession in NZ, General Level Framework (GLF) for pharmacists in the UK.

The primary purpose of the GLF is stated as being to help with training and development activities. Features of the competency framework that support this purpose include (see Table 11):[26]

- The framework itself being a tool for assessment (self and peer assessment), with a four-point rating scale of *Never*, *Sometimes*, *Usually* and *Always* for each behavioural statement associated with each competency; and
- The framework facilitating periodic assessments at 4-monthly intervals so that progress can be recorded.

Table 11: General Level Framework for pharmacists in the UK – extract of assessment tool[26]

Need for the drug												
Relevant patient background	Retrieval of all relevant and available information	a	b	Retrieval of most relevant and available information	a	b	Retrieval of some relevant and available information	a	b	Does not retrieve relevant or available information	a	b
		c	d		c	d		c	d		c	d

a = Initial self assessment
b = Four month facilitation
c = Eight month facilitation
d = Twelve month self assessment

Other assessment tools have also been developed to support the assessment against the framework, e.g. mini-PAT, mini-CEX, case-based discussion, which use a rating scale of *Significantly below*, *Below*, *Borderline*, *Meets expectations*, *Above*, and *Significantly above*.

There is substantial research supporting the use of the GLF for professional development in different contexts. However, misalignment with the advanced level framework (the Advanced to Consultant Level Framework) has been reported.

A lack of focus in some areas in early career stages (e.g. in areas of research, training and leadership) has been reported to underpin difficulties for individuals achieving advanced level performance of these competencies when in more senior roles.[35]

Consultation questions: Competencies for ongoing professional development of pharmacists

29. Would you like to provide a response relating to this Section? (Yes or No)
30. In the past 5 years, have you used the competency framework in the context of ongoing professional development?
    a. If yes, please describe how you have used it.
    b. If limited or no use, are you an individual pharmacist practitioner?

c. If yes, please describe what might make the competency framework more useful and assist you to use it more?

31. In considering how the current competency framework has *facilitated* a professional development activity or desired outcome:

    a. Please describe an example(s).

    b. What features of the current competency framework were important in *facilitating* the professional development activity or desired outcome?

    c. Would the incorporation of any of the features described in Part A of this consultation paper have *hindered* this professional development activity or desired outcome?

32. In considering how the current competency framework has *hindered* a professional development activity or desired outcome:

    a. Please describe an example(s).

    b. What features of the current competency framework *most hindered* the professional development activity or desired outcome?

    c. Would the incorporation of any of the features described in Part A of this consultation paper have *better facilitated* this professional development activity or desired outcome?

33. With consideration of the features of competency frameworks in Part A, to what extent do you support the following statements as they relate to professional development for the pharmacy profession in Australia? (Please explain your rating where possible.)
    [Likert scale: Strongly Disagree to Strongly Agree]

    a. 'Competent' should be identified as one level of performance along a continuum from Incompetent through to Mastery (i.e. the modified Dreyfus model). *[Refer to Section A.1 – The relationship between competence and performance]*

    b. A reduction in the level of detail and specificity in the current competency framework would improve the framework's practical value without impacting negatively on the purpose for which it is used. *[Refer to Section A.2 – Reducing the level of detail]*

    c. The development of markers of poor behaviour would be useful in the assessment of performance, providing a basis for support and remediation, in professional development. *[Refer to Section A.3 – Markers of poor behaviour]*

    d. The way in which competencies are grouped affects my use of the competency framework and the way a pharmacist's role is perceived. *[Refer to Section A.4 – Grouping competencies]*

    e. The development of competencies should be supplemented with a consideration of professional identity formation. *[Refer to Section A.4 – Grouping competencies]*

    f. A competency framework that provides a clear mechanism for demonstrating competence in, or capability for, extended scopes of practice should be pursued. *[Refer to Section A.5 – Variations in scope of practice]*

    g. The milestones in a performance continuum for pharmacist competencies should exist within one competency framework. *[Refer to Section A.6 – Reflecting the performance continuum]*

    h. Assessments of performance would benefit from the existence of performance rating scales that align with milestones in a performance continuum (rather than the dichotomous decision of competent or incompetent). *[Refer to Section A.6 – Reflecting the performance continuum]*

i. Interpretation and implementation of the competency framework for professional development would be assisted by the development of entrustable professional activities and levels of entrustment. *[Refer to Section A.7 – Supporting implementation with entrustable professional activities]*

34. Would consistent workforce competency frameworks across different professions facilitate inter-profession CPD, without impacting negatively on the purpose for which competency frameworks are used for individual professions? Why or why not? If yes, identify the professions for whom it would be most appropriate to align in such a competency framework.

35. Please provide any other feedback you have about the competency framework as used in professional development for the pharmacy profession in Australia.

C.5 Competencies in the workplace

C.5.1 Frameworks to underpin development in the workplace

While professional development (particularly for registration purposes) is the responsibility of the individual practitioner, employers also have an interest in the development and advancement of health professionals.

Health service managers have been reported to use competency-based career frameworks for:[3]

- Conducting service reviews
- During workforce planning and development
- Redesigning or defining roles
- During appraisal, self-appraisal and personal development planning
- Conducting reviews of skill mix
- Developing and delivering training programs or qualifications.

Factors advocated in order to effectively implement competency frameworks in the workplace have been identified and include:[80]

- Keep it simple. Both language and structure should be kept simple in creating the framework. If it is too complicated, long or detailed, or if the language is not meaningful to the people who use it, it won't be used. However, if it a framework is too broad or contains only general statements, it will fail to provide adequate guidance.
- Communicate the purpose. Employees need to understand how their behaviours contribute to personal and organisational success.
- Train, don't blame. It must be kept in mind that the framework is a tool, and if users don't know how to use it, it will either not be used or it will fail to meet its full potential.

C.5.2 Competency-based career frameworks in Australia

The Australian Public Service (APS) *Work level standards for APS Level and Executive Level classifications*[81] provides an example of a comprehensive, multi-dimensional framework, developed to provide a consistent platform for classifying jobs. They accommodate the diversity of roles across the APS and are structured to clearly differentiate between the work expected (i.e. responsibilities and duties) at each classification level through identifying behaviours for each standard.

The APS has a *Senior Executive Leadership Capability Framework* for higher level positions, with descriptions and behaviours for each capability. An *Integrated Leadership System*[82] has also been developed to provide a comparative view of the behaviours at each level to provide a pathway for the development of leaders (See Table 12).

Table 12: Australian Public Service Integrated Leader System[82] – extract

Shapes strategic thinking					
EL1		**EL2**	**SES B1**	**SES B2**	**SES B3**
Inspires a sense of purpose and direction.	Provides direction to others regarding the purpose and importance of their work. Illustrates the relationship between operational tasks and organisation goals. Sets work tasks that align with the strategic objectives and communicates expected outcomes.	*Translates the strategy into operational goals and creates a shared sense of purpose within the business unit. Engages others* in the strategic direction of the work area, *encourages their contribution* and communicates expected outcomes.	*Develops the strategic direction for the business unit* and creates a shared sense of purpose by demonstrating *how elements of the strategy fit together and contribute to higher-level goals.* Encourages others' input and communicates required actions and expected outcomes.	*Champions the organisation's vision and goals and promotes a shared commitment to the strategic direction. Helps create organisational strategies that are aligned with government objectives and likely future requirements.* Encourages others' input and communicates expected outcomes from organisational strategies.	Champions the organisation's vision and goals and *unifies* business units with the strategic direction. Helps create organisational strategies that are aligned with government objectives and likely future requirements. Encourages others' input and communicates expected outcomes from organisational strategies.

Consultation questions: Competencies in the workplace

36. Would you like to provide a response relating to this Section? (Yes or No)
37. In the past 5 years, how have you used the competency framework in the context of the workplace?
38. In considering how the current competency framework has *facilitated* an activity or desired outcome in the workplace:
    a. Please describe an example(s).
    b. What features of the current competency framework were important in *facilitating* the activity or desired outcome in the workplace?
    c. Would the incorporation of any of the features described in Part A of this consultation paper have *hindered* the activity or desired outcome in the workplace?
39. In considering how the current competency framework has *hindered* a an activity or desired outcome in the workplace:
    a. Please describe an example(s).
    b. What features of the current competency framework *most hindered* the activity or desired outcome in the workplace?
    c. Would the incorporation of any of the features described in Part A of this consultation paper have *better facilitated* the activity or desired outcome in the workplace?

40. With consideration of the features of competency frameworks in Part A, to what extent do you support the following statements as they relate to the use of competency frameworks in the workplace? (Please explain your rating where possible.)
[Likert scale: Strongly Disagree to Strongly Agree]

    a. 'Competent' should be identified as one level of performance along a continuum from Incompetent through to Mastery (i.e. the modified Dreyfus model). *[Refer to Section A.1 – The relationship between competence and performance]*

    b. A reduction in the level of detail and specificity in the current competency framework would improve the framework's practical value without impacting negatively on the purpose for which it is used. *[Refer to Section A.2 – Reducing the level of detail]*

    c. The development of markers of poor behaviour would be useful in the assessment of performance, providing a basis for support and remediation, in the workplace. *[Refer to Section A.3 – Markers of poor behaviour]*

    d. The way in which competencies are grouped affects my use of the competency framework and the way a pharmacist's role is perceived. *[Refer to Section A.4 – Grouping competencies]*

    e. The development of competencies should be supplemented with a consideration of professional identity formation. *[Refer to Section A.4 – Grouping competencies]*

    f. A competency framework that provides a clear mechanism for demonstrating competence in, or capability for, extended scopes of practice should be pursued. *[Refer to Section A.5 – Variations in scope of practice]*

    g. The milestones in a performance continuum for pharmacist competencies should exist within one competency framework. *[Refer to Section A.6 – Reflecting the performance continuum]*

    h. Assessments of performance would benefit from the existence of performance rating scales that align with milestones in a performance continuum (rather than the dichotomous decision of competent or incompetent). *[Refer to Section A.6 – Reflecting the performance continuum]*

    i. Interpretation and implementation of the competency framework in the workplace would be assisted by the development of entrustable professional activities and levels of entrustment. *[Refer to Section A.7 – Supporting implementation with entrustable professional activities]*

41. Would consistent workforce competency frameworks across different professions facilitate their use in the workplace, without impacting negatively on the purpose for which competency frameworks are used for individual professions? Why or why not? If yes, identify the professions for whom it would be most appropriate to align in such a competency framework.

42. Please provide any other feedback you have about the competency framework as used in the workplace for the pharmacy profession in Australia.

Closing questions

It is clear that competency frameworks are being used for diverse purposes. This consultation paper has been prepared to facilitate consideration of the value and appropriateness of different features of competency framework models in the current competency standards landscape, as they relate to these different purposes, and as they apply to the pharmacy profession in Australia.

However, through this consultation process, conflicting requirements for the different purposes may be identified and prioritisation of requirements may be necessary.

Consultation questions: Closing questions

43. Please indicate the value of a competency framework when used for each purpose: *[Likert scale: No value; Limited value; Average value; Much value; Extreme value]*
    a. To meet the healthcare needs of the Australian community
    b. Regulation
    c. Education leading to registration
    d. Assessment of overseas trained practitioners
    e. Ongoing professional development of pharmacists
    f. In the workplace
44. To address the feedback you have provided, please indicate whether you believe there needs to be no change, incremental change or a fundamental change to the current competency framework for pharmacists in Australia.

Appendix 1

In preparing this consultation paper, competency frameworks for the following professions were selected for inclusion in the background review:

AUSTRALIA – Professions regulated under the National Law

- Aboriginal and Torres Strait Islander Practitioner
- Chinese medicine
- Chiropractor
- Dentist
- Medical practitioner
- Medical radiation practitioner
- Nurse and midwife
- Occupational therapist
- Optometrist
- Osteopath
- Physiotherapist
- Podiatrist
- Psychologist
- Surgeon

AUSTRALIA – Other professions/areas

- Aboriginal and Torres Strait Islander health
- Allied health
- Australian Public Service
- Cultural
- Dietitians
- Interprofessional
- Internal auditor
- Leadership
- Prescribing
- School counsellor

INTERNATIONAL – Health professions

- Interprofessional (Canada, United Kingdom, United States of America)
- Medical practitioner (Canada, United Kingdom)
- Patient safety (Canada)
- Pharmacist (Canada, England, Ireland, New Zealand, United States of America)

INTERNATIONAL – Other professions

- Government communication (United Kingdom)
- Social worker (United Kingdom)
- Graduate school (United States of America)
- Program and project management, Ministry of Justice (United States of America)

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