Council, 3 December 2014

Preventing small problems from becoming big problems: a study of competency drift and disengagement in health and care professionals

Executive summary and recommendations

Introduction

In March 2014, we initiated a piece of research to gain a better understanding of the factors which gives rise to complaints and concerns about health and care professionals. The purpose of this research was to explore what causes registrants to become 'disengaged' and to understand more about what the public and registrants views are on the causes of disengagement and 'competency drift.' Picker Europe have been engaged to undertake this piece of research. It is anticipated that Council will receive this research report in February 2015. Alongside this we also commissioned ZUbin Austin from the University of Toronto to review the relevant literature related to competence in the context of the health and care professions. That review is attached to this paper as an appendix.

Decision

The Council is asked to discuss the attached paper 'Broadening the Discourse of Competence'

Background information

None

Resource implications

Accounted for in the 2014-15 Fitness to Practise Directorate Budget

Financial implications

Accounted for in the 2014-15 Fitness to Practise Directorate Budget

Appendices

Appendix One Austin, Z, University of Toronto 'Broadening the Discourse of Competence'

Date of paper

25 November 2014

Broadening the discourse of competence

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The purpose of this paper is to review relevant literature related to competence in the context of the health and care professions. Around the world, and in most professions, "competence" has become the most commonly used word to describe the knowledge, skills, and attributes of professionals. In most cases, however, the word is used without further elaboration, with the assumption that everyone has the same understanding of its meaning and application. Given the ubiquity of the word itself and the sometimes contradictory ways it has been used in the academic literature, it is essential that those using the term have a clear understanding of its multiple meanings and significance.

I. Competence: Evolution from Education to Regulation

It is difficult to pinpoint a moment when competence became entrenched in the academic literature, or in the thinking and work of regulators and educators. McGaghie et al (1978) and Carraccio et al (2002) have argued that the idea of competencies was a response of educational institutions to concerns regarding the perceived inability of health and care professions' graduates to actually manage real-world problems and effectively deal with real-world patients and their needs.

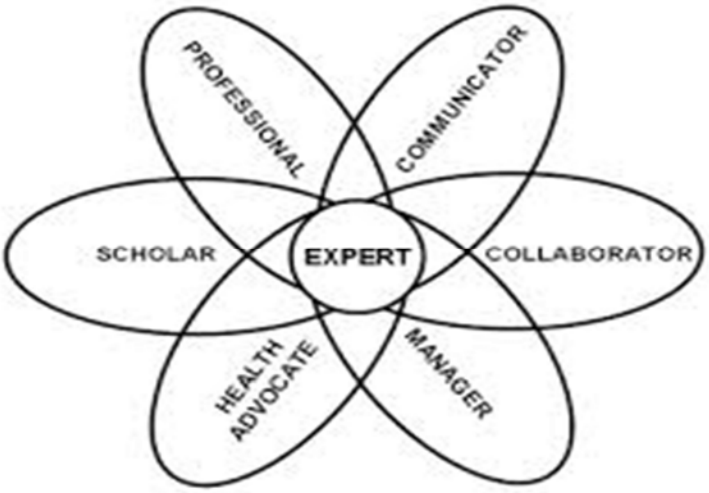
Competence-based education was initially driven by the need for greater accountability in training, the desire to demonstrate relevance to societal needs, and a desire to provide learners with reassurance that they actually were being well-prepared for a valuable role in society (McAshan (1979)). As such, competence-based education directly challenged the prevailing mid-20th century status quo of higher education that emphasized theory, knowledge-acquisition, and a didacticism that presumed learners themselves could translate theory into practice. This movement emerged within medical education but subsequently spread throughout other health and care professions such as psychology (Rubin et al (2007) and social work (Anema and McCoy (2010)), and had established itself in other professions such as engineering (Dainty et al (2005)) and teacher training (Houston (1973) as well.

As competence-based education became more commonplace in health and care professions' training programs, accreditation and regulatory bodies became more interested in this model. This further accelerated adoption of competence-based education within academic settings (Sullivan (2011)). In the context of public concerns about patient safety, disparities in access to care, and health and care professionals' struggles with increasingly ambiguous and complex practices, competence-based approaches that focus upon real-world performance and "doing" (rather than simple

acquisition of knowledge or theories) aligned well with regulators' needs vis-à-vis public protection, and their interests in demonstrating social responsibility and accountability in their roles (Hodges and Lingard (2013)).

As dialogue evolved between educators, regulators, and employers around the notion of competence, a key challenge emerged. Defining competencies as a series of real-world performance expectations and tasks, then using these as a foundation for curriculum purposes (as educators did), requires a certain level of accuracy, impartiality, and validation. Using these competencies (as regulators wished to do) as the foundation for entry-to-practice assessment, maintenance-of-competency evaluation, or fitness-to-practice decisions increased the stakes considerably. The level of definitional clarity, validity, and defensibility of what "competence" actually means and looks like – the "psychometric burden" - is higher within a regulatory context due to the high-stakes nature of decisions made by regulators that directly affect the general public (Bleakleyet al (2011)). The scrutiny faced by proponents of competence-based education increased significantly as the dialogue shifted to high-stakes evaluation within regulatory and accreditation processes. Of importance, this shift towards higher stakes lead to a new scrutiny around what activities should actually be measured and assessed. The need for defensibility and standardisation (due to fear of litigation) resulted in greater emphasis on the more objective, technical, and visible activities of professionals (for example, physical assessment skills) and a hesitancy to assess subjective or less visible activities (for example, conflict management skills, or empathy).

As interest in competence evolved from teaching/learning to assessment/evaluation, it became increasingly clear that no single or simple definition of competence could adequately capture the gestalt of professionals' work (Malone and Supri (2010)). As a result, the notion of "competency frameworks" emerged, as a tool for describing and defining the constellation of interdependent knowledge, skills, behaviours, values, and attitudes necessary for effective real-world performance (CIPD UK (2013)). Competence frameworks typically eschew specific tasks or activities, and instead conceptualise performance as an interlaced/overlapping series of *roles*, each of which is necessary but by itself insufficient for effective real-world performance. One of the most widely cited, frequently emulated, and best known models is CanMEDS (Frank (2005)). CanMEDS was one of the first national competency frameworks developed for medicine, but is now used in various countries such as Canada, Australia, and the Netherlands (Whitehead (2013)), and increasingly adapted for various health professions such as nursing, occupational therapy, pharmacy, and physical therapy (Verma et al (2006); Ringsted et al (2006)).



CanMEDS Competency Framework (2005)

In the CanMEDS framework, expertise as a health or care professional is conceptualized at the intersection of various other roles such as communicator and collaborator. Role-specific competencies are further described but do not form the actual substance of the framework, in an effort to move away from a reductionist task-centred view of competence. This holistic, integrative, role-centred view provides both conceptual clarity and enhanced face validity and has, as a result, become an increasingly dominant mode for presenting competency frameworks across other sectors (Frank (2005); Whitehead et al (2011))

In the UK, Individual health and care professional bodies (including physiotherapists (Chartered Society of Physiotherapy (2013)), occupational therapists (Winchcombe and Ballinger (2005), and mental health professionals (Roth et al (2012)), have produced bespoke competency frameworks.

Competency frameworks have now become the dominant vehicle by which educators, regulators, employers, and others communicate performance expectations with professionals, the public, and other stakeholders (Whitehead (2013); Simpson et al(2002)). In distilling complex and nuanced aspects of professional practice into visual forms or rubrics, they provide a common starting point for understanding and discussing expectations and requirements of health and care professionals in practice.

II. Competence: Questions and Critiques

Competence frameworks now underpin health and care professions training, education, and regulation in many countries (Simpson et al (2002)), leading to greater scrutiny of their development and implementation. There are of course positive and productive elements in these initiatives, around achieving consistency and transparency in different

contexts. However, some have argued that this approach is a “striving for mediocrity” (Brawer(2009)) that arises when we “focus our attention on minimum requirements only” as competency frameworks tend to do (Bleakley et al (2010)). When dealing with complex, ambiguous professional work, the whole is greater than the sum of the parts (Anderson and van der Gaag (2005)); slavish adherence to competence as a guiding principle of teaching and assessment risks atomising professional work, overemphasising routine skills, and inculcating a teaching-to-the-test mentality (Huddle and Heudebert(2007); Malone and Supri (2010)). Frank et al (2010) note that formulaic competency frameworks (“prescriptions”) may produce a form of reductionism and utilitarianism, with an emphasis on the lowest-common-denominator rather than an aspirational vision of professionals, to their best potential, serving the public good (“professionalism”).

Curiously absent from much of the competency literature is discussion of professionalism, reflective practice, and willingness to ‘go-the-extra-mile’ for patients and service users (Lingard(2009)). An emerging theme in the competency literature, this notion of ‘going the extra mile’ is well-understood by patients, service users and employers as an important component of health and care professionals’ work. Mann et al (2009) and McGivern and Fischer (2012) note that health and care professionals’ responses to competency frameworks may tend towards reactive compliance: in complex situations, instead of asking “what does the client/patient need me to do?” they may ask “what am I minimally required to do?”

This inherent tension between “prescription” and “professionalism” is perhaps best illustrated through the recent experience in the UK. The Francis Report (2013) made a series of 290 recommendations in response to the systemic failures at the Mid-Stafford Hospital, to legally enforce duties of openness, transparency, and candour in the NHS. These recommendations in turn prompted criticism from some academics around the UK: Fischer and Ferlie (2013) argue that “…rules to enforce openness, transparency and candour among NHS staff can create an impetus for change, but increasing micro-regulation of clinicians and managers is likely to undermine, rather than support high-quality patient care.” They further note: “…we are seeing a shift from micro-management to micro-regulation…what is needed instead is reanimation of the (health and care) professions…micro-regulation is not going to bring about culture change needed”.

This tension is also recognized in the Francis recommendations themselves: “1.75: The current structure of standards, laid down in regulation, interpreted by categorisation and development in guidance, and measured by the judgement of a regulator, is clearly an improvement on what has gone before, *but it requires improvement”.*

This finding was further reinforced through the *Review of Staff Engagement and Empowerment in the NHS Report* (2014). The review found evidence connecting high

levels of staff engagement (health and care professionals and staff who are strongly committed to their work and involved in day-to-day decision making) to better quality care and outcomes (including lower mortality rates, better patient experience, and reduced staff absence and turnover). Importantly, the *Report* also connected low levels of staff engagement with the type of failures demonstrated at the Mid Staffordshire NHS Foundation Trust. The *Report* called for all NHS organisations to prioritise *staff engagement* (not just competency frameworks) as a vehicle for improving delivery of safe, effective and competent care.

Historically, competence has been understood as a technical function of a profession, well-aligned to assessment through analytical checklists based on in-service performance (Witz (1992)). Reducing complex professional work to a checklist, then in a circular way, defining competencies simply *because* they are already codified on a checklist then tested on examinations, has traditionally been the mechanism by which competency frameworks and standards have evolved. Of significance is the notion that activities or behaviours that do not lend themselves to checklists or yes/no observations *do not consequently become defined as competencies* (Rogers et al (2005)). This has been illustrated recently in the UK by the *"Compassion in Practice"* campaign, a "…***new*** vision for nurses, midwives and care-staff in England" (Chief Nursing Officer of England (2012)). The very need to actually define "compassion in practice" and to produce guidance around "6Cs" (six areas of action, with accompanying implementation plans) points to limitations inherent in the way in which the discourse of **competence** has evolved. Words such as "care" and "compassion" do not necessarily lend themselves to measurement through checklists, and consequently are not easily incorporated into competency frameworks as traditionally developed.

It is difficult to argue against the notion of competence underpinning our understanding of safe and effective practice in health and care professions. Competence by itself may be a necessary but insufficient construct to help shape safe and effective practices. New ways of seeing and understanding competence are evolving to address this gap.

III. "Competence" as an evolving discourse

The term "discourse" has been used to describe the implicit meanings behind the words we use, and how these meanings shape our thoughts and ideas. Hodges (2006, 2009) has described five dominant discourses that have emerged over time in the health and care professions literature related to "competence":

1. **Knowledge discourse:** competence is a function of ability to recall facts and basic science knowledge. From this perspective, competence is assessed using multiple choice tests or other methods that emphasize memorization and rote reproduction of knowledge. As Miller (1990) has noted, this leads to book-smart professionals who lack interpersonal skills and the propensity to care is another issue
2. **Performance discourse:** competence is a function of the ability to actually behave or perform in a prescribed manner in a specified situation. From this perspective, competence is assessed using objective structured clinical examinations or other in-practice observations. We are less concerned with what people know and more interested in what they do; Norman et al (1996) have noted that this may lead to mindless reproduction of practices rather than deliberative and well-reasoned care. It may also lead to an inability to actually perform effectively in non-standardised or ambiguous situations.
3. **Psychometric discourse:** competence is a function of the ability to demonstrate attainment of pro-forma standards and expectations in a statistically defensible manner. From this perspective, competence is assessed through sampling with the objective of reducing variance and ensuring reliability, validity, generalizability, and defensibility of the assessment. Schuwirth and van der Vleuten (2006) have noted that this drive for standardisation negates the actual essence of human-focused care.
4. **Reflection discourse**: i competence is a function of mindfulness and self-assessment in practice. From this perspective, intelligent and well-intentioned individuals provided with an environment to safely reflect and self-improve will enhance their own practice. Nelson and Purkis (2004) have noted that an overemphasis on reflection may result in technical incompetence being overlooked.
5. **Production discourse:** as health systems have become more complex, filled with "cases to be managed" rather than "people to be cared for", the imperative of operational efficiency has grown. There is a strong emphasis on monitoring and a culture of surveillance in the name of outcome measurement. Questions regarding the objective of efficiency at the potential expense of empathic care are challenges to the production discourse.

Over the past 30 years, these dominant discourses have produced a variety of rules, checklists, algorithms and guidelines that are meant to hold health and care professionals accountable to a clear, objective, minimal standard of practice. To Whitehead (2013), answering the question of "accountability" by producing checklists and competence frameworks not only does not address the problem itself, it paradoxically distorts the essence of professionalism by only promoting *minimal* expectations. This finding has been echoed by Fischer and Ferlie (2013): "increasing micro-regulation across the NHS

is likely to aggravate tensions between externally focused regulation, oriented towards transparency, accountability and external scrutiny, and locally important values of delivering high-quality care. Paradoxically, the Francis recommendations extend regulation still further as a dominant idea, which is misguided."

No single existing competence discourse adequately captures the nuanced complexity of contemporary health and care professionals' work. Recognizing that each discourse brings with it a series of assumptions (and in addition blocks or crowds out other assumptions) means that no single discourse by itself truly captures the full essence of "competence".

IV. Competence: Emerging Discourses

The current system of health and care professionals' education and regulation has been built upon competing and evolving discourses of competence. For some, this represents the triumph of the 'Production' discourse: large, chaotic, complex health systems (catering to multiple needs and employing hundreds of thousands of individuals) need systems to ensure they actually function. Competence discourses that emphasise processes, that utilise checklists, and that rely upon centralised leadership and hierarchies, provide a comforting and recognisable structure that appears business-like and efficient (Mylopoulos(2013)).

A significant critique of existing competence discourses has emerged: if, after decades of work (and billions of pounds) spent developing competence frameworks, why do large system failures such as Mid Staffordshire still occur? Does this suggest a problem with "competence" itself as a safeguarding concept?? How could the Mid Staffordshire tragedy (among others) have occurred given the complex, interwoven web of local, national, and profession-specific competence frameworks that have existed for many years? Failure on this scale and at that level raises questions about the adequacy and sufficiency of existing frameworks for public protection: as Francis himself noted in *Patients First and Foremost: The initial government response to the report of the Mid Staffordshire NHS Foundation Trust Public Inquiry (2013), "*(t)he system as a whole failed in its most essential duty"- including the existing system of competence frameworks as a bulwark against harm.

In this spirit, several scholars have begun to point out the limits of existing competency discourses and have suggested complementary discourses of competence to broaden understanding of the term itself.

1. Competence as an inter-relational/collective construct

Care today is provided by teams. Patients with sore elbow are referred to medical imaging specialists for x-rays, have medical laboratory technologists take blood samples,

visit pharmacists for medications, work with physical and occupational therapists to restore function etc. The reality of inter-professional care delivery poses central challenges to the uni-professional and highly individualistic construct of competence as currently understood. As Lingard et al note (2007), teamwork is mostly learned through socialization (e.g. observation and experience). Lingard (2012) notes these realities produce important paradoxes, particularly since competence is generally seen as a *quality* or *capacity* an individual possesses or does not possess:

a. Competent individuals can come together and still form an incompetent team
b. Individuals who perform competently in one team may not in another team
c. One incompetent member functionally impairs some teams but not others

Lingard suggests these three paradoxes point to the limitation of current discourses of competence. Real world experience of health care today suggests that competence is more than simply a quality that individuals acquire and possess, free from context or location. High-profile examples of organisational and institutional failures suggest competent practitioners who find themselves in floundering systems are not as self-contained as the current discourse pre-supposes. Lingard (2012) suggests a collectivist discourse to competence must evolve, one premised on the following notions:

a. Competence is achieved through participation in authentic, real-world situations, not contrived academic settings
b. It is distributed across a broad network of persons and artifacts
c. It is a constantly evolving set of multiple, interconnected behaviours enacted over time

Lingard's work examining the nuanced interpersonal interactions amongst operating theatre staff and surgeons points to the notion of the whole being greater than the sum of the parts. Building on the work of Salas et al (2007) in "team cognition", this collectivist view of competence emerges at a time when health is increasingly recognized as a network, not a dyadic relationship between a single professional and a patient. Drawing upon the experience of other industries (notably aviation), the idea of collective competency (which includes not only practitioners but the organisational context within which they practice) requires alternative methods of understanding and assessment.

Critics of this approach note that logistical difficulty of developing and implementing team-competency assessment models. However, as Lurie et al (2009) have noted, this criticism presumes that current competence assessment systems are indeed robust and actually do what they purport to do well – when in fact (with the exception of the medical knowledge domain) few competence assessment tools actually are actually simultaneously reliable, valid, generalizable, and feasible.

Broadening the discourse of competence to recognize the centrality of collaboration, interdependence and teamwork in today's health system is necessary. Many system problems and errors characterized as "communication failures" are not the result of substandard or incompetent communication skills per se: instead they reflect failures to recognise that teams are the true unit of care delivery in most systems today and further work is necessary to articulate and construct discourses that recognise this reality. As Berwick observed, "(h)ealth and care professionals…want to offer safe care: in spite of that, patients get injured because of defects in the care system. Blame and accusations are not the answers. Teamwork and improvement are the answers. Commercial air travel didn't get safer by exhorting pilots to please not crash. It got safer by *designing planes and air travel systems* that support everyone to succeed in a very, very complex environment. We can do that in healthcare too." (Berwick(2011)).

2. Competence as an emotional construct

McNaughton and LeBlanc (2012) note that, "…within the health professions, emotion sits uneasily at the intersection between objective scientific fact and subjective humanistic value". From early on health professionals are taught and encouraged to separate their professional and personal selves, the implication being that human emotions cloud judgement and professional effectiveness. Increasingly, there is recognition that this traditional approach may be counterproductive to the objective of safe and effective health care delivery.

Williams (2001) has noted the long-held ambivalence towards emotion within the health professions education literature: he notes that emotion is traditionally viewed as "the opposite" of reason, and consequently seen as uncontrollable and something that needs to be transcended. Increasingly, psychologists have grown to understand that emotion and reason are not isolated processes but interconnected dualities: without emotion, there cannot be reason and vice-versa. Kensinger (2009) has noted that emotion plays a critical role in memory function: the emotional context fundamentally shapes the way in which memory is formed and recalled. Raghunathan and Pham (1999) have that emotion has a formidable influence in decision making: Phelps (2005) and Damasio (1994) note that emotion can influence a wide range of cognitive functions, including perception, attention, memory, and decision making.

Competence as an emotional construct has been popularized through the work of Goleman (see *Emotional Intelligence: Why it can matter more than IQ* (1995)). His model combines skills, abilities and personality traits and formulates a command function of "emotional management". The literature applying emotional intelligence (EI) to health

professions education is broad and extensive., EI principles are now utilised in admissions interviewing (Libbrecht et al (2014); Humphrey-Murto et al (2014)), clinical skills assessment (Stratton et al (2005); Cherry et al (2013); Romanelli et al (2006))and clinical teaching (Allen et al (2012)) in health and care professions such as nursing, physiotherapy, speech and language therapy, pharmacy, medicine, midwifery, and psychology.

A consensus emerging from this literature is emerging: empathy is the core of health and care professional practice, significantly challenging historical assumptions of the centrality of technical or cognitive skills (McNaughton and Leblanc (2012). From this perspective, discourses of competence that focus on the technical or cognitive domains actually miss the mark: superior technical and cognitive skills with limited empathy and emotional intelligence give rise to poor care (McNaughton and Leblanc (2012)). This insight reinforces the work of McGivern and Fischer (2012) who note that "…rules-based regulation tends to erode values-based self-regulation, producing professional defensiveness and contradictions which undermine, rather than support, good patient care".

Human factors in patient safety are currently of significant research interest. There is a critical need to understand the distinction between "knowing" and actually "wanting to do" the right thing in a complex environment, particularly when doing the right thing requires the health or care professional to go beyond what might be normally expected or overcome a system barrier (Feldman (2001)).

This link between competence and emotional intelligence has been underdeveloped, in part due to the psychometric emphasis of much of the contemporary competence literature. EI resists reduction in the form of a checklist that has historically been the approach taken in competency-based systems (Carrothers et al (2000)). Framing competence as a form of emotional intelligence or "emotional regulation" (Phelps, 2006) is challenging due to the difficulties associated in measuring it using standard statistical tests such as reliability, validity, or generalisability.

How can recent insights into emotional intelligence be integrated into a broadened discourse of competence? At a psychometric level, increased reliance on global/holistic forms of assessment may be one alternative. Conceptualizing competence as a gestalt, rather than as a checklist aligns with the notion that emotion and reason are as indivisible as a dancer and a dance: change one and of necessity the other changes. Current attempts to translate competence discourses into assessment tools suffer from an overly-rationalist bias, the belief being that measurement is quantitative, behaviour is observable, and performance can be subdivided into constituent components. Competence discourses that emphasise emotional intelligence at the core would resist these biases and instead examine ways in which the link between emotion and reason,

clinical decision making and empathy, and professionalism and ethics are more explicitly acknowledged.

3. Competence as a psychological engagement construct

The work of Csikszentmihalyi (1990) and Gardner et al (2001) with respect to the psychology of positive experience provides a unique insight into the connection between motivation and performance. This model suggests that human beings are at their best when environmental challenges and opportunities align with personal skills and interests. Csikszentmihalyi (1990) coined the term "flow" to describe a state of absorption in an activity, "…your whole being is involved and you're using your skills to the utmost".

Csikzentmihalyi's description of flow echoes the work of Schon (1983) who coined the term "reflective practitioner" to describe the unique feature of professional work: cognitive ambiguity. If professional practice were straightforward and formulaic, it would easily be performed by machines. What makes professional work unique – and valuable to society – is that decisions must be made when information is imperfect and answers are not clear. At these times, professionals must demonstrate a psychological flexibility that allows them to recognize there may not actually be a right answer, only so-called least worst alternatives.

The work of Schon and Csikzentmihalyi raises important issues regarding the role of *motivation* in human behaviour. Simply because individuals *can* do something does not necessarily mean that (in a given circumstance) they *will* do it, especially when barriers (including inertia, complexity, organisational culture, or time constraints) exist. The psychological energy necessary to transcend routine, bureaucracy, standard operating procedures, or any other form of resistance, requires "flow" (Csikzentmihalyi (1990)).

There has been increasing interest in the notion that competency frameworks may actually be antagonistic towards "flow" and the psychological/motivational needs of health and care professionals. As Bereiter and Scardamalia (1993) note in *Surpassing Ourselves*, rules-based systems (including checklists and competency frameworks) generally do not create the type of environment, or produce the psychological interest and energy, required by most people to use their skills and knowledge to their fullest abilities.

The work of McGivern and Fischer (2012) and Fischer and Ferlie (2013) have illustrated how rules-based regulation of health and care professionals erodes values-based self-regulation. They have raised concerns that any attempt to regulate or prescribe the work of professionals will compromise motivation and engagement, fundamentally changing the nature of professional work.

The need to create a psychologically *engaged* workforce has been identified by experts in the UK: proposals for staff-led health and care services with devolved decision-making have been described as a vehicle that will improve patient care. West et al (2014) have argued that development of engaged, collective leadership for health care is critical: individuals must assume responsibility for the success of their organization, not just their own jobs. Campling (2013) presents the notion of *intelligent kindness*: behaviours not found in any job description, specification, or competency framework, but ones that actually "…capture the essence of kind practice". This kind practice, she argues, builds a virtuous circle producing better outcomes which "…could be useful in our quest following the Francis Enquiry to transform the culture of healthcare".

This emphasis on cultural transformation is echoed by West and Dawson (2012) who note that "(i)t has long been recognised that engagement of employees with their work and organisation is a factor in their job performance." In their report *Employee Engagement and NHS Performance,* they conclude that staff engagement "…is linked to a variety of individual and organisational outcome measures including staff absenteeism and turnover, patient satisfaction and mortality, and safety measures, including infection rates".

Traditional competence frameworks have focused on development of individual's capabilities, which does not necessarily translate into organisational advancement. As described in the *Review of Staff Engagement and Empowerment in the NHS* (2014), such shifts in culture and organisational administration produce the type of psychological engagement necessary to unleash health and care providers' potential. In their White Paper *Delivering a Collective Leadership Strategy for Health Care (2014),* Eckert et al highlight the connection between devolved decision making, staff engagement, morale, and ultimately improved health care outcomes. Literature on the connection between staff engagement and outcomes in the health and care professions is emerging. Prins et al (2010) in a study in the Netherlands noted that physicians who scored higher on professional engagement were statistically significantly less likely to make medical, diagnostic, or prescribing errors. A large study involving over 8000 hospital nurses by Laschinger and Leiter (2006) noted that those who ranked hire in terms of professional and organisational engagement had better patient safety outcomes. Boorman (2009) in the *NHS Staff Health and Well-Being Report* noted that staff absenteeism cost the system over 1.75 billion (equating to the loss of 45 000 full time staff positions) annually, and that absenteeism itself is linked strongly with engagement scores.

Berwick (2011) has emphasized "(t)he workforce is not the problem…they want to offer safe care. Good people get trapped into bad systems. (Safety) is not about enforcement; it's about involvement." As noted by Eckert et al (2014), disengaged professionals are disinclined from "going the extra mile" and instead are more likely to do only that which is minimally required.

Can one be simultaneously competent and disengaged? Austin et al (2003) have noted that pharmacists in Ontario, Canada at highest risk of not meeting competence standards i) graduated from educational programs more than 25 years ago; ii) work in sole practitioner arrangements; and iii) received their professional education/training outside North America, and argues that these risk factors are general symptoms of isolation and professional disconnection. Grace et al (2014) identified predictors of physician performance on competence assessment and noted similar personal characteristics and practice context features, suggesting professional isolation is a risk factor for competence drift. Wenghofer et al (2014) note that attendance at and participation in continuing professional development activities may serve an inoculating function for those who are at risk of competence drift: engagement with one's peers and involvement with one's professional community provides peer-benchmarking opportunities that may relate to competency. This literature suggests a connection between disengagement and competence drift that further research.

As noted by West et al in *NHS Staff Management and Service Quality (2012)* "...the more positive the experiences of staff within an NHS trust, the better the outcomes for that trust…the more engaged staff members are, the better the outcomes for patients and the organisation generally". The language of engagement has only recently been included in discussions related to competence, and has not yet been incorporated within most competency frameworks. As this discourse matures and evolves, this perspective will continue to grow in importance.

IV: Competence as a cultural construct

Competence problems are identified in only a very small number of professionals within any cohort (HCPC Annual Report 2012, 2013). In these cases – including the system failures at Mid Staffordshire – organisational culture has been identified as an important potential cause (Francis, 2012). No matter how competent each individual practitioner may be in the practice of his/her profession, s/he may simply be unable to demonstrate competence due to dysfunctional or suboptimal leadership, line management, supervision, or organisational culture.

As noted by Dixon-Woods et al (2013), within the English NHS there is "…an almost universal desire to provide the best quality care…", but "…consistent achievement of high quality care was challenged by unclear goals, overlapping priorities that distracted attention and a compliance-oriented bureaucratised management….(g)ood staff support and management were also highly variable, though they were fundamental to culture and were directly related to patient experience, safety, and quality of care." This raises the question of whether the current model of assuring competence of each individual health and care professional's competence is adequate and sufficient, or whether a new construct – such as organisational culture competence – should be developed. A

consistent theme - from Francis (2012) to Berwick (2013) to West (2014)-has been the need for culture change in the NHS to prevent future tragedies.

While calls for strategic culture change within the NHS are ubiquitous, specific tactics continue to be elusive. For example, the National Advisory Group on the Safety of Patients in England, in *A Promise To Learn – A Commitment to Act* (2013) noted that "(w)hen responsibility is diffused, it is not clearly owned; with too many in charge, no one is". Simultaneously they call for more involvement to "engage, empower, and hear patients" and "foster whole-heartedly the growth and development of all staff". The authors of *Patient Centred Leadership: Rediscovering our Purpose (2014)* state: "(i)t is time for the NHS to rediscover its purpose" and propose a model of shared leadership and bottom-up collaborative decision making focused on patients, which may produce conditions of diffused responsibility. Storey and Holti (2013) in *Towards a New Model of Leadership for the NHS* describe elements such as motivating teams and individuals, creating a positive emotional tone/climate, and encouraging staff involvement and engagement as the most effective evidence-informed tools for organisational cultural change.

Further research is ongoing to try to better understand what specific tactics to produce cultural change within organisations can actually support meaningful improvement.

V: Conclusions:

Traditional constructs of competence have emphasised an individual health or care professional's technical and cognitive skill set. As described in this synthesis, this may be a necessary but insufficient way of thinking about competence.

Emerging notions of teamwork, emotional intelligence, and engagement represent important steps in broadening the discourse of competence. The idea that organisational culture influences individual professional's abilities to demonstrate competence raises important challenges and questions. The traditional checklist-approach to defining and measuring knowledge and skills, while necessary, may not be sufficient as the complexity of health care and service delivery increases. Broadening our understanding of competency and recognizing the limitations of traditional approaches are important first steps in ensuring the best, most effective health and care possible.

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