



CLASSIFICATION DESCRIPTORS – Q AND A

What is the thinking and meaning behind the new and changed terminology in the proposed descriptors?

The revised terminology reflects the outcomes and recommendations of the Independent Review, which identified that existing classification language was outdated and no longer adequately described contemporary professional practice, career pathways or expectations. The changes are intended to modernise the descriptors, improve clarity and consistency across levels, and better articulate progression, scope of practice and professional contribution. The revised terminology also responds to feedback provided through the review process, including matters previously raised and supported by the HSU, and is designed to align the descriptors with current workforce realities and future career pathway reforms.

Below are the different references to “level” in the proposed descriptors. How are they defined?

The attached documents — Summary: Mapping of Descriptor Across P Levels and Matrix: Descriptors Across P Levels — have been provided to assist in clarifying how different references to “level” are used within the proposed classification descriptors and how this terminology is intended to operate in practice. The terminology used throughout the descriptors is intended to function as qualitative indicators of progression in work value, scope, responsibility, autonomy and influence, rather than as fixed or prescriptive definitions. The terms are applied in context to describe the nature and scale of work and to support differentiation between roles based on overall work value rather than any single attribute.

Definitions

Unless otherwise specified, the terminology used in the descriptors is intended to be applied according to its ordinary dictionary meaning, consistent with established work value and classification practice. Where greater precision or clarity is required to support consistent interpretation and application, the Department acknowledges and supports HSUWA feedback and will consider the inclusion of additional definitions within the descriptors where appropriate. In relation to the term “domain,” as discussed at the meeting, this is intended to refer to the primary field or fields within which the role exercises influence or expertise. This may include one or more of the following: leadership, research, clinical practice, or education.

Does this provide opportunities for those on the G-scale to move back on to the P-scale?

Yes. The revised classification descriptors are intended to support appropriate transition opportunities between classification streams, including enabling movement from the G-scale back to the P-scale where this is consistent with the nature of the role. An important consideration as to whether it’s appropriate is whether the formal qualification and/or professional registration essential for the incumbent to do the role. A field of applicants for a position may not be inappropriately restricted by the inclusion of unnecessary requirements for formal qualifications and / or professional registration or other unnecessary requirements in the essential selection criteria. The citation of the registration requirement is only appropriate where the duties to be undertaken fall



within the regulatory scope of the statutory registration authority. Where other legislation or an industrial award or instrument requires formal qualifications for appointment to a position, these requirements are to be included as essential selection criteria. Any incumbent would need to meet the registration requirements as stated in the agreed document.

Transition arrangements remain unclear from the document – namely, the draft does not address how existing incumbents will be mapped across from the old system. Without a transition framework, there is significant risk of inconsistent application across HSPs. How is consistency across HSPs going to be effectively managed?

The draft classification descriptors are being consulted on as part of Priority 2 of the Health Professional Career Pathways Plan. The development of detailed transition arrangements, including how existing incumbents may be assessed or mapped against revised descriptors, will form part of the broader implementation phase. Implementation of Priority 2, including transition considerations, will be discussed with the State Secretary of the HSUWA as part of ongoing consultation. Consistency across Health Service Providers will be supported through system-level oversight, with the System-wide Classifications team playing a central role in promoting coordination and consistency across HSPs. This includes providing advice, quality assurance and system-level guidance on classification matters as revised arrangements are implemented. In addition, the Department, in its system manager role, provides formal oversight through the System-wide Classification Review Committee, which supports consistent interpretation and application of classification standards across the WA health system.

Are the HSPs going to be appropriately funded to enable listed changes to be made?

Funding has been provided to Health Service Providers to support implementation of the Career Pathways Plan. However, this funding is finite and HSPs will be required to take a holistic and strategic approach to its utilisation, including considerations of equity across professions, demonstrated workforce need, and the efficient use of available resources. The Career Pathways Plan did not commit to the creation of new or additional positions, nor did it provide for automatic reclassification beyond the specific measures outlined within the Plan itself. Any new initiatives, position establishment or changes beyond those explicitly contemplated in the Plan will need to be progressed and assessed by HSPs through existing governance, approval and funding frameworks.

Why is size of department being introduced into the position descriptors when it was not previously? And most importantly how is this equitable?

Department size often correlates with the scope and complexity of a role. Managing a larger team or overseeing a bigger department typically involves greater responsibility, decision making and risk. Equity does not mean treating every role identically, but rather recognising the unique contributions and challenges associated with different positions. By acknowledging the scale of responsibility, the classification descriptors ensure those managing larger or more complex departments are appropriately recognised and rewarded.

There appears to be some compression at P6. If P6 is not tightly scoped, it may absorb roles that should be P7 or P8, effectively recreating the old Level 11/12 compression problem at a different point in the scale.



This is not the intention of the revised classification structure. The descriptors have been deliberately drafted to more clearly articulate the increasing work value, scope, complexity and impact associated with progression across levels, including between P6, P7 and P8.

The revised descriptors are designed to support clearer differentiation between levels and to mitigate the risk of compression by ensuring that roles are assessed against the full range of work value factors, rather than defaulting to a single level based on title or tenure. This approach is intended to avoid replication of historical compression issues and to support consistent and appropriate classification outcomes across the structure.

The draft scope statements for P7–P9 use terms such as 'major', 'large and complex', and 'health service group level' without quantitative thresholds (e.g. FTE, budget, number of sites). Without clearer definition, these terms remain contestable in reclassification disputes. How are these terms operationalised?

The revised draft has removed reference to the term “major” to reduce ambiguity. More broadly, the descriptors are intended to be applied using a work value-based assessment rather than prescriptive quantitative thresholds. Terms such as “large and complex” or “health service group level” are used to describe the nature, scale and impact of work in a qualitative sense, taking into account factors such as scope of responsibility, organisational influence, decision-making authority, risk, autonomy and system impact, rather than relying on fixed numerical measures alone.

The inclusion of rigid thresholds (for example, FTE, budget size or number of sites) can unintentionally constrain appropriate classification outcomes and may artificially limit roles that are substantively comparable in work value but sit marginally below a defined numerical threshold. The descriptors are therefore designed to be applied holistically, with roles assessed against the full range of work value considerations to determine the appropriate classification level, rather than being determined solely by quantitative indicators. This approach is intended to support fair, consistent and defensible classification outcomes across diverse organisational contexts.

The distinction between 'health service group level' (P7), 'HSP level' (P8), and 'system-wide' (P9) requires clear operational definitions. Departments operating across multiple sites within a single HSP may be ambiguously positioned between P7 and P8.

Various distinctions are intended to reflect increasing scale of influence, accountability and organisational impact, rather than being determined by a single factor such as the number of sites operated. While the operation of services across multiple sites may be a relevant consideration, classification outcomes are determined holistically, based on the overall scope, level of responsibility, decision-making authority, organisational impact and accountability of the role. This approach is intended to provide flexibility while supporting consistent and appropriate differentiation between levels.

Would the P7-P9 descriptors benefit from drawing somewhat from the Public Sector Capability Profiles – specifically Level 7+ in that framework?

This approach is not favoured. While the Public Sector Capability Profiles provide a useful high-level framework for general public sector roles, they are not designed to be applied to clinically-based or



profession-specific positions. The P7–P9 classification descriptors are intended to reflect health-specific work value considerations, including professional leadership, clinical governance, service delivery accountability and system or organisational impact within a health context. The Public Sector Capability Profiles do not sufficiently capture these clinical and professional dimensions. The revised descriptors have therefore been deliberately developed to support accurate and consistent classification of senior health professional roles, rather than drawing on capability frameworks that are not well aligned to clinical classification and work value assessment in the WA health system.

**Is anyone currently in a P9 position and how do they compare to positions on the g-scale?
Ie. Allied Health Director**

There is currently one position classified at P9, being the Principal Medical Scientist – Anatomical Pathology. This role operates across PathWest and covers one of the largest and most complex areas of the organisation. The position combines significant management accountability with highly specialised scientific leadership and enterprise-level professional oversight. The draft P9 descriptor has been made less restrictive than the current wording to better reflect contemporary senior professional and organisational leadership roles and to afford increased opportunity where positions demonstrate the requisite work value. However, until the descriptors are finalised, agreed and applied through formal classification assessment, it is not possible to determine whether additional positions will be appropriately classified at this level (this includes looking at Allied Health Professionals in the G-scale).

It is not clear from the draft document how the classifications map against the grade levels for Clinical Psychology and Neuropsychology positions and the classifications in the draft may change how our positions are classified. For example, for P3 the term ‘independent’ (current classification) appears to have been superseded by the term ‘advanced’ in the draft. Our Grade 2 crosses across P3.1-4.2 and this change in wording would impact that grade. How are the Grade level positions for our profession being taken into account in this process?

The draft replacement classification descriptors do not apply to Clinical Psychology and Neuropsychology positions. These professions operate under grade-based classification arrangements, with Grade 1 and Grade 2 positions explicitly established within the HSU Agreement. Accordingly, changes in draft terminology within the P-scale descriptors, such as the use of the term “advanced” at P3, are not intended to alter or map across to existing Clinical Psychology or Neuropsychology grade structures.

Separately, the Department is progressing work to engage an external consultant to undertake a dedicated review of Clinical Psychology classifications. This work will be considered independently of the current draft P-scale descriptor consultation and will be subject to appropriate consultation processes.

WITHOUT PREJUDICE

MAPPING OF DESCRIPTORS ACROSS P LEVELS

The table below maps the selected descriptor terms across the P levels in the Consultation Draft - Classification Descriptors and provides an interpretation of how each term operates within the descriptor framework.

Term	P level(s) in which term appears	Context of use in descriptors	Comment
Entry level	P1	Used in the level title ("Base / Entry Level") and in the scope statement describing positions from commencement following tertiary graduation.	Functions as a career entry-point descriptor rather than a capability gradient. It identifies the commencement level for newly qualified practitioners.
Foundational level	P1	Used in relation to "profession-specific foundational level of knowledge and skills."	Serves as the principal knowledge descriptor for the base level, indicating developing capability, routine practice, and supervised professional growth.
Professional level	P2	Used in relation to "a thorough professional level of knowledge."	This has been omitted from the revised draft – refer to document 4 Classification Descriptors 202 (Tracked Changes).
Independent level	P2	Used in the accountability section to describe service delivery "at an independent level." Professional practice with discretion, but still can access guidance from higher level professionals/management.	Denotes the first clear step into routine independent practice, while still contemplating access to higher level guidance for decisions related to matters such as professional practice, service delivery, supervision of staff or students.
High level	P3, P4, P6, P9	Applied in different contexts, including professional knowledge and expertise (P3 & P4), management expertise (P6), and communication (P9).	Operates as a broad intensifier rather than a precise classificatory term.
Higher level	P1, P2, P3, P4, P5	Used in a range of ways, including as a relational reference to higher level professionals or management, signifies degree of clinical practice or profession-specific practice.	Functions primarily as a relational or comparative term. It does not itself define a specific classification point, but instead refers to progression, escalation, or a more senior point in the hierarchy or degree of clinical/professional practice.
Independent and expert level	P4	Used in the scope of the P level to describe specialised clinical/profession specific services, including in a designated Advanced Scope role.	Compound descriptor to clearly differentiate P4 from earlier independent practice levels.

Autonomous level	P4, P6, P7	Used in relation to service coordination, management functions, and accountability for outcomes.	Indicates a stronger and broader degree of self-direction. Its use is associated with service leadership, management, and accountability across larger operational scopes.
Substantial level	P5	Used in relation to "a substantial level of professional knowledge and expertise."	Operates as the mid-senior expertise descriptor at P5, conveying depth, maturity in acquired professional knowledge and expertise.
Comprehensive level	P6	Used in relation to "a comprehensive level of professional knowledge and expertise in relevant practice area."	Conveys that integrated depth and command of knowledge and expertise for the relevant practice area.
Extensive level	P6	Used in relation to "an extensive level of professional knowledge across multidisciplinary practice areas."	Contrasted with 'comprehensive level' which denotes breadth and scale of knowledge and expertise across multiple areas.
Expert level	P7	Appears at P7, used in relation to "expert level advice and recommendations to executive management."	Used to describe the quality and authority of advice provided to executive management.
Executive level	P8	Used in the leadership and influence section to describe "authoritative advice that informs executive level decisions."	Only occurrence of this term, which positions the P8 as shaping decisions at the executive tier, even if the role itself is not necessarily framed as "executive."
Very high level	P9	Used in the accountability section to describe "a very high level of independence."	Appears as the strongest explicit descriptor of independence / autonomy / accountability and represents the ceiling point for this factor.

SUMMARY MATRIX: DESCRIPTOR MAPPED ACROSS P-LEVEL

	P1	P2	P3	P4	P5	P6	P7	P8	P9
Entry Level	✓	—	—	—	—	—	—	—	—
Foundational Level	✓	—	—	—	—	—	—	—	—
Independent Level	—	✓	—	—	—	—	—	—	—
Independent and expert level	—	—	—	✓	—	—	—	—	—
High Level	—	—	✓	✓	—	✓	—	—	✓
Higher level	✓	✓	✓	✓	✓	—	—	—	—
Autonomous Level	—	—	—	✓	—	✓	✓	—	—
Substantial Level	—	—	—	—	✓	—	—	—	—
Comprehensive Level	—	—	—	—	—	✓	—	—	—
Extensive Level	—	—	—	—	—	✓	—	—	—
Expert Level	—	—	—	✓	—	—	—	✓	—
Executive Level	—	—	—	—	—	—	—	✓	—
Very high level	—	—	—	—	—	—	—	—	✓

*Professional Level – has been omitted due to deletion from the current draft Classification Descriptors document – See attachment 4.