

Project Report

Rural and Remote Generalist: Allied Health Project

December 2013



The Greater Northern Australia Regional Training Network is a cross-jurisdictional collaboration between the Western Australia, Queensland and Northern Territory Departments of Health, made possible by funding provided by Health Workforce Australia through the Integrated Regional Clinical Training Networks initiative.

This report was commissioned by the GNARTN Council. The findings, outcomes and recommendations of this report, do not constitute agreement or endorsement from the individual partners or governments who are party to the GNARTN Council and/or its processes.

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Date 04/03/14

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Executive Summary

The Greater Northern Australia Regional Training Network governing Council approved the Rural and Remote Generalist: Allied Health Project, as part of the 2013 GNARTN workplan, in April 2013.

The aim of the project was to support the development of clinical training models for allied health professions that meet the needs of northern Australian health services, and rural and remote communities in particular, by mapping and describing the clinical tasks that are or could potentially be safely skill shared within multi-disciplinary teams.

The rationale for the project was that there is currently no published comprehensive description at the task-level of the clinical requirements of rural or remote practitioners from allied health professions. This has been a significant limitation to the development of rural and remote-specific clinical training programs and resources, and generalist models of care in allied health teams.

The project was conducted over 30 weeks (6/5/13 – 30/11/13) and was managed by a 0.8FTE project officer seconded from the Allied Health Professions' Office of Queensland, Department of Health.

Project Strategy & Method

The project used a “bottom-up” approach to scope the clinical practice requirements of rural and remote generalists in six allied health professions; occupational therapy, physiotherapy, dietetics & nutrition, speech pathology, social work and podiatry. Five teams in northern Australia were funded to undertake a comprehensive task identification and analysis process using the Calderdale Framework. The teams partnering with GNARTN in this work were Apunipima Cape York Health Council, Katherine Region Aged & Disability Service, Katherine Hospital Sub-acute and Rehabilitation Allied Health Team, Gascoyne Allied Health Team, and Top End Remote Disability Team. The data from the five sites was aggregated and analysed to produce a single task list, which was reviewed by rural and remote allied health professionals from four additional services. The five project sites then undertook a risk-based assessment of the potential for skill sharing or delegation of clinical tasks. Their decisions were integrated into the task list. The project findings indicate the clinical tasks judged by clinical teams to be most appropriate, feasible and useful to be skill shared between rural and remote allied health professionals.

Findings & Deliverables

The primary deliverable for the project was a comprehensive task list describing the current clinical tasks undertaken by rural and remote allied health professionals in the project sites, and of those, which are most appropriate for inclusion in a skill sharing model of care. This is provided in Attachments 1 to 3 of this report.

Project summary findings were:

1. Delivery of clinical tasks and functions by more than one profession is relatively common in current rural and remote allied health practice (45% of clinical tasks are delivered, at least in part, by more than one profession).

2. One hundred and twenty-seven (127) of the 337 tasks identified in the aggregated task list were assessed to be appropriate for skill sharing between two or more allied health professions, assuming training, clinical governance and all other requisite supporting processes were implemented. Skill sharing was most commonly proposed to be modest expansion of existing scope of task delivery / skills rather than larger-scale re-orientation of practitioners' skills sets and scope of practice in the service.
3. The project findings show clusters of related tasks that are identified as appropriate for skill sharing in rural and remote allied health teams. The clusters are logical groupings for translation into clinical training programs for rural and remote allied health professionals. Thirteen clusters are proposed; Activities of daily living (ADL) and function; Mobility and transfers; Prevention of foot morbidity in high risk groups; Children's development; Cognition & perception; Communication; Psycho-social; Fatigue, sleep and energy conservation; Pressure care, skin and wounds; Diet and nutrition; Neuro-musculoskeletal and pain; Cardiovascular fitness & exercise tolerance; and Continence assessment and basic intervention.
4. The generalisability of the task list to other services and settings was tested in a small review activity. The review activity found that the task list represented the clinical tasks undertaken by physiotherapists, dietitian/nutritionists and podiatrists relatively well. Greater variation in clinical tasks was noted for social work. No occupational therapists participated in the review.
5. Greater potential for use of the allied health assistant workforce is evident in the project findings. Less than a third of potentially delegatable tasks are currently delegated by project site teams. Although not a primary focus of the project, information on delegation was an opportunistic product of the methodology employed.

Recommendations

Recommendations are provided in summary below and in more detail in the [Recommendations](#) section of this report.

Recommendation 1

The GNARTN Council endorse this project report and accept the project deliverables as consistent with the approved project plan.

Recommendation 2

A validation process should be undertaken of the project products, particularly the clusters of clinical tasks identified as appropriate for skill sharing between two or more of the allied health professions examined in the project (i.e. occupational therapy, physiotherapy, speech pathology, nutrition and dietetics, social work and podiatry).

Recommendation 3

Following validation, the project findings are promoted to training providers in the education and/or health sectors to support the development of rural and remote-focused clinical training that is broadly accessible by allied health practitioners across jurisdictions and health care providers.

Recommendation 4

Resources to support organisations to safely and appropriately implement governance and other supporting processes for skill sharing are developed and made broadly available.

Recommendation 5

Strategies to facilitate implementation of expanded breadth of practice generalist workforce models are developed in partnership with rural and remote allied health services and professional bodies.

Recommendation 6

RRG:AH project sites are supported by their organisations to maximize the benefits from the three year Calderdale Framework license and training of the site coordinator as a Facilitator.

Recommendation 7

Project findings are promoted to jurisdictions and health workforce agencies working on rural and remote allied health assistant models of care, and skill sharing models between allied health and non-allied health professions.

Recommendation 8

Strong interagency collaboration at a national level is utilised to negotiate roles and responsibilities for the range of implementation activities outlined in previous recommendations. Specifically, coordinating agency/ies and structures for collaboration should be identified and agreed by relevant stakeholders in the health and education sectors.

Acknowledgements

Project Sites

Katherine Hospital, Northern Territory Government

Project Site Coordinator / Facilitator	Rebecca Farmer
Project Site Sponsor	Allan Kingsley
Team	Sub-acute and Rehabilitation Allied Health Team

Katherine Regional Aged & Disability Services, Northern Territory Government

Project Site Coordinator / Facilitator	Jessica Stott
Project Site Sponsors	Kim Clayworth, Elaine Jaeschke
Team	Katherine Regional Aged & Disability Service

Top End Remote Disability Service, Northern Territory Government

Project Site Coordinator / Facilitator	Rebecca Jarrott
Project Site Sponsors	Kim Clayworth, Jasmin Baksh
Team	Top End Remote Disability Service

Apunipima Cape York Health Council

Project Site Coordinator / Facilitator	Judith Aliakbari
Project Site Sponsors	Aletia Twist, Paul Stephenson
Team	Healthy Lifestyle Team

Western Australia Country Health Service, Mid-West Population Health

Project Site Coordinator / Facilitator	Nigel Holmes
Project Site Sponsor	David Richardson
Team	Gascoyne Allied Health Team

Review Sites

Western Australia Country Health Service – Derby Allied Health Team

Central Queensland Medicare Local – Rural Allied Health Team

Central & North West Queensland Medicare Local – Allied Health Team

Townsville Mackay Medicare Local – Rural Dietitian

Steering Committee

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Calderdale Framework Practitioner

Mackay Hospital and Health Service – Associate Professor Alison Pighills

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Background & Overview

The Greater Northern Australia Regional Training Network (GNARTN) was established in late 2012 through a partnership between the Northern Territory, Western Australia and Queensland health departments, with support being provided by Health Workforce Australia (HWA) through its Integrated Regional Clinical Training Network initiative. The primary role of the GNARTN is to drive collaboration, advocacy and support to increase clinical education and training, clinical placements and workforce initiatives across the northern Australia geographical area, particularly in relation to rural and remote areas. The 2013 GNARTN Workplan, approved by the GNARTN Council in April 2013, included priority work on rural and remote generalist workforce models for the allied health professions.

Key concepts: “rural and remote generalist” and allied health professions

The term “generalist” and its variants (e.g. “specialist generalist”^(1, 2), “expert generalist”⁽³⁾) in the context of rural and remote practice have been used in relation to one or more allied health professions in the published literature⁽¹⁻¹⁰⁾, by government departments^(11, 12) and by workforce agencies and professional bodies^(13, 14). The proposition that health practitioners, irrespective of profession, need to be “generalists” in rural and remote areas is widely promoted⁽¹⁵⁻²¹⁾. Beyond this common assertion that generalism is the most appropriate workforce model for rural and remote service, there is limited detail about what this comprises.

The allied health literature identifies the following uses of the term:

1. “Generalist” as components of the model of care in a rural or remote setting.

Rural and remote generalist practice is described as the practitioner’s response to the need to provide services across the lifespan^(3, 4, 8), for a wide range of health needs^(3, 4, 8) or across the continuum of care⁽²²⁾. The term is also used in relation to a service / practitioner’s “diverse” caseload⁽²³⁾, “generalist” caseload^(24, 25) or wider scope⁽⁷⁾. Generalist practice is also described as relating to the workforce model in rural and remote areas, commonly with only one practitioner per profession in the location. The practitioner consequently does not have access to the same level of profession-specific advice and supervision available in larger centres, particularly clinical advice^(3, 7, 8, 24). Diversity of rural and remote caseload and autonomy in decision-making as components of generalist practice, have been identified as recruitment incentives for allied health professionals, particularly in the early career stage^(2, 3, 5, 9, 22, 24).

2. “Generalist” as a set of skills

The term is used to describe individual health professionals’ skill set e.g. “generalist skills”^(4, 19, 20, 24, 26) or related descriptions such as reference to a broad skill base^(7, 23). Generalist is used as both a description of a service and workforce model and as a description of practitioners’ skills in that setting. There is however, very limited published information on what constitutes the component clinical tasks of either the model of care or practitioners’ skills set at either the profession-specific level or as common skills shared across professions. Non-clinical skills for rural and remote practitioners have been identified to some degree in work produced or funded by jurisdictions⁽²⁷⁻³⁰⁾.

Three forms of rural and remote generalists in the allied health professions are evident in the literature.

1. Full scope of practice

A number of studies have found that graduate allied health professionals identify that they lack the full complement of clinical skills to work in rural or remote practice^(8, 24). This implies that entry-level competencies and standards are not completely consistent with rural and remote practice requirements and that a certain level of post-entry training is required to obtain these skills. This is unsurprising and not inconsistent with other areas of practice that require ongoing development. Schoo and associates stated that “Health service delivery is likely to be enhanced when skills of allied health professions are used to their full potential”⁽³¹⁾. Information from the literature underlines the key point that although generalist practice is most often described as indivisible from a rural or remote setting (i.e. an inherent component of the model of care), this does not directly translate to all practitioners possessing the clinical skills set to practice to the full scope of the generalist role. Some level of development from entry-level competence to full scope practice is required. However, the extent of development, what clinical tasks and skills a practitioner requires and the extent to which these are common between professions is unknown as this mapping work has not been undertaken to date.

Allied health practitioners working to full scope in their rural or remote service generally work in a small multi-disciplinary team and with limited profession-specific support. The practitioner will potentially work with consumers across the age spectrum and continuum of care and need to be competent providing services across a broad range of clinical areas. Depending on the composition of the team / other service providers available, this model may include some sharing of clinical tasks between professions. This workforce model exists in many rural or remote locations currently but it is identified by allied health leaders nationally that there are significant deficits in the training pathway from early career professional to full scope rural or remote practitioner. Consequently, access to full scope rural / remote generalist practitioners is far from universal across rural and remote Australia and potentially contributes to discrepancies in health service outcomes.

2. Expanded Breadth of Practice

This practitioner works in a model of care that includes significant sharing of skills / tasks from other allied health profession/s +/- nursing. The practitioner will work to at least full scope within their own profession and also have undertaken training, assessment and ongoing supervision and monitoring to perform clinical tasks that traditionally sit in the scope of practice of another profession. This model is sometimes referred to as “trans-professional practice” or “skill transfer”⁽³²⁾.

There is limited published evidence but overwhelming anecdotal evidence from rural and remote practitioners that skill sharing occurs in an ad hoc fashion as part of local models of care, generally driven by limited access to other professions⁽¹⁾. Outreach models involving periodic visits by clinical staff to satellite locations challenge traditional allied health service provision. A study by Boshoff and Hartshorne⁽²²⁾ of rural occupational therapists identified clinicians primarily used a one-on-one service delivery model with a high travel component to service a highly geographically dispersed population. This study showed a consequently high clinician-to-patient ratio and identified time

intensiveness and inefficiency as issues associated with this model. Lin and associates⁽³⁰⁾, examining rural and remote allied health competencies in Western Australia identified that “job re-design that includes using skilled workers in roles beyond the traditional scope of their work, is seen as one way of addressing future challenges in healthcare delivery”. Travel time, especially in unpaid overtime has been identified as an issue for allied health retention⁽²⁶⁾. Skill sharing in outreach teams, supported by appropriate task analysis, competencies, training and monitoring/supervision (including use of ehealth solutions), could provide opportunity to address service gaps between outreach visits, improve timeliness of intervention for clients and increase efficiency of travel for clinicians.

3. Expanded Depth of Practice

Expanded depth of practice models involve a practitioner working largely within the traditional clinical area/s of their profession. However the practitioner gains, through training, assessment and ongoing supervision and monitoring, the capacity to provide advanced level clinical tasks, and even extended scope tasks (e.g. pathology and imaging ordering and interpretation, prescribing or administering drugs). In a rural or remote service the nature of expanded depth of practice should relate to the service and health needs of rural and remote communities, and the general skill mix and common skill gaps of rural and remote health teams. Like expanded depth of practice models in metropolitan locations, the model should target system pressures and opportunities for enhanced patient outcomes through better utilising highly skilled allied health practitioners.

Very little has been written in the literature about the potential associated with expanded depth of practice for the allied health professions in rural and remote areas. Ruston⁽¹⁰⁾ discussed the potential value of physiotherapists with expanded depth of practice (including extended scope of practice) in musculoskeletal management in rural and remote areas. Other possible models include expanded depth of practice dietitian diabetes clinical management and radiography limited scope image reporting and limited scope sonography.

NOTE: The term Allied Health “Rural and Remote Generalist” should not be confused with the term “Generic (Allied) Health Worker” which has been used to describe a worker without a primary health professional qualification that can perform a basic range of tasks in a number of clinical areas. To date, there is no such worker in Australia. There are currently no training or regulatory instruments in Australia for such a role.

Key concept: skill sharing

The form of rural and remote generalism examined in this project is expanded breadth of practice (skill sharing, also known as trans-disciplinary practice). In the context of the GNARTN Rural and Remote Generalist: Allied Health project skill sharing is understood to mean delivery by a health practitioner of a clinical task (e.g. assessment or intervention) that is not generally performed by that profession. The individual health practitioner will acquire the capacity to deliver the skill shared task through undertaking training, and being competency assessed by a practitioner from a profession with the task in their commonly accepted scope of clinical practice. The practitioner who has acquired the capacity to deliver the skill shared task will perform that task as part of their *independent* scope of practice.

That is, the professional is solely accountable for the decision to undertake the clinical task. Skill sharing is not the same as delegation. Delegation involves a health professional providing authority to another health care worker to deliver a clinical task, but retaining accountability for the provision of care to the client, including the delegated task. Although the trained practitioner is accountable for the performance of the skill shared task, skill sharing must be underpinned by rigorous clinical governance, regular peer review and support provided by a practitioner from a/the profession with the task in its scope of practice.

Assumptions used for skill sharing decisions in this project.

Project site teams implementing the Calderdale Framework to make decisions about the appropriateness of tasks for skill sharing used the assumptions listed below. The aggregated data from these teams forms the basis of the RRG:AH project findings and so must be viewed to be the underpinning principles of skill sharing for this project. Skill sharing:

- can only be implemented when appropriate training, competency assessment, clinical governance (including clinical supervision and credentialing) is in place in the work unit. This is a minimum requirement to ensure safety and quality of clinical services is maintained.
- must be implemented only when the skill share-trained practitioner can access advice and support of a practitioner with the task in their full scope of practice. Support may be accessed in person, or more likely in a rural or remote context through ehealth.
- decisions to skill share relate only to non-complex patients. That is, rare events and patients with less frequently encountered complex clinical problems are generally not appropriate for the skill share-trained practitioner to address, and would revert to management by the profession/s with a more extensive scope of competency in that clinical task. Project teams described this in their decision making processes as the “80:20 rule”, referring to the scope of the decision to be the average (i.e. 80% of the caseload) rather than the exception (i.e. 20% of the caseload).

For the reasons above, skill sharing involves limited task substitution, *not* worker substitution. Skill sharing, if appropriately implemented, will not allow one profession to be wholly substituted for another in a team’s staffing establishment. Instead the purpose of skill sharing is to enhance the capabilities of all members of the multi-disciplinary team to provide an expanded range of services to clients. This is particularly relevant to rural and remote teams, especially in relation to outreach service models. It is for this reason that GNARTN has undertaken this exploration of the potential for skill sharing in rural and remote allied health teams.

Rationale

The dearth of detailed information on the breadth of practice of rural and remote allied health professions, including clinical tasks that are or could be safely skill shared, currently limits:

- tertiary education providers ability to develop pre-entry training programs (including clinical placement models) targeting rural and remote profession-specific and skill sharing clinical training requirements,

- education providers' (universities, health service-based education units) ability to provide targeted work-based and award-based clinical training programs for allied health practitioners entering/in rural and remote practice, and
- health services' development of skill sharing models of care which are supported by competencies, training and governance processes.

Production of a detailed list of high frequency skill share tasks relevant to rural and remote allied health services is the foundation step required to generate clinical training pathway and models of care that incorporate expanded breadth of practice rural generalism in the allied health professions. This work was consequently identified as the focus of the GNARTN project.

Project Outcomes & Performance

The project plan was endorsed by the steering committee and approved by the project sponsor on 01/07/13. A minor project amendment related to the addition of a data review activity was endorsed by the steering committee and approved by the sponsor on 23/08/13.

Aim and objectives

The aim of the RRG:AH project was to support the development of clinical training models for allied health professions that meet the needs of northern Australian health services, and rural and remote communities in particular, by mapping and describing the clinical tasks that are or could potentially be safely skill shared within multi-disciplinary teams.

The objectives listed in the project plan were generally achieved with related outputs / products delivered to the sponsor within the prescribed timeframe of the project. The objectives, activities and outputs of the project are detailed in [Appendix A](#).

Scope of project

The form of rural and remote generalism examined in this project is expanded breadth of practice (skill sharing). Consequently, allied health teams with a broad clinical focus were recruited for the project. Rural or remote service teams with a narrower clinical focus (e.g. mental health or developmental / paediatrics) were not sought for participation. Recruited teams provide allied health services in rural or remote areas (defined as ASGC 4 or 5) in the GNARTN footprint of northern Queensland, the Northern Territory and northern Western Australia.

The allied health professions examined in the project were occupational therapy, physiotherapy, dietetics & nutrition, speech pathology, social work and podiatry. These professions were targeted as they are commonly represented in small rural and remote multi-disciplinary services and work in a team-based model of care, which lends itself best to skill sharing. The professions of psychology, exercise physiology and pharmacy would also have been considered in the project but they were not available in the staffing establishment of recruited project site teams.

The focus of the project was clinical tasks undertaken by the team, and therefore the clinical skills and knowledge requirements of allied health professionals working in rural and remote services. Non-clinical tasks were not in scope. Refer to [Appendix B](#) for further information.

Method and activities

The project drew on the experience and expertise of a range of allied health teams in northern Australia to describe the scope of their current clinical practice, and to make decisions on the potential for skill sharing clinical tasks. The project methodology is described in detail in [Appendix C](#). The main project activities were:

- Allied health teams in five organisations in northern Australia were selected and funded to implement the Calderdale Framework, a workforce re-design methodology. The participating teams were Katherine Hospital Sub-acute and Rehabilitation Allied Health Team, Katherine Region Aged & Disability Service, Top End Remote Disability Services, Gascoyne Allied Health team, Western Australia Country Health Service and the Healthy Lifestyle Team, Apunipima Cape York Health Council.

The Calderdale Framework provided a structured process for the teams to map all clinical tasks undertaken by the team (Service Analysis stage) and to analyse each task using a risk-based structured decision tool for potential to skill share or delegate the task (Task Analysis stage). Information on the Calderdale Framework is presented in [Appendix D](#).

- Five project site coordinators (project leaders in each site) were trained as Calderdale Framework Facilitators and supported to conduct the Service and Task Analysis stages as part of the RRG:AH project.
- Project sites mapped the clinical tasks currently undertaken by the team and compiled descriptive information on the tasks including professions responsible for delivering the task and approximate frequency it is undertaken.
- The descriptive task lists were submitted to GNARTN for aggregation and compiling into a single task list representing clinical practice of the six allied health professions across the project sites.
- An additional four allied health teams in northern Australia were recruited and partnered with GNARTN to examine the preliminary task lists generated from the project site data, reviewing the tasks and frequency information and reporting on its consistency with their team's practice.
- Project sites undertook the Task Analysis phase of the Calderdale Framework, examining their tasks for potential to skill share to other professions or to delegate to an allied health assistant. (Note: although not a focus of the RRG:AH project, the Calderdale Framework includes analysis of potential for delegation so this was also examined by project sites and reported to GNARTN in the final site project outputs).
- Project site task analysis findings, along with review site data were aggregated by the GNARTN project officer into a final project task list.

Deliverables

The primary project deliverable was a comprehensive list of clinical tasks delivered by six allied health professions in the sample of rural and remote services participating in the project. This aggregated task list comprises:

- 337 tasks in 25 clinical areas,
- information on allied health professions currently undertaking each task in project sites and approximate frequency that the task is undertaken by the team,
- decisions of all teams undertaking the relevant task regarding appropriateness for skill sharing to other allied health professions or delegation to an allied health assistant,
- information on non-allied health team members' current or potential responsibility for tasks identified by the team, and
- existing training programs and resources used to support current skill sharing in project teams.

The primary deliverable is presented in a series of task lists that are [attachments](#) to this report and as summary findings presented in appendices as follows:

- [Appendix E](#) - task list by clinical area
- [Appendix F](#) - tasks identified as appropriate for skill sharing between allied health professions
- [Appendix G](#) - occupational therapy findings
- [Appendix H](#) - physiotherapy findings
- [Appendix I](#) - speech pathology findings
- [Appendix J](#) - dietetics & nutrition findings
- [Appendix K](#) - podiatry findings
- [Appendix L](#) - social work findings
- [Appendix M](#) - delegation (i.e. allied health assistants) findings
- [Appendix N](#) - other health professions

The second project deliverable was training of project site coordinators as Calderdale Framework Facilitators, allowing them to implement this workforce re-design process in their organisation during and beyond the term of the project. Although not the primary objective of the project, this represents a valuable skills investment in the rural and remote Project Sites and useful 'bi-product' of the project. This was important for reciprocity, considering the investment of time and energy of project site teams and organisations in the task mapping and analysis process. The training was provided in full to project site coordinators and an agreement with Effective Workforce Solutions (Ltd), owners of the Effective Workforce Program, will allow project sites to use the Calderdale Framework for up to three years.

Findings

The information generated by the project provides some key learning in relation to rural and remote generalist clinical skills and knowledge requirements for the allied health professions. The data in the aggregated task list provides a useful map of clinical tasks undertaken by each of the six professions examined in the project, both within their historic scope of practice and also with regard to actual and potential skill sharing to and from other allied health professions. The limitations of the findings should be recognised as they are based primarily on information from five teams (see [Appendix O](#) for discussion of internal and external validity of project findings). It is not suggested that the aggregated task list comprehensively represents the practice of all rural and remote allied health practitioners. However, findings are likely to represent a useful approximation of clinical requirements of rural and remote generalist practitioners in the six professions. Key findings from project are presented below and discussed in more detail in referenced appendices and attachments.

1. Multi-professional delivery of clinical tasks and functions is relatively common in current rural and remote allied health practice (45% of clinical tasks are delivered, at least in part, by more than one profession). Multi-professional delivery of a task may be due to that task being within the accepted scope of practice of more than one profession, or because skill sharing has occurred at the local level in one or more project sites. (See [Appendix E](#) for overview information on clinical tasks undertaken as part of current practice; and Appendix G to N for more specific information on each profession / workforce group that participated in the data collection)
2. One hundred and twenty-seven tasks (127) of the 337 tasks were identified as appropriate for skill sharing between allied health professions, assuming training, clinical governance and all other requisite supporting processes were implemented. A task identified by a project site team to be suitable for skill sharing could be an existing uni-professional task or multi-professional task that the team identified as advantageous to be delivered by additional profession/s. Additionally, some tasks identified for skill sharing were current multi-professional tasks but the team identified that more structured training and competency assessment was required to maximise quality and safety. Skill sharing was most commonly proposed to be modest expansion of existing skills rather than larger-scale re-orientation of practitioners' skill sets and scope of practice in the service. To illustrate this point, 60% of tasks proposed for skill sharing in project sites were already being performed (at least in part) by more than one profession in the team. Moreover, two-thirds of tasks (66%) proposed for skill sharing include the same two professions, occupational therapy and physiotherapy. These professions have greater consistency in underpinning professional knowledge and skill sets than most other allied health professions. They were also represented in more project sites and had the greatest staffing establishments of the professions included in the project, which would have also contributed to the finding. (See [Appendix F](#) for further discussion on this finding)
3. Greater potential for use of the allied health assistant workforce is evident in the project findings. Less than a third of potentially delegable tasks are currently delegated by project site teams. The reasons for this are likely to include organisation-factors such as limited AHA staffing, service models that do not allow AHAs to be used optimally for service delivery (e.g. inadequate capacity to travel to provide outreach services, competing administrative and operational tasks), training and capabilities of AHAs, and

the confidence and capacity of health professionals to work in a delegated practice model. Further examination of rural and remote delegated practice models, particularly those involving remote supervision through the use of telehealth is indicated. Training for rural and remote allied health professionals should include the skills and knowledge required to work successfully with AHAs in a safe and well support delegated practice model. (See [Appendix M](#) for more detailed information on findings related to allied health assistants)

4. The project findings show clusters of related tasks that are identified as appropriate for skill sharing in rural and remote allied health teams. The clusters are logical groupings for translation into clinical training programs for rural and remote allied health professionals. Thirteen clusters are proposed; Activities of daily living (ADL) and function; Mobility and transfers; Prevention of foot morbidity in high risk groups; Children's development; Cognition & perception; Communication; Psycho-social; Fatigue, sleep and energy conservation; Pressure care, skin and wounds; Diet and nutrition; Neuro-musculoskeletal and pain; Cardiovascular fitness & exercise tolerance; and Continence assessment and basic intervention. (See [Appendix F](#) for further information)
5. The generalisability of the task list was tested through a small review activity (See [Appendix P](#)). Allied health practitioners from additional northern Australian rural or remote allied health teams contributed to the review of the task list in its draft form. The review activity found that the task list represented the clinical tasks undertaken by physiotherapists, dietitian/nutritionists and podiatrists relatively well. Greater variation in clinical tasks was noted for social work. No occupational therapists participated in the review. The review activity did not examine validation of skill share or delegation decisions, only the composition of the task list.

Project Term

The project was 30 weeks in duration, 6/5/13 – 30/11/13.

Resourcing

Labour

A project officer was seconded at 0.8FTE for 30 weeks from the Allied Health Professions' Office of Queensland (AHPOQ), Department of Health. The project officer had previous experience with a similar project methodology, including the use of the Calderdale Framework. GNARTN and AHPOQ contributed to project officer funding.

Non-labour

Funding agreements with third parties (GST excl)	\$ 90,254
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Includes purchase of license for Calderdale Framework, Calderdale Framework
Practitioner engagement from Mackay HHS and project site funding x 5

Other non-labour	\$ 23,356
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Includes travel, workshop catering, JCU auspicing fee, office equipment costs
NB: some costs are approximate as they are part of GNARTN running costs

Governance and stakeholder engagement

The GNARTN Senior Director sponsored the project and was responsible for reporting on the project to the GNARTN Council.

Operational management of project activities was effected through a partnership between the GNARTN Senior Director and Chief Allied Health Officer, Queensland Department of Health as the employing agency for the project officer.

The project was oversighted by a steering committee comprising members from the Northern Territory Department of Health, Queensland Department of Health, Western Australia Country Health Service, Western Australia Department of Health, Services for Australian Rural and Remote Health (SARRAH) and Health Workforce Australia. The terms of reference for the steering committee is provided as an [attachment](#) to this report. The steering committee met monthly from June to December 2013.

Activities in relation to the project sites were coordinated through fortnightly working group meetings chaired by the GNARTN project officer and attended by the project site coordinators. Four working group meetings were conducted.

Information on the project was communicated to stakeholders and interested parties by the GNARTN Senior Director, Project Manager and RRG:AH project officer. Communication strategies employed included:

- GNARTN internet site (www.gnartn.org.au)
- Presentations - National Allied Health Conference, Queensland Department of Health Allied Health Rural and Remote Generalist Forum.
- Meetings and consultation – Health Workforce Australia Rural and Remote Generalist Allied Health Professions consultation, individual meetings with health services in Queensland, Northern Territory and Western Australia.

Project Management

The risks identified in the project plan and their management are discussed below.

Potential risk 1.

Difficulties / delays in recruiting project sites and securing funding agreements.

Moderate delays were experienced in recruiting rural and remote teams to participate. Barriers to participation included vacancies, use of a service brokerage model (generally episodic engagement of private practitioners) that would not permit either examination or implementation of a skill sharing model of care, and existing challenges for teams to meet service demands and manage current restructures. These issues were addressed primarily through the support of jurisdiction allied health leaders and networks.

Potential risk 2.

Concerns in participating sites and more widely amongst stakeholders of skill sharing.

Some limited concerns regarding skill sharing were expressed at a local level in project sites but were addressed by working through the Calderdale Framework, and change management support provided by project site coordinators and local project sponsors.

Potential risk 3.

Tight timeframes for the completion of a complex, multi-site project and capacity of small rural and remote teams to participate.

Timeframes proved the most challenging aspect of the project, with delays experienced in securing agreements from rural and remote allied health team and in submission of project deliverables from project sites to GNARTN. Timeframes for completion of the work required at project sites was challenging and is reflected in the project evaluation (see below). The challenges of completing site projects was addressed by the GNARTN project officer providing support to project site teams, jurisdiction steering committee members and project site sponsors engaging with teams, and through the considerable talents, determination and professionalism of the project site coordinators and their teams. Significant delay in completing site project activities and submitting deliverables was experienced in just one site. This delay was managed by adjusting timeframes for completion of the data aggregation and analysis by the GNARTN project officer. The consequence of this was a delay in providing the draft report to the steering committee for review and the removal of a planned two-three week review of the draft aggregated task list by project site teams. The former was approved by the steering committee and addressed by the addition of a post-project meeting in mid December to allow the committee time to review the draft project report. The latter limited the opportunity for project site teams to review the output of data aggregation and analysis for interpretations errors. A shorter (7 days) review period and some specific targeting of professions for further information / data checking was actioned to reduce the impact of this amendment to the project.

Potential risk 4.

Potential for duplication of work between GNARTN and other agencies such as HWA and jurisdiction health departments.

This risk was satisfactorily managed through the project steering committee and by additional ad hoc meetings between GNARTN and these agencies.

Evaluation

1. Project Evaluation

a) Process evaluation

Evaluation component 1: Project activities completed within allocated budget and within approved timeframes.

Project activities and deliverables were completed in approved timeframes and budget.

Evaluation component 2: Project completion report approved by sponsor.

The project completion report submitted to project sponsor on 2 December 2013. The report will be provided to the project steering committee for review and recommendation to the sponsor.

b) Impact evaluation

Evaluation component 3: Project site teams undertake a survey related to change readiness and experience of participating in the RRG:AH project.

The survey was developed from change readiness tools used for previous Calderdale Framework projects in Queensland. It was distributed to all participating team members in project sites by the project site coordinators and completed at the start of the Service Analysis stage, and then again after the Task Analysis stage had been completed. The project site coordinators did not participate in this survey. Approximately 30 people participated in the five site projects (the number varied slightly across the data collection period due to leave, recruitment etc). Response rate for the pre-project survey was 11 (36%) and post-project survey was 11 (36%), and varied by team (i.e. 100% of eligible team members vs <10% of eligible team members completing the survey). The outcomes of the survey are shown in [Appendix Q](#). The pre and post surveys were anonymous and not respondent-matched. Due to the response rate, considerable response bias is likely and caution should be used when interpreting the results. In particular, comparison of pre and post project survey data is meaningless as one site provided no pre-project surveys but three of eleven post project surveys. Any differences between pre and post survey results are likely to relate to different samples rather than to change attributable to project participation. Instead, pre and post survey responses were pooled and examined for general themes. The surveys indicated the following:

- Respondents identified that their teams provided a valuable service and indicated generally positive relationships with current referrers, good intra-team communication, and reasonably good care coordination within the team.
- Responses were more varied on the topic of service accessibility for patients and waste / inefficiency being an issue for the team.
- Responses were quite varied in relation to the orientation and induction experiences of new staff, and the extent to which new staff encounter difficulties adapting to the clinical requirements of their role.
- Respondents generally felt that they had a good understanding of the role of others in the team, but also indicated that the role of each team member did lack some clarity.
- The outcomes of the question related to team members working to their full scope of practice was mixed.
- Responses indicated that allied health assistants' scope of practice is not consistently understood and actioned by health professionals and that allied health assistants were not always able to work to their full scope of practice.
- Views on participating in the GNARTN RRG:AH project were supportive in the pre and post-project survey responses.
- Adequate resourcing for the project was a concern for a small number of respondents in both surveys. The post-survey responses may relate to the next phase of local site implementation, following the conclusion of GNARTN funding.
- Adequate capacity to participate in the project was also a concern of some respondents in both surveys.
- Written comments highlighted challenges in terms of timeframes and a lack of backfill for project site coordinators. Positive comments on the experience of participating as a project site were also included in the post-project surveys, as were hopes for translation of project work into tangible benefits for the team.

2. GNARTN evaluation strategy

A broader impact and outcome evaluation process of all GNARTN initiatives commenced in November 2013. RRG:AH project site coordinators, their managers, and the project steering committee were invited to participate in this online survey. The survey allows the respondent to identify the project they participated in, and so will collect data that is directly attributable to the RRG:AH cohort of stakeholders. The outcomes of this evaluation will be available after the conclusion of the RRG:AH project and be reported through GNARTN communication channels.

Lessons Learned

Key learnings from the project were:

- Implementing separate site projects with a tightly prescribed common methodology and standard data collection tool produced data of adequate quality and consistency to aggregate. This method proved a valid and reasonably successful way to develop, in a relatively short timeframe, a large and detailed data set on clinical tasks undertaken by multiple professions.
- The support and organisation-level advocacy of senior allied health leaders, particularly at jurisdiction level, was crucial for the completion of the project within tight timeframes.
- The challenges of undertaking projects in rural and remote allied health teams cannot be underestimated. Recruitment of project sites was difficult, with many potential sites identifying workforce shortages and high service loads as barriers. Although funding was available to cover backfill of project site coordinators, difficulties with short-term recruitment and other factors made this generally infeasible for project sites. Project site teams, particularly the coordinators, needed to divert considerable time away from normal duties to complete project activities. This impact would have been reduced if greater time had been available to allow teams to recruit backfill or reorganise services to a greater degree in order to release staff to work on project activities.

Project closure activities

The following activities will be undertaken to close the project.

1. Ongoing Project Site support. The project site coordinators were fully trained as Calderdale Framework Facilitators during the term of the GNARTN RRG:AH project, and can facilitate the implementation of workforce re-design at the discretion of the organisation. Ongoing support for the facilitators has been negotiated with AHPOQ, in the form of:
 - continued access to advice from the GNARTN project officer when she returns to her AHPOQ substantive position, and
 - inclusion of facilitators in the AHPOQ-coordinated Calderdale Framework Facilitator Network which meets monthly via teleconference and communicates via an email group to provide peer support and learning for members

2. Records Management

All files and documents associated with the project will be provided to the Senior Director GNARTN in electronic format. Inter-agency agreements and key project documents (e.g. project plans) will be provided in hard copy in a project file.

3. Finance Management

Any outstanding arrangements for payment of project site invoices will be handed over to the Senior Director.

4. Post-project communication strategy

At the Senior Director's discretion, the project report will be

- published to the GNARTN website, and
- distributed by email to all project site and review site representatives, steering committee members and GNARTN stakeholders.

Recommendations

Recommendation 1

The GNARTN Council endorse this project report and accept the project deliverables as consistent with the approved project plan.

Recommendation 2

A validation process should be undertaken of the project products, particularly the clusters of clinical tasks identified as appropriate for skill sharing between two or more of the allied health professions examined in the project (i.e. occupational therapy, physiotherapy, speech pathology, nutrition and dietetics, social work and podiatry).

The validation process should examine validity and extent of generalisability of the project findings beyond northern Australian allied health teams. The validation process will require input from experienced rural and remote practitioners from the six professions examined in this project, and could include involvement of rural or remote practitioners from a small number of other allied health professions that were not part of the primary data collection in this project. Management of the validation process, including identification of key informants in rural and remote allied health services, will require resourcing and leadership / coordination, the latter of which may be a potential role for the continuation of the RRG:AH Project Steering Committee. Further information on the potential scope of the validation process is provided in [Appendix R](#).

Recommendation 3

Following validation, the project findings are promoted to training providers in the education and/or health sectors to support the development of rural and remote-focused clinical training that is broadly accessible by allied health practitioners across jurisdictions and health care providers.

Accessibility will require consideration of barriers to rural and remote practitioner engagement in training including structure, delivery mode, cost and articulation between levels of training. The variation in current skill sharing requirements between sites found in this project highlights the need to provide modularised, flexible clinical training for practitioners such that an individual can design their training program in response to their local model of care and community needs. Flexible post-professional entry training programs will also recognise the variation in extent of development required of practitioners across career stages, from intensive and highly supported development of new and recent graduates, to upskilling in a small number of clinical tasks potentially required of experienced practitioners moving between rural or remote services. Training programs should integrate clinical skill and knowledge requirements outlined in this project with non-clinical / service-related requirements of rural and remote practice that have been developed in projects in Western Australia Country Health Services⁽²⁸⁻²⁹⁾, South Australia, Queensland and others. The number of clinical tasks identified in this project, across a large range of clinical areas, indicates that a partnership or consortium model for the development of training programs may be most appropriate. Consequently, issues of recognition between training providers and intellectual property will need to be addressed. Recognition of training by professional associations and registration boards should also be examined. Integration of findings into

pre-entry training programs should also be examined and will require collaboration between universities, professional bodies and the health sector. An agency with a coordination and overarching leadership role for this work will be required.

Recommendation 4

Resources to support organisations to safely and appropriately implement governance and other supporting processes for skill sharing are developed and made broadly available.

Although currently available in some larger rural and remote service provider organisations such as government departments, broad access to best practice skill share supporting resources is required. These are likely to include a recommended governance framework, guidelines, and other resources such as training, assessment and audit templates, supervision guidelines and templates. The resource suite is broadly similar to that published for delegated practice models⁽³³⁾ in recent years. Development of these resources should draw on the work already completed in Queensland⁽³³⁾ and by Health Workforce Australia, and in rural and remote generalist programs in other professions such as medicine. A coordinating agency will be required for this work.

Recommendation 5

Strategies to facilitate implementation of expanded breadth of practice generalist workforce models are developed in partnership with rural and remote allied health services and professional bodies.

Implementation of expanded breadth of practice rural and remote generalist roles in the allied health professions will occur at the health service level. Mechanisms to facilitate this implementation will be required beyond the development of training and supporting processes identified in Recommendation 3 and 4. A range of implementation strategies should be examined in close partnership with service providers, reflecting the significant variation between services in terms of existing workforce models and supporting resources. The implementation strategy should also drive the development of a structured rural and remote generalist training pathway for the allied health professions which is recognised by professional bodies and employers. A structured training pathway should support workforce sustainability and address the current workforce mal-distribution impacting rural and remote areas. Resourcing and leadership of this work at a national level, including an evaluation process, would be required to develop and coordinate implementation strategies.

Recommendation 6

RRG:AH project sites are supported by their organisations to maximize the benefits from the three year Calderdale Framework license and training of the site coordinator as a Facilitator.

To support this recommendation, GNARTN should continue current work to facilitate resource sharing between sites and stakeholder organisations. Queensland Department of Health shall include the GNARTN Facilitators in the existing Calderdale Framework Facilitator Network to support peer learning and support. It will also support continuation of some limited post-project support of the Facilitators by the Calderdale Framework Practitioner based in the Allied Health Professions' Office of Queensland. (See [Appendix S](#) for a list of project sites)

Recommendation 7

Project findings are promoted to jurisdictions and health workforce agencies working on rural and remote allied health assistant models of care, and skill sharing models between allied health and non-allied health professions.

Although not the primary purpose of the project, opportunistically several project sites included non-allied health team members who also participated in the service and task analysis processes, and therefore are reflected in the aggregated data. The non-allied health disciplines are nursing (in Disability Coordinator positions), Indigenous Health Workers and Aboriginal and Torres Strait Islander Health Practitioners. Project findings indicate the potential for skill sharing some allied health tasks with these disciplines. The project findings also include a list of tasks considered safe and feasible to delegate to allied health assistants. As opportunistic, and incomplete secondary products of the project, further work to validate these skill share and delegation task lists would be required.

Recommendation 8

Strong interagency collaboration at a national level is utilised to negotiate roles and responsibilities for the range of implementation activities outlined in previous recommendations. Specifically, coordinating agency/ies and structures for collaboration should be identified and agreed by relevant stakeholders in the health and education sectors.

As highlighted in Recommendations 2 to 5, translation of project findings into tangible changes to training and support processes, and models of care for rural and remote allied health professions will require leadership and strong interagency collaboration. The recommendations in this project report span health service delivery models, workforce reform and pre and post-entry education, indicating a coordinated network of organisations is required. Leadership / coordination functions will need to be negotiated and agreed by stakeholders for each major component of the implementation work, based on alignment to organisational mandate, expertise, resources and capacity. In the first instance, agencies represented on the GNARTN RRG:AH Project Steering Committee, including jurisdictions and Health Workforce Australia, should identify additional stakeholder groups to be engaged in the broader implementation activities and the suggested governance structure for future collaboration.

List of attachments

1. Rural & Remote Generalist: Allied Health project – aggregated data (MS Excel spreadsheet)
2. Task List – Full task list
3. Task List – Proposed skill share / multi-professional tasks
4. Task List – Occupational Therapy
5. Task List – Physiotherapy
6. Task List – Speech Pathology
7. Task List – Dietetics & Nutrition
8. Task List – Podiatry
9. Task List – Social Work
10. Task List – Delegation to Allied Health Assistants (AHAs)
11. Task List – Psychology (from review activity)
12. Task List – Non-allied health professions
13. Task clusters for translation to training resources
14. Terms of Reference – Steering committee

List of abbreviations

ADL	Activities of daily living
AH	Allied Health
AHPOQ	Allied Health Professions' Office of Queensland
CF	Calderdale Framework
DOH	Department of Health
DN	Dietetics & nutrition
EWS	Effective Workforce Solutions (Ltd) (owners of Calderdale Framework)
FIFO	Fly-in, Fly-out
FTE	Full-time equivalent (staff)
GNARTN	Greater Northern Australia Regional Training Network
HWA	Health Workforce Australia
NT	Northern Territory
OT	Occupational therapy
Pod	Podiatry
PT	Physiotherapy
QLD	Queensland
RRG:AH	Rural and remote generalist: allied health (project)
SARRAH	Services for Australian Rural and Remote Allied Health
SP	Speech pathology
SW	Social work
WA	Western Australia
WACHS	Western Australia Country Health Services

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Appendix A – project objectives & activities

The project objectives, as listed in the project plan are shown below, along with a brief account of activities undertaken in support of them.

Project Objective 1

Using data from a sample of rural and remote allied health services in northern Australia, identify and map clinical tasks that are currently or could be skill shared between allied health professions or between one or more allied health professions and other members of the health care team, assuming competencies, training and governance processes are available to support the skill sharing model.

Outcome:

This objective was fully realised and presented in this project report.

Activities:

- GNARTN provided resourcing and support to five project site to complete the task identification / mapping and analysis (see Project Objective 2).
- The GNARTN project officer aggregated and analysed project site data.
- Four additional rural or remote allied health services were recruited and conducted a review activity of the draft aggregated task list, which was integrated into the project findings.
- Findings were presented in the project report.

Project Objective 2

Support up to six health services in northern Australia to use the Calderdale Framework to

- map and analyse their current clinical tasks and workforce model,
- conduct a risk-based analysis of these tasks and,
- identify potential for enhanced patient access and outcomes, and team efficiency through re-design of the workforce model.

Outcome:

Only five rural and remote allied health teams in the GNARTN footprint area could be recruited, three in the Northern Territory and one each in Queensland and Western Australia. The project site details are listed in [Appendix S](#). Barriers to participation are discussed in the [Project Management](#) section of the report. The five recruited teams completed all required task identification and analysis activities (stages 1- 3 of the Calderdale Framework) and submitted the resultant task lists to GNARTN for aggregation and analysis.

Activities:

- GNARTN secured an agreement with Effective Workforce Solutions (Ltd), owners of the Calderdale Framework, to allow access to the resource by project sites for up to

three years; and agreement from Mackay Hospital and Health Service to release Dr Alison Pighills to co-facilitate the training program for project site coordinators (local project leader).

- GNARTN provided 6 days face-to-face training and ongoing support for project site coordinators to implement the Calderdale Framework in their teams.

Project Objective 3

Partner with rural and remote allied health teams beyond the RRG:AH-funded Project Sites, which are using the Calderdale Framework, in order to expand the pool of data available and contribute to the refinement of the skill share task list.

Outcome:

It was anticipated during the development of the project that one or more jurisdictions may undertake projects using the Calderdale Framework in rural or remote areas in 2013, and so the findings may be used opportunistically to increase the pool of data for analysis. This did not occur and so this objective is unrealised at this time. However, the opportunity remains to undertake this work through inter-agency partnerships and supports the continued cooperation between GNARTN, HWA and jurisdictions to examine future opportunities for adding to the findings of this project (See [Recommendations](#) for discussion of future partnerships).

Project Objective 4

In a sample of rural and remote allied health services, identify training processes and supporting systems for clinical tasks that are currently skill shared, with particular focus on how students and new clinicians obtain, demonstrate and maintain the skills required to perform these tasks.

Outcome:

The training programs currently accessed to support skill sharing, and rural and remote practice skills in general, were identified as part of the site projects and reported to GNARTN. These are presented in [Attachment 1](#). Beyond a few existing training programs and resources, mostly related to either administration of standardised testing instruments, and equipment prescription training provided by aids subsidy schemes, few resources were identified. This underlines the anecdotal evidence from rural and remote allied health practitioners that there is limited clinical skill-focused training available that is relevant to their learning needs as generalists with a broad scope of clinical practice requirements.

Activities:

Project sites captured information on existing training programs and resources, which was consolidated and presented in the project findings.

Appendix B – non-clinical tasks

The focus of the project was clinical tasks undertaken by allied health professionals in the project sites. Non-clinical tasks are acknowledged to be a vital part of rural and remote health service provision for all members of the multi-disciplinary team. Project sites were not required to examine the non-clinical functions or tasks of the team as this was not in scope of the GNARTN project. Sites could, if they wished, collect non-clinical information in the task identification process undertaken in the Service Analysis stage. Definitions of both clinical and non-clinical broad functions were provided to project sites for reference prior to data collection (see table on next page). These were drawn from previous Calderdale Framework projects undertaken in Queensland Health and also from work in WACHS and Queensland Health ⁽²⁷⁻²⁹⁾.

Some project sites and review sites did collect and present some non-clinical tasks in their data collection forms. Although not analysed in detail, tasks identified were consistent with the non-clinical functions included in the table on the following page.

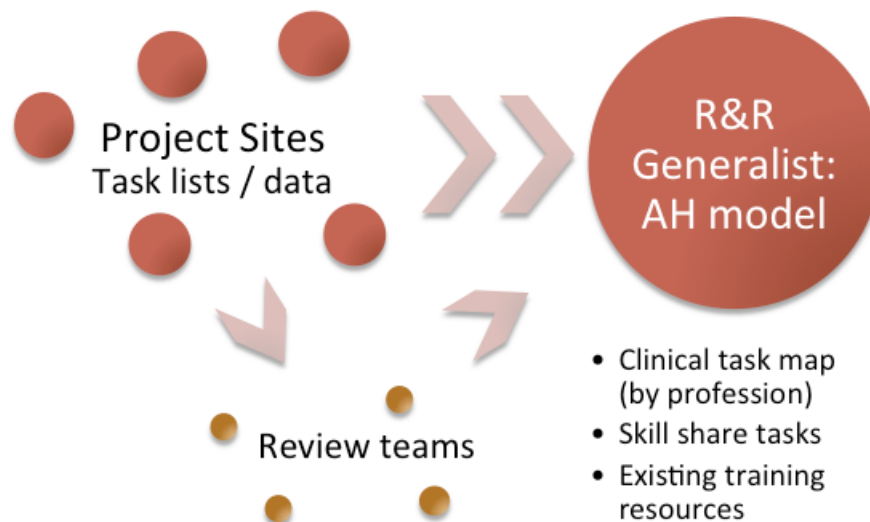
Form of Task (Acknowledgement: Allied Health Professions' Office of Queensland, Department of Health)

Term	Key concepts	Example
Screening	Screening occurs prior to comprehensive assessment and diagnosis; is exploratory in nature; may include subjective or objective information collection; is generally performed on patient groups defined by general inclusion criteria rather than by clinical reasoning of individual patient health status.	All patients over 65 admitted to XX ward have an MST done within 48 hours of admission, irrespective of their presenting diagnosis.
Assessment	Primary outcome is clinical information required to support diagnosis formation and care decisions; may include subjective or objective information collection; includes some level of decision making on the information obtained (even if decision is just to refer to another team member for assessment)	Foot pulses, review of X-ray or biochemistry, gait assessment, dysphagia assessment, bioimpedence measures of oedematous limb, kitchen assessment
Intervention	A clinical activity intending to change or support a change to the health status of a patient (i.e. "treatment"); supported by clinical reasoning and evidence-based practice principles	Exercises, counselling techniques, prescription of thickened fluids, education, training to improve performance of a functional task, wound debridement, taping.
Care coordination	Activities that contribute to the formation of care plans for an individual patient e.g. intake and discharge decisions; relate to the patient's journey through the system; generally involves collaboration and consensus decision-making with other members of the multi-disciplinary team.	Case conference or ward round attendance and contributions; providing a referral to another health professional based on one's own assessment findings / clinical reasoning, contributing to discharge planning.
Other clinical function	Components of providing clinical care that cannot be analysed as a discrete task separate from the context or completely delegated to another worker due to their nature.	Formulating a diagnosis; applying clinical reasoning to make a clinical decision; collaboratively developing a treatment goal with a patient.
Administrative / Operational	Tasks that do not involve direct clinical risk and relate to the administration or operation of a service.	Cleaning equipment, ordering stock from an inventory list, photocopying, registering an appointment on the scheduling system, charging patients for consumables, managing department budget and HR, doing 'stats'.

Professional	Encompasses tasks that are not directly related to individual patient care but are a component of being a practicing health professional	Student supervision; attending or conducting inservices; doing a chart audit or other QI activity, reflecting on own practice, undertaking research activities.
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Appendix C - methodology

The project methodology is shown graphically below and described in detail for the purpose of transparency and review.



Project site recruitment

Up to six project sites were sought, meeting the following criteria:

- Health service organisation with two or more allied health professions working in a team-based multi-disciplinary model of care. The target allied health professions were occupational therapy, physiotherapy, speech pathology, dietetics & nutrition, podiatry, social work, psychology, exercise physiology and pharmacy.
- Teams provide generalist health services, the majority of which are delivered in rural and remote areas within the GNARTN footprint of northern Australia.
- Teams were able to nominate a member to be trained as a Calderdale Framework Facilitator and judged that they were able to meet the time commitments to complete the project deliverables within the prescribed timeframes.

Data collection at project sites

Project sites completed and submitted a data collection form to GNARTN as the primary deliverable of their funded project. The data collection form (MS Excel spreadsheet) included the following data:

1. Team / service descriptive data including professions / workforce groups represented in team, FTE, service locations

2. Master Task List including

- clinical task descriptive data including
 - o broad function (Assessment, Intervention, Care Coordination, Administration, Professional, Operational, Research) - pre-loaded into data template (based on findings from Queensland Health projects), but could also be amended or added to if required,
 - o clinical area (e.g. ADL & Function, Mobility & Transfers, Foot Care, Diet & Nutrition) – pre-loaded into data template (based on findings from Queensland Health projects), but could also be amended or added to if required,
 - o task title (defined by team),
 - o task description (defined by team but with examples provided by GNARTN),
 - o task frequency chosen from the following categories; daily, 2-3 x week, weekly, fortnightly, monthly, 2-6 monthly, >6 monthly. This was the approximate frequency that the task was performed by the team (i.e. by all relevant members of the team), and
 - o professions currently undertaking the task and whether the task was currently delegated to an allied health assistant.
- task analysis data including
 - o decision of the team to delegate, skill share or keep the task with current profession/s,
 - o if the decision was to skill share, which professions in the team would most appropriate for the task to be shared with, considering (1) the potential benefits and risks to clients, (2) efficiencies for the service, (3) efficiencies in terms of the extent of training required to undertake the task, balanced against potential benefits in (1) and (2).
- existing training resources available to the team to support skill sharing or delegation if this was the decision of the team.

3. Task analysis decision tables. The decision tables are part of the Calderdale Framework and examine, using a 10-point risk analysis process, the potential for skill sharing or delegation of the clinical task. The decision tables captured additional data including rationale for a decision or the scope of the decision e.g. skill sharing only a component of the task.

Aggregation and analysis of project site data

Aggregation of project site data was undertaken in the two phases (1) task list aggregation, (2) task decision aggregation and analysis.

1. Task list aggregation

Following completion of the Service Analysis stage of the Calderdale Framework, project sites submitted their draft master task list to GNARTN. The Service Analysis stage produced the list of clinical tasks undertaken by the team (including all data described in

points 1 and 2 above). Aggregation of project site data was undertaken by the GNARTN project officer to produce a single task list. This involved:

a) Aggregating task descriptive information (title, descriptions) into a single task list.

The process involved:

- reviewing all tasks supplied by project sites and clustering them by clinical area (e.g. ADL & Function, Diet & Nutrition)
- clustering like tasks together as indicated by task title or task description. Some tasks were presented consistently across two or more sites e.g. Time Up and Go test was presented as a stand alone task with consistent task description in a number of sites. The remaining tasks were drawn from information presented in different ways by project sites. For example, one project site included all ADL equipment activities in one combined task, but other sites divided it into a number of separate tasks related to different pieces of equipment (e.g. over toilet frame, kitchen aids). Another example was presenting components of tasks as multiple separate tasks e.g. dividing delivery of a health education program to individual clients into five tasks; development and design of the program, development of resources, decision to provide the program (prescription), delivery of the program and evaluation/review of the outcomes. To develop tasks from disparate representations in project site data, the project officer used the following decision rules:
 - o Assessment and intervention activities were divided into separate tasks. This decision is informed by the project officer's previous work using the Calderdale Framework, and experience that often assessment and intervention processes have different decisions regarding delegation or skills sharing.
 - o Project site data that presented a single clinical activity as multiple separate tasks was generally included in one task in the aggregated task list. That is, all components were included in one task e.g. prescription, source / supply, trialling and instruction, and evaluation of an intervention were included in one task, even if broken into multiple tasks by individual project sites.
 - o Data that presented multiple clinical activities as a single tasks were allowed to remain as one task in the aggregated task list if:
 - the different activities had similar risk profile and/or underpinning knowledge and skills and therefore would be likely to produce the same decision regarding skill sharing or delegation e.g. Comprehensive assessment – cognition (CP05) remained a single task that included a broad range of clinical activities including a range of different tests,
 - training for skill sharing or delegation, if relevant, would logically include the different activities as a cohesive skill set for clinical reasons e.g. Transfers – assessment (MT08) was kept as one task, rather than being broken into chair, bed, wheelchair, bath bench transfers etc; Lymphoedema self-management program (LO06) remained a single task as the component activities would be taught and delivered together in a clinical setting, or

- low task frequency indicated it was unlikely to be skill shared or delegated and remaining together as a single task was efficient e.g. electro-physical agents remained a single task rather than breaking it into its component modalities of LASER, ultrasound, TENS etc.
- o project site data that presented multiple clinical activities as a single task were broken into multiple separate tasks in the aggregated task list if:
 - the risk or complexity of activities was different e.g. transfer aids was broken into separate tasks for hoist and all other aids (e.g. transfer bench, bed stick),
 - the underpinning knowledge and skills are significantly different e.g. Functional mobility assessment (MT03) was separated from Comprehensive mobility assessment (MT04), or
 - a standardised testing process of relatively low risk / complexity could be drawn out from the broader task, as this was likely to be more amenable to delegation or skill sharing e.g. spirometry (RE03) was separated from comprehensive respiratory assessment (RE02). Standardised tests of greater complexity in administration or interpretation (and therefore less likely to be skill shared or delegated), such as some cognitive or speech / language testing, remained in one task if presented that way in project site data.

b) Task frequency:

Task frequency was collected by all project sites for each task they identified. The project site data indicated the approximate frequency that the task was performed by the team (i.e. by all relevant members of the team). When the sites' task list data was aggregated, frequency was estimated by comparing site responses. Frequency was broadly categorised in the aggregated task list as follows:

High frequency	Task occurs at least once a week
Moderate frequency	Task occurs less than weekly but more than monthly
Low frequency	Task occurs monthly or less frequently

If there was discrepancy between task frequencies recorded between sites, the average frequency was determined as follows:

- an 'outlier' was discounted from consideration if multiple other sites had high consistency i.e. the mode frequency was used,
- where one project site task better reflected the scope of the task in the aggregated task list, it was more highly weighted in determining average task frequency. That is, the aggregation process involved combining some tasks that were separated in project sites data, or breaking apart ones that had been considered a single task in project sites as described above. Data presented in project site task lists that most closely aligned to the scope of the task in the aggregated list was used more to determine frequency.
- reviewing comments made by the team on task frequency e.g. some tasks were noted in data collection forms to be impacted by a current vacancy.

- if the task was identified at two sites, the average was used e.g. one site frequency was weekly and the other monthly, the frequency was listed as moderate. If the average fell between two categories, the more frequent was chosen e.g. one site frequency was weekly and the other was fortnightly, the frequency was listed as high.

c) Professions / workforce groups currently performing task in sites:

Project site data indicated the team members currently responsible for undertaking the task. These were translated to the aggregated task list as follows:

- The task was identified at one site only: all professions / workforce groups listed in the site data were included in the aggregated task list.
- The task was undertaken at two or more sites: professions / workforce groups identified at any site were included in the aggregated task list except if comments in the data collection form indicated otherwise e.g. a comment indicated that it was very rare for one profession to do the task.

By default, the professions listed in the project site data were understood to provide the full scope of the task. Allied Health Assistants were understood to provide the components of the task which are consistent with a delegated practice model i.e. generally excluding independent interpretation of assessment findings, diagnosis formation, development or revision / progression of treatment plan etc. Professions were recorded as providing a part of the task or inconsistently providing the task in rural or remote practice if:

- the task was identified at two or more sites with that profession in staffing establishment but was not attributed consistently to the profession,
- a comment in the data collection tool indicated the profession provided only limited scope of the task, or
- multiple tasks in the site data had been combined into one in the aggregated task list, and there was a discrepancy between the professions listed for the component tasks in the project site data.

The draft aggregated task list was reformatted as a data collection form for use by other rural or remote teams in the review activity (see below).

2. Task decision aggregation and analysis

Following completion of the Task Analysis stage of the Calderdale Framework, project sites submitted their final master task list to GNARTN. The Task Analysis stage produced the decisions regarding appropriateness of each task for delegation or skill sharing to other team members. All sites also made minor revisions to their task list from that which was submitted following Service Analysis. Aggregation of this data involved:

1. Amendments to the aggregated task list

Changes to the aggregated task list were made if additional information was available from project sites about tasks e.g. further information in task descriptions, additional tasks that had not been included in draft list.

2. Aggregation of task decisions

Tasks were listed as potentially able to be skill shared or delegated if one or more sites identified that to be the case. Some data indicated only a component of the task should be skill shared or delegated, either in the comments section of the data collection tool or in the construction of the task description. Where this was the case, the profession that would take on the skill share task was listed as “skill share (relevant profession) – component” on the aggregated task list. All delegated tasks were understood to be limited in scope to the components of the task that are consistent with a delegated practice model of care (see [Appendix M](#)).

3. Checking process

The aggregated task list was provided to four project site teams by email and feedback was invited. Due to delays in receiving the project data from one site, and consequent delays in completing the analysis, the timeframe for this checking process was only one week. It is acknowledged that this was not adequate for a good quality review by busy rural and remote teams with significant outreach travel commitments. For individual tasks or collections of tasks that had been difficult to aggregate or otherwise interpret, specific feedback was sought from the relevant professionals. The feedback was received by email comments or through a short interview which was audio recorded (with consent of participants).

Review activity

Four additional rural or remote allied health services were recruited to contribute to the review of the draft aggregated task list. The purpose of the review activity was to assess the representativeness and comprehensiveness of the task list data from the five project sites. Note: the review activity related to the descriptive aspects of the task and not the decision to skill share or delegate the task.

Review sites were provided with the draft aggregated task list in the form of a checklist data collection form. Participating allied health professionals in the review site teams logged all clinical tasks they undertook in a 10-day period and matched them to the draft task list. As the data collection period was only 10 days in duration, participants could also note approximate frequencies for task that they do usually undertake as part of their role, but which did not occur during the data collection period (e.g. low frequency tasks). Participants could also record tasks that they undertook but which were not listed on the draft task list.

Data from the review activity was compiled by profession. Task frequency was averaged for professions with more than one participant and recorded using the same categories of high, moderate or low used in the task list aggregation. Additional tasks were compiled and examined. In the analysis of the task list, the review site data was compared with the data from the project sites, particularly with regard to tasks performed by project sites and not review sites and vice versa.

Appendix D – Calderdale Framework

The Calderdale Framework was developed in the United Kingdom by two physiotherapists, Rachael Smith and Jayne Duffy, while working in Calderdale and Huddersfield NHS Foundation Trust. Smith and Duffy now own the rights to the Calderdale Framework (Effective Workforce Program) and trade as a limited company, Effective Workforce Solutions. The Calderdale Framework (CF) has been used and evaluated in many allied health services in the United Kingdom for more than a decade. The Calderdale Framework was purchased by the Allied Health Professions' Office of Queensland in 2011 and has been rolled out in several dozen projects in the Queensland Public Health System since that time, including several in rural or remote allied health services.

The Calderdale Framework is a 7-step process used to the workforce aspects of a team's model of care. It is a comprehensive clinician-lead process, which is focused on delivering patient centred care. It is driven by the team, with a Calderdale Framework trained Facilitator providing support with each step. The two main uses of the CF in a health service team are to scope, design, implement, evaluate and monitor:

1. a delegation model for assistants and other support workers
2. a workforce model for skill sharing across professions in the team.

The Rural & Remote Generalist: Allied Health Project involved the implementation of the first three stages of the Calderdale Framework as part of the funded project. The project site coordinators were fully trained in the Calderdale Framework, allowing their team to engage in the last four stages of the process, and implement changes to their workforce model if they wish to do so.

The Calderdale Framework components utilised for the Rural & Remote Generalist: Allied Health Project were:

- training of the Project Site Coordinator as Calderdale Framework Facilitators
- a one-day 'foundation' training program provided by the project site coordinator and GNARTN project officer to the team
- Stage 1: Awareness raising meetings with key stakeholders
- Stage 2: Service Analysis
 - o Service analysis meeting/s as a team
 - o Individual practitioners mapped current clinical tasks undertaken as part of normal work and present information related to each task (task description, frequency)
 - o Production of a draft task list reflecting clinical functions and tasks undertaken by all members of the team
- Stage 3: Task Analysis
 - o Task analysis meeting/s as a whole team and/or as smaller groups using a ten-point risk analysis tool to determine if each task is appropriate for skill sharing or delegation

- o Production of a final task list, including decision about which members of the team can / should undertake the task, assuming training, governance and other supporting processes are implemented.

Components that sit outside the scope of the Rural & Remote Generalist: Allied Health Project (and therefore may be implemented at the discretion of the project site)

- Stage 4: Competency development for tasks determined by the team to be implemented as skill sharing and/or delegation
- Stage 5: Supporting systems. Identifying, developing and implementing changes to processes within the team to support the new workforce model.
- Stage 6: Training of relevant staff
- Stage 7: Evaluation of the change to the model of care

Further information:

- Effective Workforce Solutions: <http://effectiveworkforcesolutions.com/>
- Smith R and Duffy J. (2010). 'Developing a competent and flexible workforce using the Calderdale Framework'. Int J Ther Rehabil 17(5); 254-262.
- Kaltner M, Wilson J, Scott A (2012). The Calderdale Framework: Shared Competencies and Delegation Practice. Health Workforce Australia Workforce Innovation Database. At: <http://www.workforce.org.au/media/232418/kaltner,%20wilson%20&%20scott%20wic%20v2.pdf>.
- Nancarrow S, Moran A, Wiseman L, Pighills AC, Murphy K (2012) Assessing the implementation process and outcomes of newly introduced assistant roles: a qualitative study to examine the utility of the Calderdale Framework as an appraisal tool. Journal of Multidisciplinary Healthcare, 5:307-317. At: <http://www.dovepress.com/assessing-the-implementation-process-and-outcomes-of-newly-introduced--peer-reviewed-article-JMDH>
- Queensland Government projects using Calderdale Framework: <http://www.health.qld.gov.au/ahwac/docs/min-taskforce/initiatives.xls>
<http://www.health.qld.gov.au/ahwac/docs/min-taskforce/ahaprojectphase2.pdf>
<http://www.health.qld.gov.au/ahwac/docs/moc-list-11-13-proj.pdf>

Appendix E – task list

The primary deliverable of the project was an aggregated task list drawn from the data collected at the five project sites. The full task list is provided in Attachment 1. Attachment 2 presents a summary task list that includes task codes, titles, descriptions, number of sites identifying the task and average task frequency.

The breakdown of the task list by profession, frequency and clinical area is provided in this appendix. It should be noted that the task list reflects:

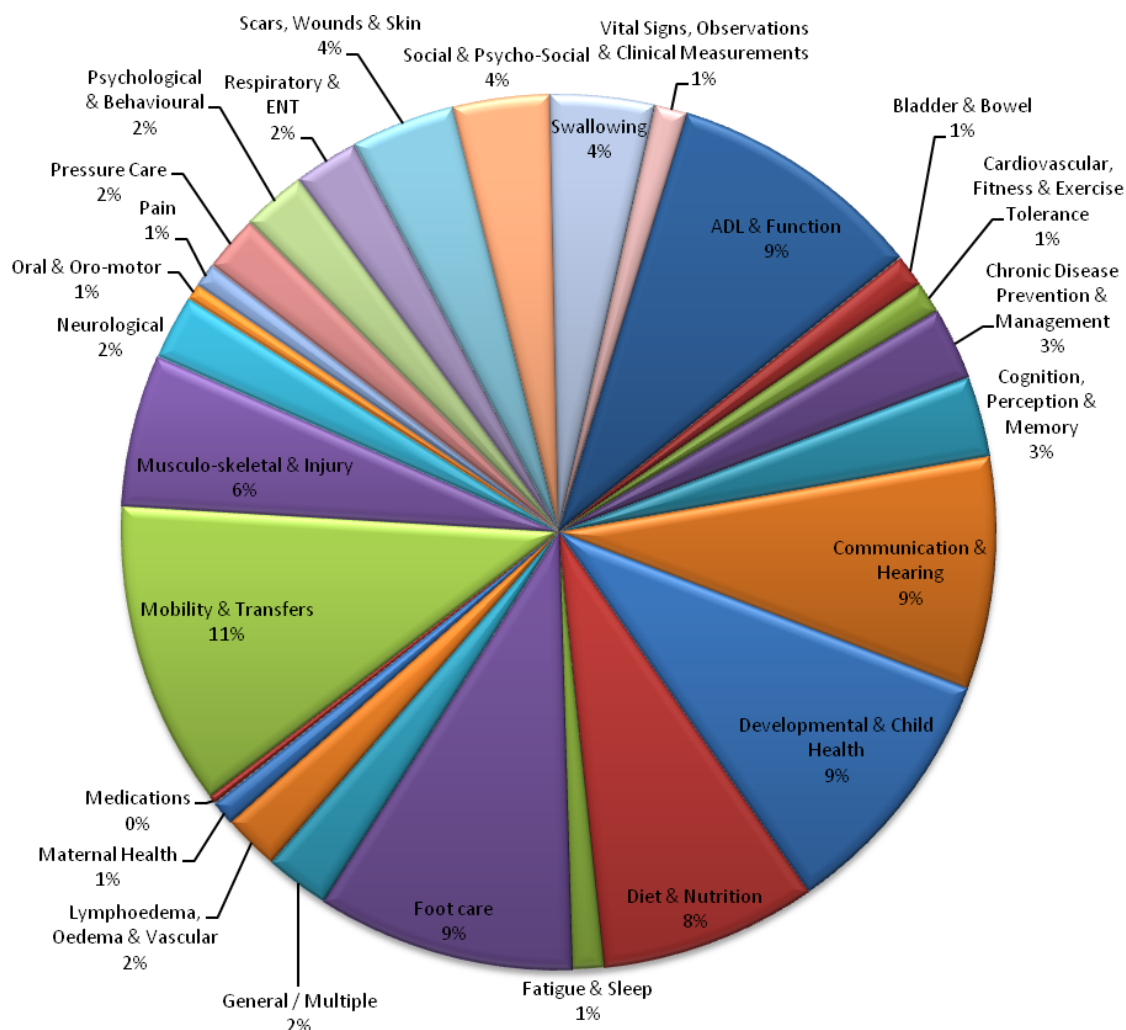
- the professions present and service models in the project sites
- differences between clinical areas and professions in amenability to fractioning clinical services into discrete tasks. For example, a significant proportion of ADL & Function and Mobility & Transfer tasks relate to different equipment/aids. Similar discrepancies between clinical areas in terms of task numbers, particularly between physical rehabilitation areas and psycho-social areas, have been noted in previous projects using the Calderdale Framework in Queensland.
- the purpose of the Calderdale Framework as a tool for development of training and competencies to support delegation or skill sharing. This weights the task identification (service analysis stage) to dividing up tasks that are more procedural in nature (that would subsequently form a discrete competency) and combining more complex related clinical activities into a single task as it is less likely to be skill shared or delegated.
- the GNARTN project officer's views on the clustering of clinical tasks based on previous experiences using the Calderdale Framework in workforce re-design projects.

Importantly, it should be recognised that the number of clinical tasks does not directly reflect the time attributable to the clinical area in the allied health teams' service models. This could only be examined by a time-in-motion study, which was not in scope for this project.

Current tasks by clinical area

The aggregated clinical task list comprises 337 tasks. The tasks were clustered into 25 clinical areas. The breakdown of the task list by clinical areas is shown in Figure 1 on the next page.

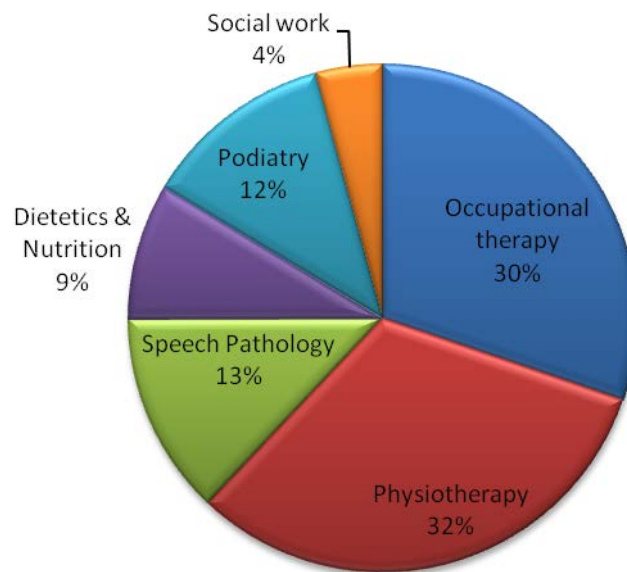
Figure 1. Aggregated task list by clinical area (n=337)



Current tasks by allied health profession

The breakdown of tasks by profession in Figure 2 includes tasks each profession currently provides in one or more of the project sites. It includes tasks that the site data indicates the profession undertakes to the full scope outlined in the task description (see Attachment 2). It also includes tasks that the data indicates a profession undertakes to only part of the scope or not consistently across all relevant project sites.

Figure 2. Aggregated task list by profession

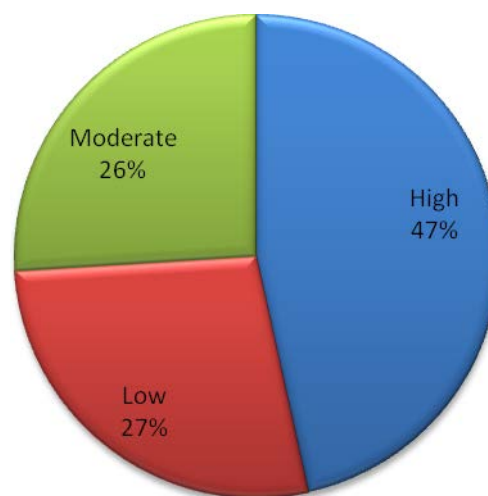


Current tasks by frequency

Task frequency was captured by all project sites and average frequency was recorded in the aggregated task list using the following categories:

- High frequency Task occurs at least once a week
- Moderate frequency Task occurs less than weekly but more than monthly
- Low frequency Task occurs monthly or less frequently

Figure 3. Aggregated task list by average task frequency



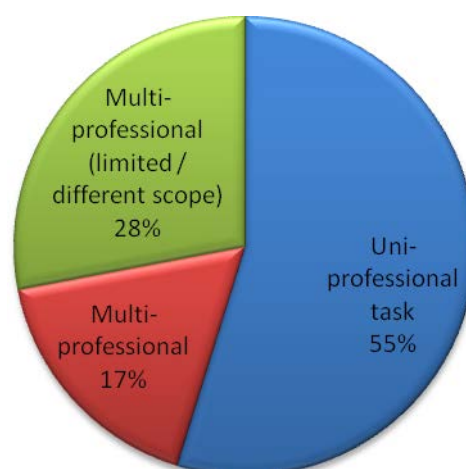
Appendix F – skill shared & multi-professional clinical tasks

Current clinical tasks

One hundred and fifty nine (159) tasks currently undertaken by project site teams were indicated to be multi-professional; that is, undertaken by more than one profession. The term “multi-professional” encompasses tasks that are within the usual scope of practice of more than one profession, and also tasks that are skill shared. An example of the former is lymphedema management, for which both physiotherapy and occupational therapy can provide the same tasks as part of the professions’ accepted scope of practice. Skill shared tasks are those which a practitioner undertakes with additional training, competency assessment and clinical governance, but which generally do not sit in the scope of practice of their profession. Tasks were further divided into those that project site data indicated the relevant professions provided with the same or similar scope of the task, and those that were provided with different scope of the task by different professions (generally because one or more professions provided only some of the component activities listed in the task description).

In the list of tasks currently provided by practitioners in project sites, it is not possible to definitively identify if a task is multi-professional because it is within the accepted scope of practice of both professions or if it has been skill shared between professions at the local level. There was little value in trying to establish this in the data collection as it is a matter of interpretation. There is no single list of tasks that are ‘in scope’ and ‘outside scope’ of each allied health profession to cross-reference project data against. Professional entry standards for allied health professions, for obvious pragmatic reasons, are not presented as exhaustive task lists, but rather as broader areas of professional competence. Essentially, the task list for this project can only present whether tasks are currently undertaken by one profession, more than one profession to the same/similar extent or by more than one profession to a different extents or not consistently between relevant sites. How a task came to be provided by more than one profession in a project site sits outside the scope of this project to address.

Figure 4. Task list by profession/s currently delivering task

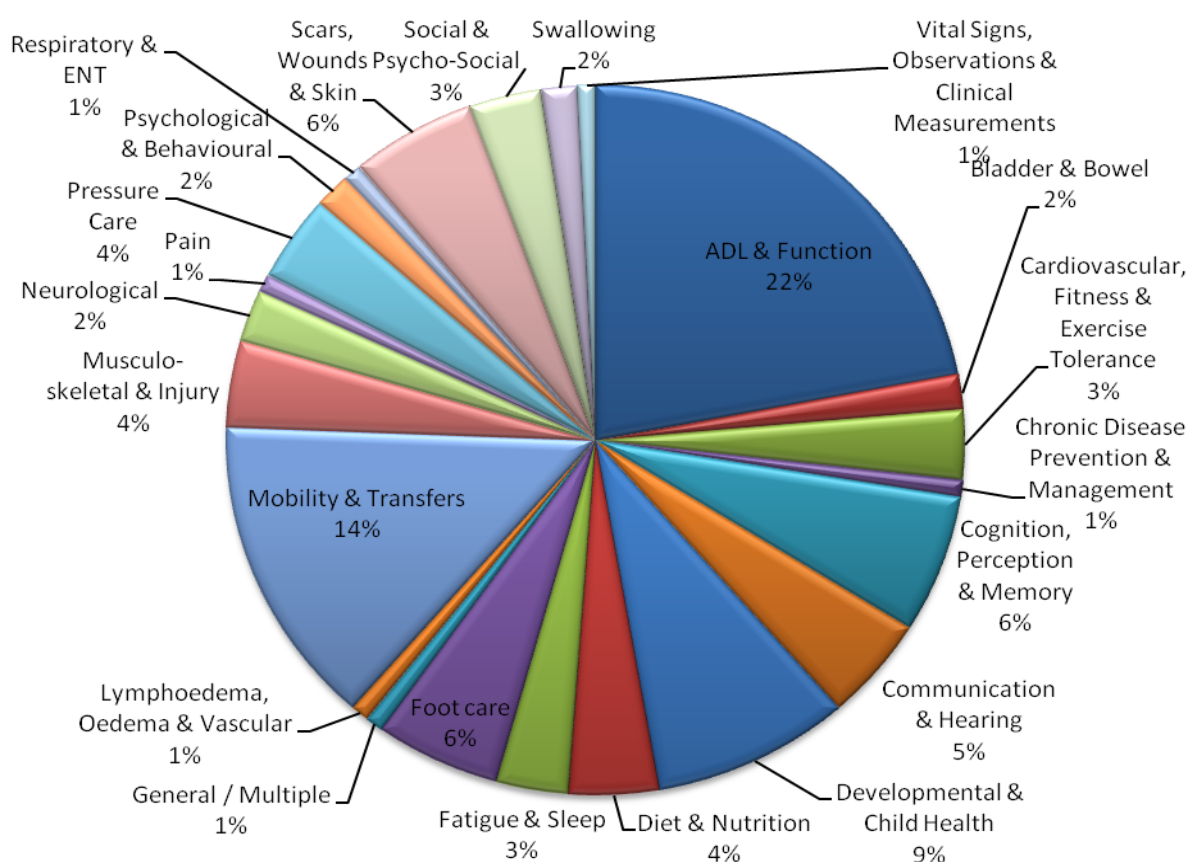


Proposed skill sharing

One hundred and twenty-seven (127) of the total 337 tasks were identified as potentially appropriate for skill sharing between one or more allied health professions. In general, a task was listed as appropriate for skill sharing in the aggregated task list if a minimum of one site determined it to be so. As part of the data collection process, sites indicated the profession/s that would be most appropriate to skill share to (i.e. to undertake training in the task), considering potential benefits for clients and weighing the potential efficiency impacts for the service in terms of training time investment, service access and activity consequences, particularly for outreach services.

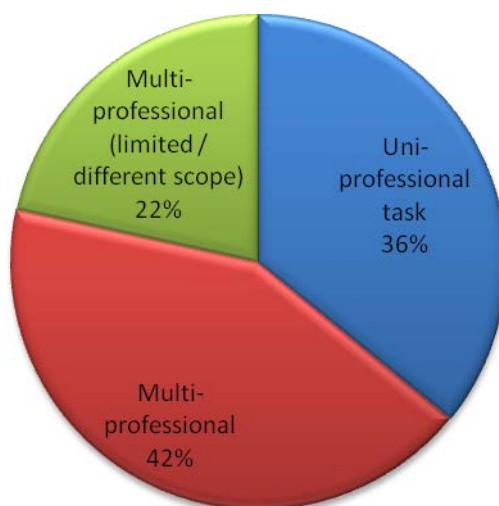
It should be noted that many of the decisions to skill share relate to tasks that are already multi-professional in at least one site. That is, a team could decide to skill share a task that is already provided to some extent by other professions with the intent of expanding the scope of the task provided by existing professions, expanding the skill sharing to other profession/s, or in order to better structure and support the informal skill sharing that already takes place in the team. Seventy-six of the 127 tasks identified for skill sharing (60%) were already listed as multi-professional tasks (full or part scope of task) in the current models of care. The breakdown of tasks identified for potential skill sharing by clinical area is shown in Figure 5 below.

Figure 5. Skill share decisions by clinical area (n=127)



Combining existing multi-professional tasks and skill sharing decisions, the composition of the full task list is shown in Figure 6. Two hundred and one (201) of 329 tasks (64%) would be multi-professional (part or full extent of task). Note: eight tasks, primarily those in the Generic / Multiple clinical area did not have a decision recorded as they were judged to be core professional functions e.g. triage, clinical prioritization, hence total n=329.

Figure 6. Task list composition if all skill sharing decisions were implemented (n=329)



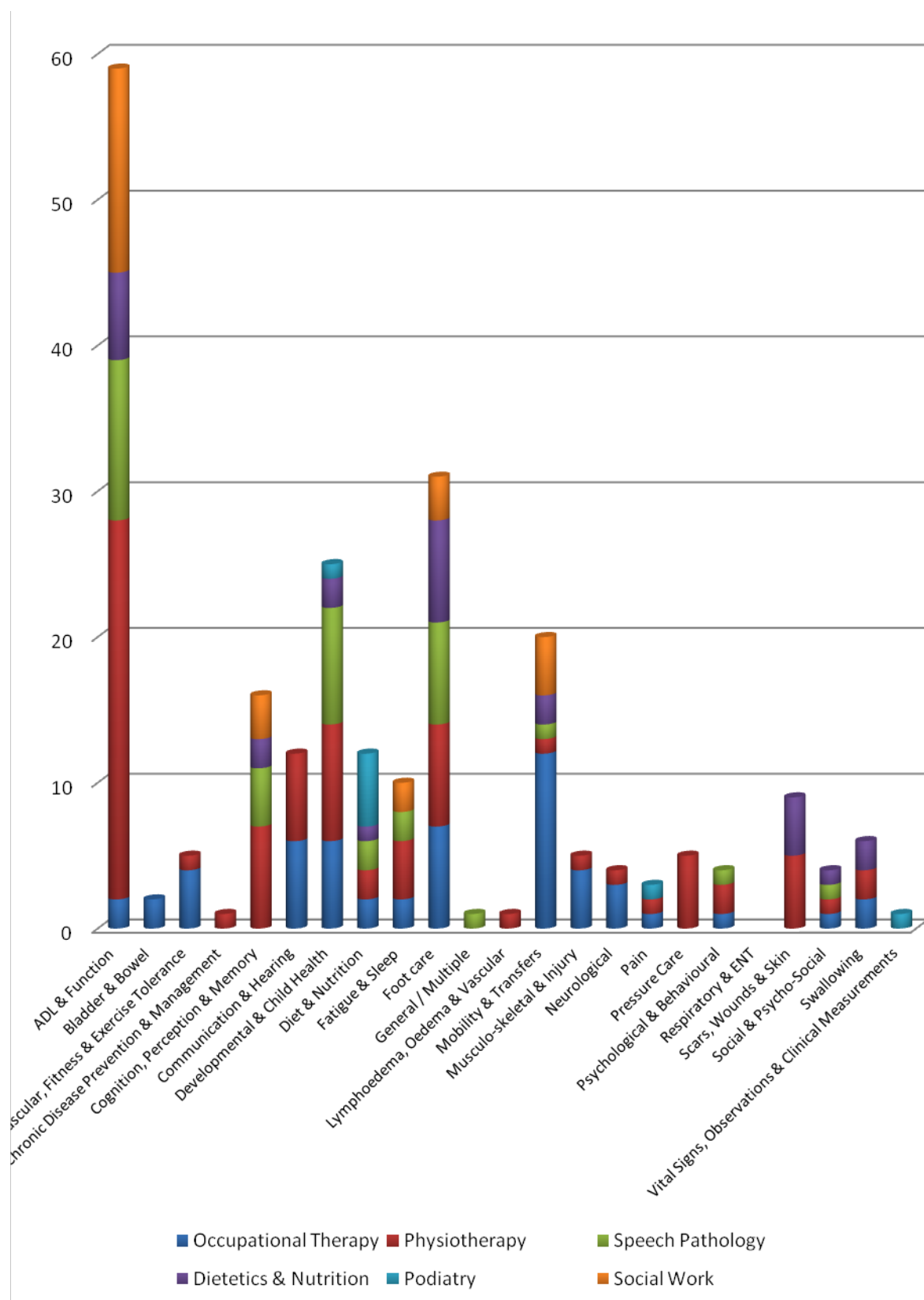
Comparing Figure 4 and Figure 6, the change in composition of the clinical service model towards greater multi-professional delivery of tasks has been effected both by skill sharing some previously uni-professional tasks and by expanding the extent of the task already delivered by more than one profession to some degree. This was also captured in the analysis of the site data. Information in project site task lists, including comments and task descriptions, were used to classify a skill share decision as either “Skill share – expand current delivery of task” or “Skill share – new skill”. Information in the data collection forms was augmented by the project officer from knowledge of professions’ general scope of practice. The findings indicated that 80 tasks were to be shared through expanding existing skills, and 67 through acquiring new skills or undertaking more significant learning. Note that the total, 147 is greater than the total number of skill share tasks as some tasks could be both skill shared (expanded) to some professions and skill share (new) to others. These findings may indicate:

- Existing levels of skill sharing are relatively high in the project site rural or remote teams, and so skill sharing is more likely through expansion of the existing extent of task delivery
- Teams’ marginal analysis of time and resource costs required to train staff and change practice versus potential service activity / access gains favours expansion of already existing skills over training practitioners in skills for which they have less underpinning knowledge. This point is supported by the finding that 84 of 127 tasks (66%) proposed for skill sharing include two professions, occupational therapy and physiotherapy. These professions have greater consistency in underpinning professional knowledge and skill sets than most other allied health professions. They were also represented in more project sites and had the greatest staffing

establishments of the professions included in the project, which would have also contributed to the finding.

The breakdown of tasks proposed for skill sharing by clinical area and profession is shown in Figure 7 on the next page. This chart reflects both the number of tasks in the clinical area proposed for skill sharing and the breadth of the skill sharing across allied health professions. That is, the columns present the sum of the number of tasks that could be skill shared to each individual profession, by clinical area. This chart provides an indication of the high priority tasks for translation into training programs and skill sharing models of care. It should be noted that this chart does not reflect the existing multi-professional practice between professions, only the decisions of the project site teams in the task analysis stage of their projects.

Figure 7. Proposed skill share tasks and allied health professions that could be trained to provide task, by clinical area (n=127)



Skill sharing task clusters

The project findings show clusters of related tasks that are identified as appropriate for skill sharing in rural and remote allied health teams. The clusters are logical groupings for translation of the project findings into clinical training programs for rural and remote allied health professionals. Although generated by teams examining skill sharing potential between two or more specific professions in their establishment, and even more specifically between two or more team members, the general themes of task clusters are informative when considering generalist training requirements.

Some clusters also have smaller groupings of tasks, shown as dot points below. The clinical tasks associated with each cluster are presented in Attachment 13.

Cluster 1: Activities of daily living (ADL) and function

- ADL screening and assessment
- Assessing and prescribing home modifications
- Equipment - ADLs and Function
- Functional training - activities of daily living

Cluster 2: Mobility and transfers

- Mobility assessment
- Balance and falls risk assessment
- Mobility aids
- Functional training - mobility and transfers

Cluster 3: Prevention of foot morbidity in high risk groups

Cluster 4: Children's development

- Developmental assessment
- Therapy program - developmental
- Plagiocephaly

Cluster 5: Cognition & perception

- Cognition assessment and interventions
- Perception assessment and intervention

Cluster 6: Communication

- Communication screening and basic assessment
- Communication education and basic therapy

Cluster 7: Psycho-social

- Psycho-social screening
- Screening for psychological morbidity

Cluster 8: Fatigue, sleep and energy conservation

Cluster 9: Pressure care, skin and wounds

- Pressure care screening
- Pressure care equipment and education
- Basic wound assessment and review
- Burns and wounds self-management program and patient education

Cluster 10: Diet and nutrition

- Diet & nutrition screening, assessment and education / bridging intervention
- Home enteral nutrition

Cluster 11: Neuro-musculoskeletal and pain

- Musculo-skeletal assessment and management
- Basic functional assessment and training for neurological conditions
- Pain assessment

Cluster 12: Cardiovascular, Fitness & Exercise Tolerance

Cluster 13: Continence assessment and basic intervention

Appendix G – occupational therapy findings

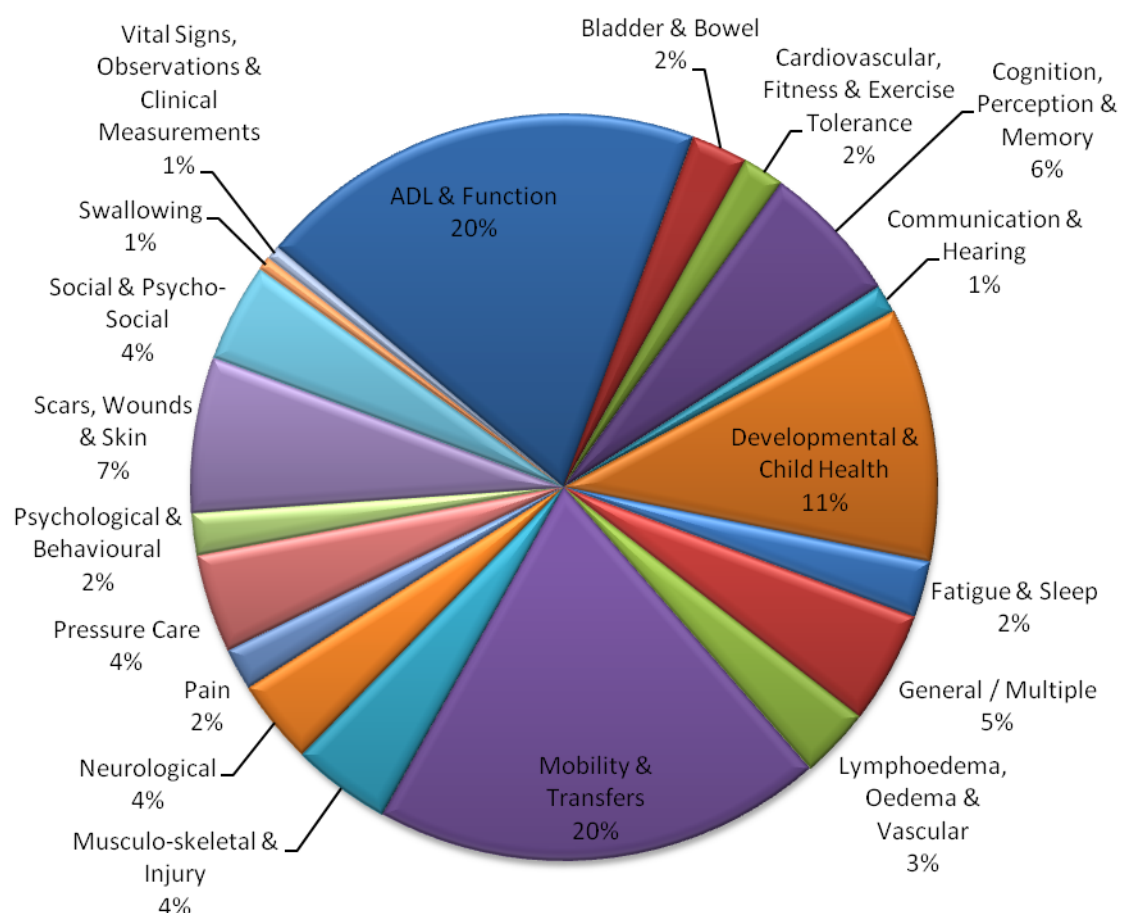
Sample

Occupational therapists participated in data collection in four project sites. The staffing at one site was 1FTE, at two sites was 2FTE and at one site was 5FTE. All occupational therapists worked in teams that had an allied health assistant. No occupational therapists participated in the review activity.

Current clinical tasks

Occupational therapy tasks were spread across 19 clinical areas and concentrated in ADL & Function, Mobility & Transfers and Developmental & Child Health. Occupational therapists were identified as delivering the full scope of 125 tasks, and a component of a further 39 tasks. A summary of the current tasks delivered is shown in Figure 8 below and in more detail in the task list in Attachment 4.

Figure 8. Occupational therapists current tasks by clinical area (full scope and components of tasks) (n=164)



Twenty-six tasks (20% of full scope tasks) undertaken by occupational therapists were identified as uni-professional in the current models of care.

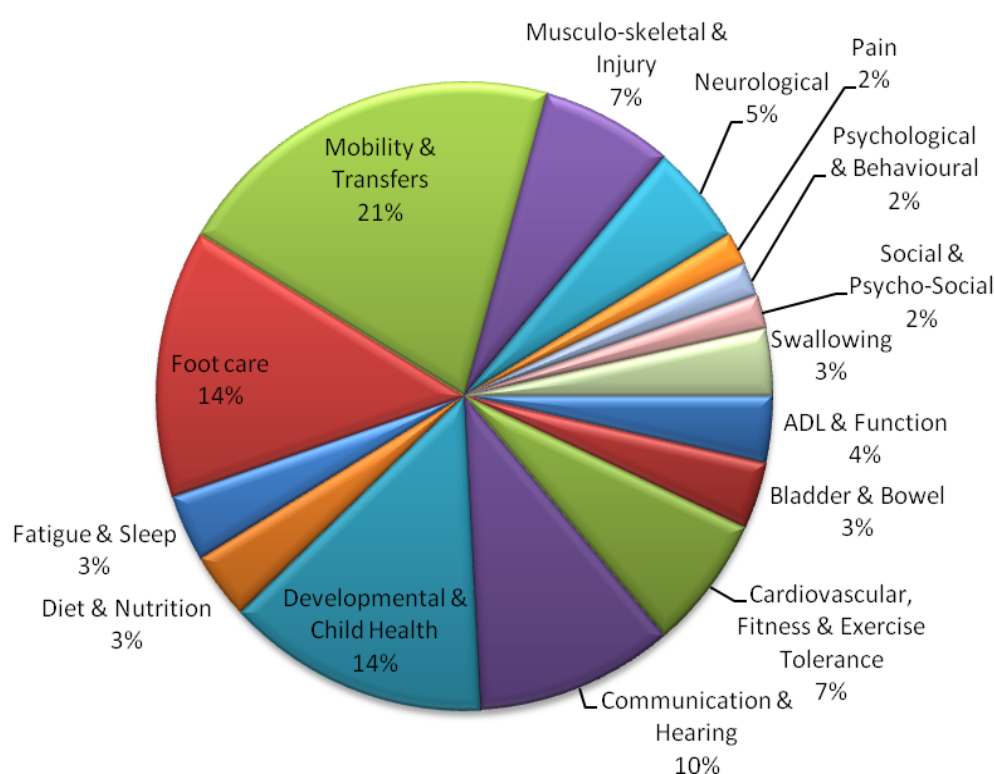
Occupational therapists in the project sites delegated 16 tasks (13% of full scope tasks) to allied health assistants in the current models of care.

Findings from task analysis

Sixty-five tasks were identified as appropriate to skill share (at least in part) from occupational therapy to other allied health professions. Twenty-seven of these related to ADL assessment, limited scope training and equipment prescription and supply by other professions. This group of tasks primarily included skill sharing to physiotherapists, who already undertake components of most tasks, in order to expand the existing scope of the service provided by physiotherapy. Cognition screening and pressure care screening and basic assessment were also a key area for skill sharing. If all tasks identified as sharable were implemented, 4 tasks would remain uni-professional occupational therapy tasks.

In total 58 tasks were identified as appropriate to skill share from other allied health professions to occupational therapy (36 as the full scope of the task and 22 as a component of the task). These were across a range of clinical areas as shown in Figure 9.

Figure 9. Tasks proposed for skill sharing from other allied health professions to occupational therapy (full or scope of task or component of task) by clinical area (n=58).



Task analysis identified 68 tasks currently provided by occupational therapists in project sites were appropriate for delegation to an allied health assistant (54% of full scope tasks).

Findings from the review activity

No occupational therapists participated in the review activity.

Appendix H – physiotherapy findings

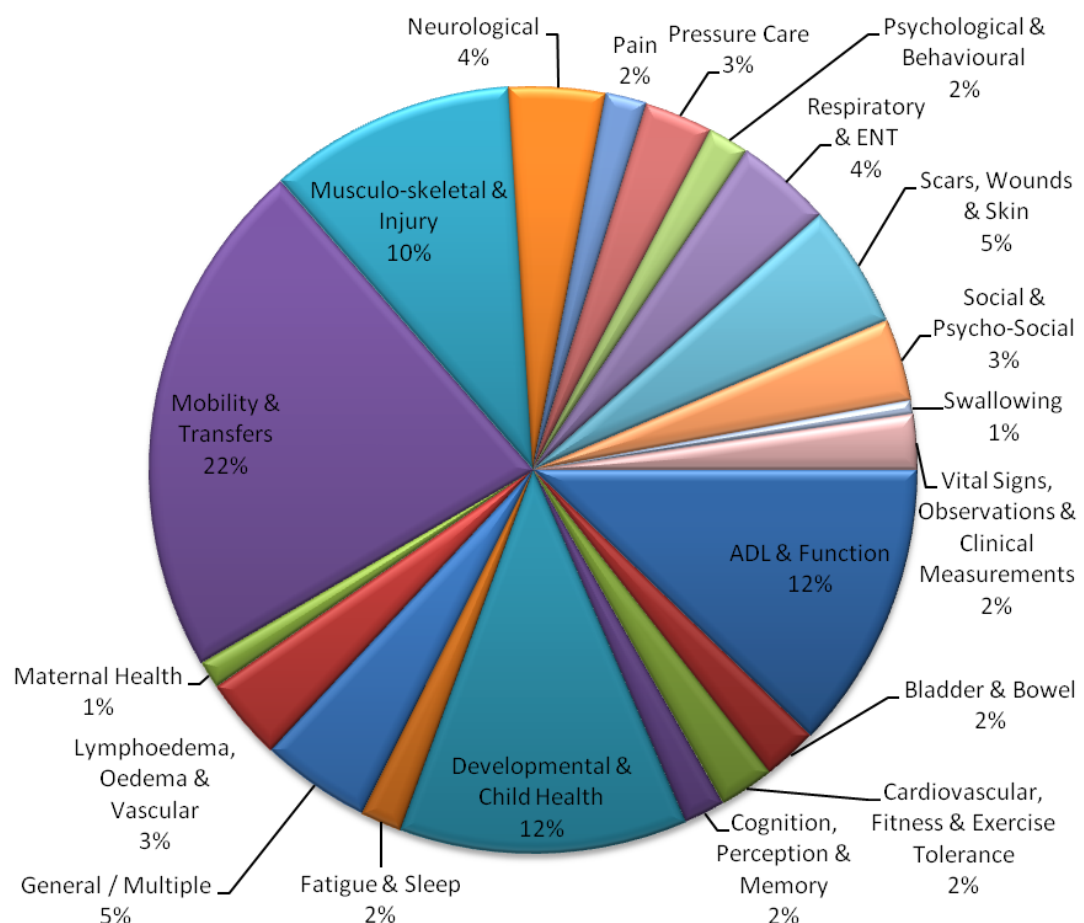
Sample

Physiotherapists participated in data collection in four project sites. The staffing at two sites was 1FTE, at one site was 2FTE and at one site was 4FTE. All physiotherapists worked in teams that had an allied health assistant. One physiotherapist from a remote area service participated in the review activity.

Current clinical tasks

Physiotherapy tasks were spread across 21 clinical areas and concentrated in ADL & Function, Mobility & Transfers, Musculo-skeletal & Injury, and Developmental & Child Health. Physiotherapists were identified as delivering the full scope of 125 tasks, and a component of a further 48 tasks. A summary of the current tasks delivered is shown in Figure 10 below and in more detail in the task list in Attachment 5.

Figure 10. Physiotherapists current tasks by clinical area (full scope and components of tasks) (n=173)



Thirty-two tasks (26% of full scope tasks) undertaken by physiotherapists were identified as uni-professional in the current models of care.

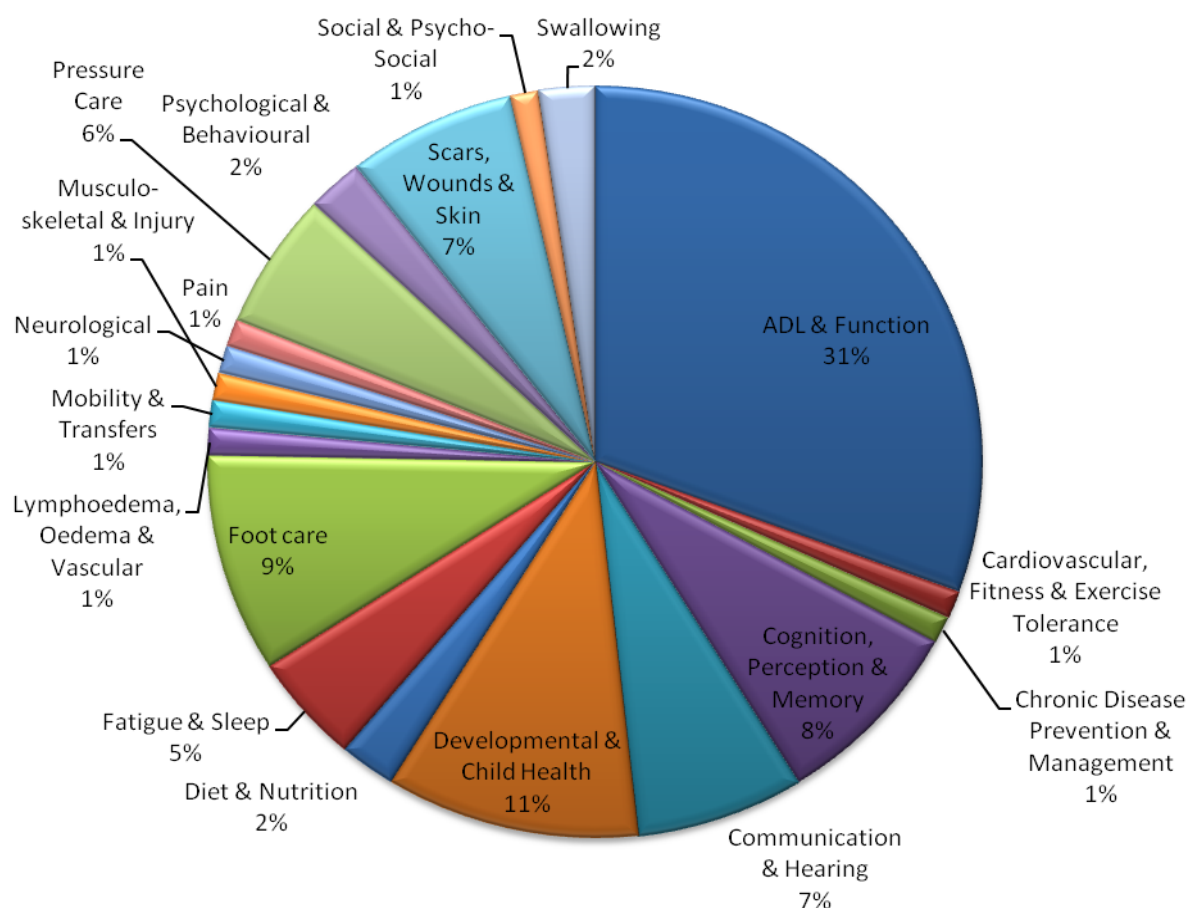
Physiotherapists in the project sites delegated 32 tasks (26% of full scope tasks) to allied health assistants in the current models of care.

Findings from task analysis

Forty-three tasks were identified as appropriate to skill share from physiotherapy to other allied health professions. This was primarily skill sharing with occupational therapy to expand existing part-shared tasks. This is evidenced by a reduction of only five currently uni-professional physiotherapy tasks (to 27 or 22% of full scope tasks) if all skill share decisions were implemented. The uni-professional tasks mostly relate to more complex neuro-musculo-skeletal assessment and intervention, and respiratory assessment and intervention.

In total 85 tasks were identified as appropriate to skill share from other allied health professions to physiotherapy (63 as the full scope of the task and 22 as a component of the task). These were across a range of clinical areas as shown in Figure 11.

Figure 11. Tasks proposed for skill sharing from other allied health professions to physiotherapy (full or scope of task or component of task) by clinical area (n=85).



Task analysis identified that 52 tasks currently provided by physiotherapists in project sites were appropriate for delegation to an allied health assistant (42% of full scope tasks).

Findings from the review activity

The method and limitations of the review method are discussed in [Appendix P](#). The findings of the review activity for physiotherapy were as follows:

- Thirty tasks were identified by the project sites that were not identified in the review activity (equivalent to 17% of current physiotherapy tasks). As four project sites (one hospital, two outreach and one mixed service) included physiotherapy data collection and only one review site, this variance is explainable primarily by the sample sizes.
- Nine tasks were identified by the review activity, from those listed on the aggregated task list, as being performed by physiotherapy that were not identified by the project site data collection (equivalent to 5% of current physiotherapy tasks). Six of these tasks relate to foot care and consequently, probably reflect the service model in the review site which includes greater foot care responsibility of the physiotherapist.
- No additional clinical tasks, beyond those already in the full task list, were identified by the physiotherapist contributing to the review activity.

Appendix I – speech pathology findings

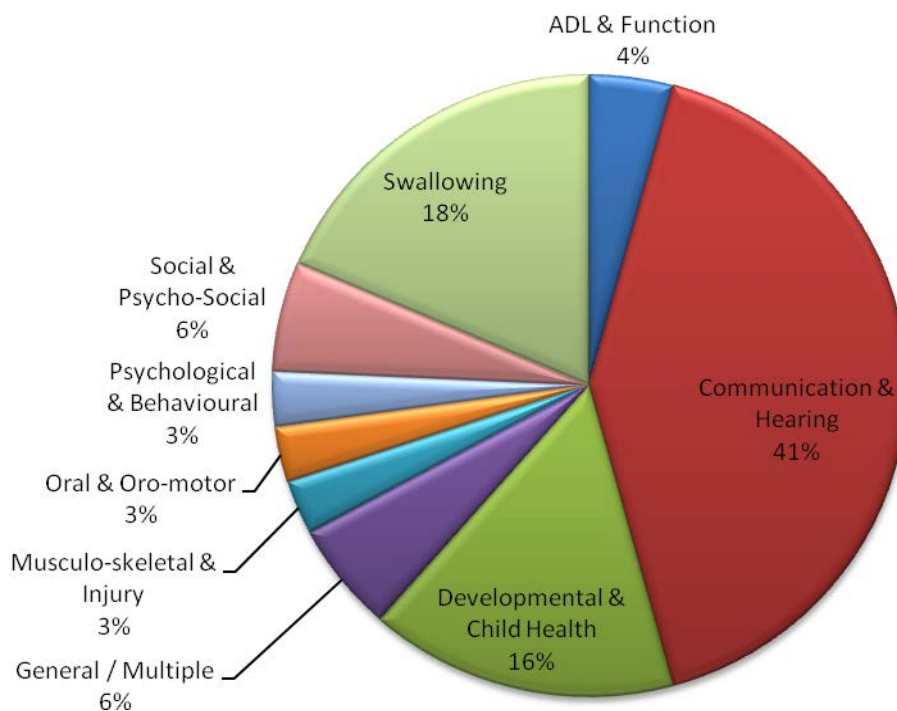
Sample

Speech pathology participated in data collection in three project sites. The staffing at one site was 1FTE and at two sites was 2FTE. All speech pathologists worked in teams that had an allied health assistant. Three speech pathologists from two remote services participated in the review activity.

Current clinical tasks

The majority of the clinical tasks undertaken by speech pathologists were in the Communication & Hearing (29) and Swallowing (13) and Development & Child Health (11) clinical areas. Speech pathologists were identified as delivering the full scope of 54 tasks, and a component of a further 16 tasks. A summary of the current tasks delivered is shown in Figure 12 below and in more detail in the task list in Attachment 6.

Figure 12. Speech pathologists current tasks by clinical area (full scope of task) (n=70)



Forty-two tasks (78% of full scope tasks) undertaken by speech pathologists were identified as uni-professional in the current models of care.

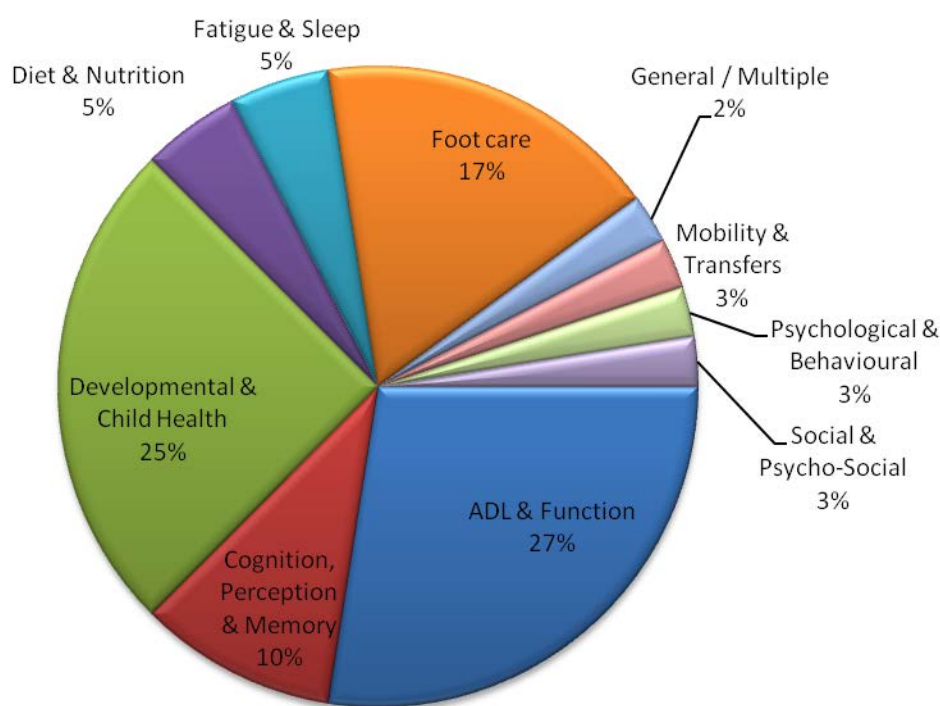
Speech pathologists in the project sites delegated six tasks (11% of full scope tasks) to allied health assistants in the current models of care; [CH18] Therapy program - speech (articulation and phonology), [CH19] Therapy program - speech (oro-motor), [CH21] Therapy program - phonological awareness/ pre-literacy skills, [CH22] Therapy program – literacy, [CH29] Compensatory communication strategies (communication partner), and [DV32] Behavioural Intervention - developmental / paediatric.

Findings from task analysis

Ten tasks were identified as appropriate to skill share from speech pathology to other allied health professions, primarily communication and swallowing screening / basic assessment. If all proposed skill sharing was implemented, 35 speech pathology tasks would remain uni-professional, mostly related to more complex assessment of communication and swallowing disorders and most interventions. Protocol-supported intervention programs, used primarily as bridging intervention between skill shared assessments and the initial comprehensive assessment by the speech pathologist has been identified in other Calderdale Framework projects in Queensland as appropriate to skill share, particularly with other rehabilitation professions. Few interventions were identified for skill sharing in the Communication & Hearing clinical area in this project. This should be examined further in the validation activity as a corollary of skill sharing screening and assessment tasks.

In total 40 tasks were identified as appropriate to skill share from other allied health professions to speech pathology (19 as the full scope of the task and 21 as a component of the task). These were across a range of clinical areas as shown in Figure 13.

Figure 13. Tasks proposed for skill sharing from other allied health professions to speech pathology (full or scope of task or component of task) by clinical area (n=40).



Task analysis identified that 19 tasks currently provided by speech pathology in project sites were appropriate for delegation to an allied health assistant (35% of full scope tasks).

Findings from the review activity

The method and limitations of the review method are discussed in [Appendix P](#). The findings of the review activity for speech pathology were as follows:

- Seven tasks were identified by the project site that were not identified by the review activity (equivalent to 10% of current speech pathology tasks); [CH28] Sign language education and training, [OM02] Therapy program - oro-motor strengthening, ROM and awareness, [PB03] Assessment – stress, [PB06] Education - stress management, [SP05] Assessment - carer burden, [SW04] Instrumental assessment - swallowing (Videofluoroscopy), and [SW10] Education - compensatory swallowing strategies.
- Six tasks were identified by the review activity, from those listed on the aggregated task list, as being performed by speech pathology that were not identified by the project site data collection (equivalent to 9% of current speech pathology tasks). These tasks are almost all screening / basic assessments and probably relate to a multi-disciplinary screening process of one of the review site teams.
- Three clinical tasks were added to the task list by a reviewer. These tasks were also represented in the WACHS data that had not been available when the review activity task list was developed. However, they were integrated into the final task list. Consequently, all tasks contributed by the reviewing speech pathologists are reflected in the final aggregated task list.

Appendix J - dietetics & nutrition findings

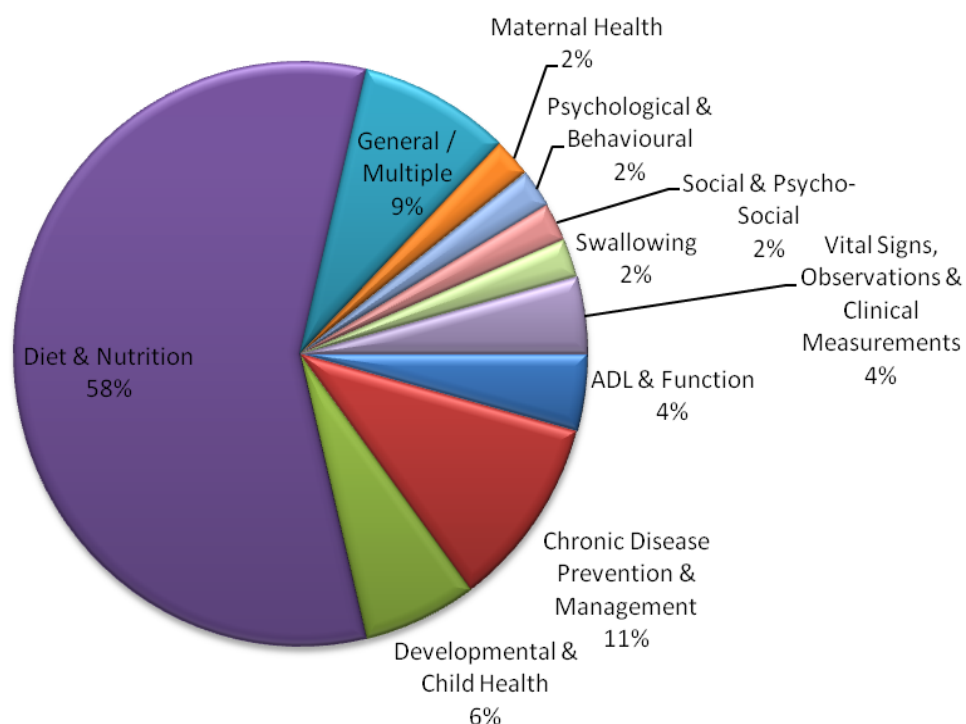
Sample

Dietitian/nutritionists participated in data collection in two project sites. The staffing at one site was 1FTE and the other site 5FTE plus the team leader. Dietitian/nutritionists worked in teams that had an allied health assistant. Four dietitian/nutritionists from two rural and one remote team participated in the review activity.

Current clinical tasks

The majority of the clinical tasks undertaken by dietitian/nutritionists were in the Diet & Nutrition clinical areas. Dietitian/nutritionists were identified as delivering the full scope of 42 tasks, and a component of a further five tasks. A summary of the current tasks delivered is shown in Figure 14 below and in more detail in the task list in Attachment 7.

Figure 14. Dietitian/nutritionists current tasks by clinical area (full or component of task) (n=47)



Twenty-nine tasks (69% of full scope tasks) undertaken by dietitian/nutritionists were identified as uni-professional in the current models of care, primarily in the Diet & Nutrition clinical area.

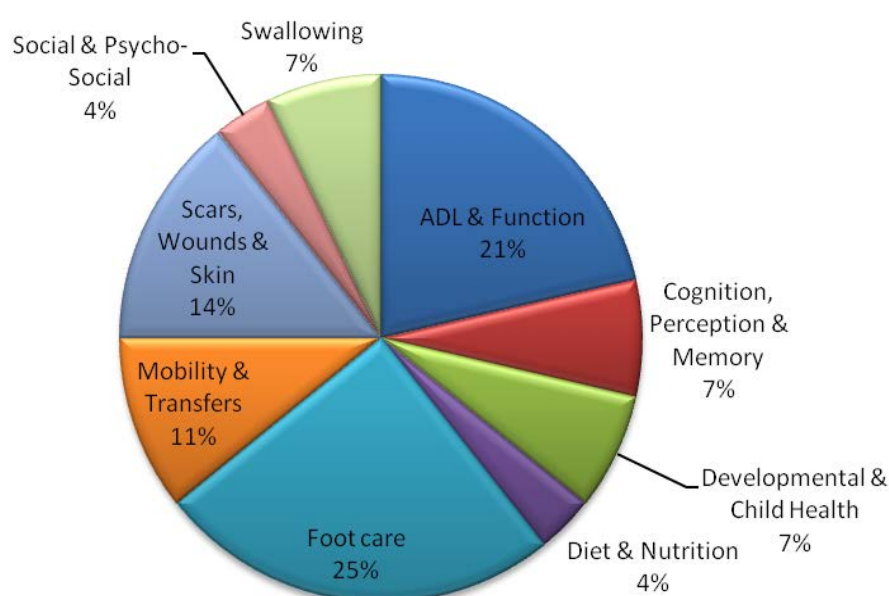
Dietitian/nutritionists in the project sites delegated three tasks (7% of full scope tasks) to allied health assistants in the current models of care, [DN13] Weight reduction / energy modified diet (individual), [DN25] Education (Group) - nutrition and healthy diet, [VS02] Weight, Height, BMI & Waist Circumference.

Findings from task analysis

Seven tasks were identified as appropriate to skill share from dietetics/nutrition to other allied health professions, [DV11] Assessment - developmental (child growth trends), [DN02] Screening Assessment - Malnutrition Screening Tool (MST), [DN03] Screening assessment - Subjective Global Assessment (SGA), [DN06] Assessment - diet history / nutritional intake, [DN09] Estimated Energy Requirements (EER), [DN24] Home enteral nutrition, [VS02] Weight, Height, BMI & Waist Circumference. If all proposed skill sharing was implemented, 17 dietetics/nutrition tasks would remain uni-professional, all related to more complex dietetics and nutrition assessment and intervention, particularly prescription of diet modification.

In total 28 tasks were identified as appropriate to skill share from other allied health professions to dietetics/nutrition (14 as the full scope of the task and 14 as a component of the task). These were across a range of clinical areas as shown in Figure 15.

Figure 15. Tasks potentially appropriate for skill sharing from other allied health professions to dietetics/nutrition (full or scope of task or component of task) by clinical area (n=28).



Task analysis identified that 13 tasks currently provided by dietetics/nutrition in project sites were appropriate for delegation to an allied health assistant (31% of full scope tasks).

Findings from the review activity

The method and limitations of the review method are discussed in [Appendix P](#). The findings of the review activity for dietetics/nutrition were as follows:

- Four tasks were identified by the project site that were not identified by the review activity (equivalent to 9% of current dietetics/nutrition tasks); [DV11] Assessment - developmental (child growth trends), [DN24] Home enteral nutrition, [DN27] Nutrition health promotion or health education program, [SP05] Assessment - carer burden.

- Seven tasks were identified by the review activity, from those listed on the aggregated task list, as being performed by dietetics/nutrition that were not identified by the project site data collection (equivalent to 15% of current dietetics/nutrition tasks). These tasks are almost all screening in nature and probably relate to a multi-disciplinary screening process of one of the review site teams.
- Three additional clinical tasks were contributed by dietitian/nutritionists in the review activity that were not stated in the same form in the preliminary aggregated task list;
 - o Post Bariatric Surgery - Provide patient with a tailored approach toward texture modification and food reintroduction
 - o IBS Management / IBS type symptom management - Provide tailored approach towards diarrhea/constipation/distention/abdominal pain/intolerances
 - o Nutrigenetics - Sampling and reporting on genetic analysis

The first two additional tasks may be incorporated into Task DN21: Education - nutrition (condition / disease specific). The third task is not represented in the aggregated task list. The task is performed with moderate frequency by one of the four participating dietitian/nutritionists in the review activity. It should be noted when considering the dietetics/nutrition task list findings.

Appendix K - podiatry findings

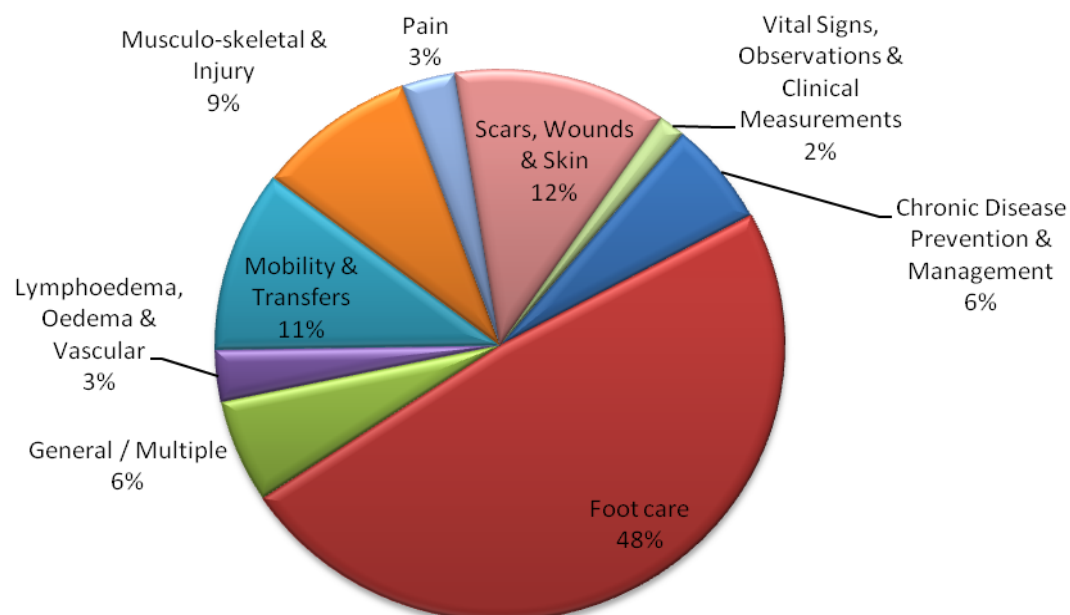
Sample

Podiatrists participated in data collection in one project site only. The podiatry staffing at that site included two podiatrists and one podiatry assistant. The podiatry data is therefore more highly influenced by a single service model than the other five target professions in this project, all of which had data collected at two or more sites. The project site was a community controlled health service with podiatrists practicing in a completely outreach (primarily FIFO) model. One podiatrist participated in the review activity and worked for a Medicare Local in a remote centre in Queensland.

Current clinical tasks

The majority of the clinical tasks undertaken by podiatry were in the Foot Care (32 tasks) clinical area. Podiatry was identified as delivering the full scope of 55 tasks, and a component of a further 11 tasks in the current model of care. Some of the tasks listed as 'component only' were related to the scope of the task description being broader than lower limb. A summary of the current tasks delivered is shown in Figure 16 below and in more detail in the task list in Attachment 8.

Figure 16. Podiatry current tasks by clinical area (full and part scope of tasks) (n=66)



Thirty-six tasks (55% of full scope tasks) undertaken by podiatry were identified as uni-professional in the current model of care. Podiatry delegates six tasks (9% of full scope tasks) to allied health assistants in the current model of care.

Findings from task analysis

Eight tasks were identified as appropriate to skill share from podiatry to other allied health professions, [FC02] Diabetes foot assessment, [FC03] Vascular assessment (foot & lower limb), [FC04] Neurological assessment (foot & lower limb), [FC08] Semmes Weinstein 10g monofilament test (foot & lower limb), [FC09] 128Hz Graduated Tuning Fork test (foot & lower limb), [FC31] Education - foot self care, [FC32] Education – Diabetes complications impact on lower limb, [MT05] Screening assessment – balance. If all proposed skill sharing was implemented, 28 podiatry tasks would remain uni-professional, primarily those related to complex foot care management.

Eight tasks were identified as appropriate to skill share from other allied health professions to podiatry. These were in the clinical areas of Developmental & Child Health (1 task), Diet & Nutrition (5 tasks), Pain (1) and Vital Signs, Observations & Clinical Measurements (1 task).

Following task analysis, 28 tasks were identified as appropriate for delegation to an allied health assistant (51% of full scope tasks).

Findings from the review activity

The method and limitations of the review method are discussed in [Appendix P](#). The outcomes for podiatry were as follows:

- Twelve tasks were identified by the project site that were not identified by the review activity (equivalent to 18% of current podiatry tasks).
- Thirteen tasks were identified by the review activity, from those listed on the aggregated task list, as being performed by podiatry that were not identified by the project site data collection (equivalent to 19% of current podiatry tasks). Some were in areas that would presumably be uncommon for podiatry generally including upper limb musculo-skeletal assessment and continence assessment. Consequently it is assumed that these related to a standardised multi-dimensional screening process present in the review site service.
- No additional tasks were contributed by the podiatrist in the review activity that were not present on the aggregated task list.

Limitations to interpretation of podiatry data

Only one project site had podiatrists involved in the task identification and analysis process. There was one podiatrist in the review activity. This reflects the relative size of the podiatry workforce in rural and remote areas, but means the findings for podiatry are more strongly influenced by the service model of a single team. Validation of tasks with other rural and remote podiatrists will be important to ensure generalist podiatry practice is comprehensively represented in the data. As podiatry was represented in a project site team with dietetics & nutrition only, the potential skill sharing between podiatry and the other allied health professions, particularly other physical rehabilitation professions, occupational therapy (function, wounds) and physiotherapy (musculo-skeletal, mobility), needs to be explored further. In the analysis, it was decided to extend skill sharing decisions to the other allied

health professions where the decision was recorded in the site data to share with dietetics & nutrition. This primarily impacted decisions in relation to screening and basic assessment of high-risk feet. The justification is that the decision to skill share with dietetics & nutrition required the team to consider the potential costs in terms of training time and support requirements for dietitian/nutritionists to undertake the task relative to the potential benefits for clients and the service. If this was judged to be in favour of skill sharing to dietetics & nutrition, the same would also be the case for physiotherapy and occupational therapy in particular, and for speech pathology and social work to a lesser extent.

Appendix L – social work findings

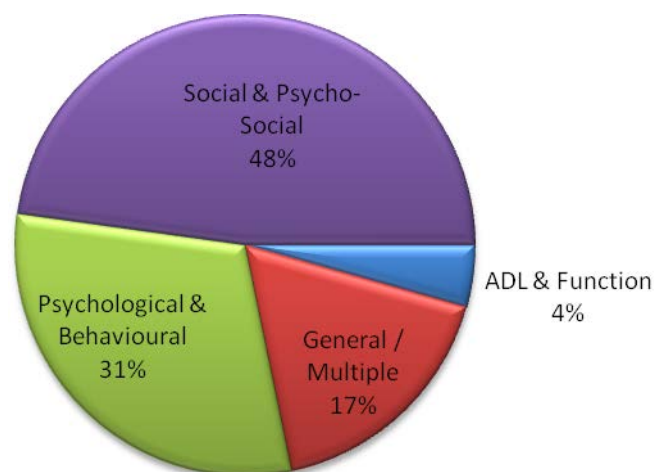
Sample

Social workers participated in data collection in two project sites. The staffing at both sites was 1FTE social worker. Social workers worked in teams that had an allied health assistant. Two social workers from a rural mental health team participated in the review activity.

Current clinical tasks

The majority of the clinical tasks undertaken by social work were in the Psychological & Behavioural and Social & Psycho-social clinical areas. Social work was identified as delivering the full scope of 20 tasks. For an additional three tasks, social work was found to either deliver part of the task or to not consistently deliver it at all project sites. A summary of the current tasks delivered is shown in Figure 17 below and in more detail in the task list in Attachment 9.

Figure 17. Social work current tasks by clinical area (n=23)



Three additional tasks were identified that social work either provide a component of, or inconsistently provide between project sites, [AD02] Assessment - instrumental ADL, [SP09] Social supports / services - facilitate access, and [SP12] Group facilitation - carer support group.

Six tasks (26% of full scope tasks) undertaken by social work were identified as uni-professional in the current models of care; [PB04] Assessment – psychological, [PB05] Cognitive behavioural therapy, [PB07] Counselling, [PB08] Counselling - body image and identity, [SP04] Assessment - parenting skills, and [SP10] End of life planning and support.

Social work delegates two tasks (9% of full scope tasks) to allied health assistants in the current models of care, [SP06] Facilitate client engagement - community and cultural, and [SP12] Group facilitation - carer support group.

Findings from task analysis

Three tasks were identified as appropriate to skill share from social work to other allied health professions, [PB01] Screening assessment - depression (client / carer), [SP04] Assessment - parenting skills, [SP05] Assessment - carer burden. If all proposed skill sharing was implemented, six social work tasks would remain uni-professional, primarily those related to complex psycho-social assessment and intervention.

In total 26 tasks were identified as appropriate to skill share from other allied health professions to social work (15 as the full scope of the task and 11 as a component of the task). These were in the clinical areas of ADL & Function (14 tasks), Cognition, Perception & Memory (3 tasks), Mobility & Transfers (4 tasks), Foot Care (3 tasks), Fatigue & Sleep (2 tasks).

Task analysis identified that nine tasks currently provided by social work in project sites were appropriate for delegation to an allied health assistant (39% of full scope tasks).

Findings from the review activity

The method and limitations of the review method are discussed in [Appendix P](#). The social workers in project sites worked in a broad scope of professional practice. Social workers in review sites worked in primarily mental health roles. The outcomes for social work were as follows:

- Five tasks were identified by the project site that were not identified by the review activity (equivalent to 22% of current social work tasks in task list). These tasks, [AD02] Assessment - instrumental ADL, [PB03] Assessment – stress, [SP04] Assessment - parenting skills, [SP08] Respite coordination, [SP10] End of life planning and support are likely to be explainable by the differing scope of social work practice between the project sites and review site.
- Fourteen tasks were identified by the review activity, from those listed on the aggregated task list, as being performed by social work that were not identified by the project site data collection (equivalent to 61% of current social work tasks in task list). They included tasks in the following clinical areas: Chronic Disease Prevention & Management, Cognition, Perception & Memory, Developmental & Child Health, Fatigue & Sleep, Medications, Mobility & Transfers, Psychological & Behavioural. Five of the fourteen tasks identified were undertaken with low frequency.
- No additional tasks were contributed by social workers in the review activity that were not present on the aggregated task list.

The findings from the review activity indicated significant variability in tasks undertaken by social worker in rural and remote settings represented in the project and review site sample. Further analysis of the project site data showed that between the two project sites with social work in the staffing establishment, 11 of the 23 (48%) tasks identified for social work were recorded in a single site. This lends further weight to the review activity finding of variation, either in actual scope of rural and remote social work practice between teams or in the data collection process, or both. This will need to be considered for the project validation activity and noted when examining the findings of this project for social work.

Appendix M - AHA findings

Although not the focus of the Rural and Remote Generalist: Allied Health Project, the Calderdale Framework Task Analysis stage required project site teams to consider the appropriateness of tasks for delegation to an allied health assistant (AHA). AHAs participated in the Service and Task Analysis processes undertaken in their project site. Information on the AHAs current tasks and potential for delegation of additional tasks was collected and presented in the project site data collection form. This information was compiled in the aggregated task list as an opportunistic finding from the project.

Delegated practice and task analysis

Allied health assistants undertake components of clinical tasks consistent with their delegated scope of practice. Consequently, information presented on tasks currently undertaken, or potentially undertaken by allied health assistants should be understood to mean that the AHA can undertake the components of the task consistent with their delegated scope of practice only, not the full task. A delegated scope of practice is described in more detail elsewhere ⁽³⁴⁾. A delegation model can only be implemented if a service has the requisite clinical governance, training, and a monitoring and supervision processes established to support it. Where these supporting processes are inadequate, implementation of delegated tasks is inappropriate and potentially introduces risks for clients. As AHAs do not possess an independent scope of clinical practice, delegation always requires the presence in the team of a profession with the relevant clinical task in their scope of practice.

Sample

Allied health assistants participated in data collection in all five project sites. Four sites had 1FTE AHA staffing, and one had 1.5 FTE. AHAs did not participate in the review activity.

Current clinical tasks

A summary of the current tasks delivered is shown in the Figure 19 and in more detail in the task list in Attachment 10.

Findings from task analysis

An additional 100 tasks, beyond those already done by AHAs in project sites, were identified as being appropriate for delegation. A summary of the proposed additional tasks is shown in the Figure 18 on the next page and in more detail in the task list in Attachment 10.

The findings show that the less than one third of tasks (47/147) identified by rural and remote teams as potentially delegatable currently are. This under-utilisation of allied health assistants may relate to a range of factors including:

- limited AHA staffing,
- service models that do not allow AHAs to travel with the team or independently to outreach locations,
- competing administrative and operational tasks limiting use of clinical skills,

- the training, qualifications and clinical capabilities of AHAs,
- variation in AHA roles between teams, and
- confidence and capacity of health professions in the team to delegate to assistants. The evaluation survey of participating project site team members indicated some self-reported and observed gaps in awareness of AHA's scope of practice and confidence delegating tasks.

This finding may be of interest to rural and remote health service providers examining workforce challenges and service efficiency. Further work to examine delegated practice models relevant to rural and remote practice (particularly those which involve remote supervision through use of ehealth) is indicated. Training for rural and remote allied health professionals should include the skills and knowledge required to work successfully with AHAs in a safe and well-supported delegated practice model (e.g. delegation and supervision skills).

Figure 18. Currently delegated tasks by clinical area (n=47)

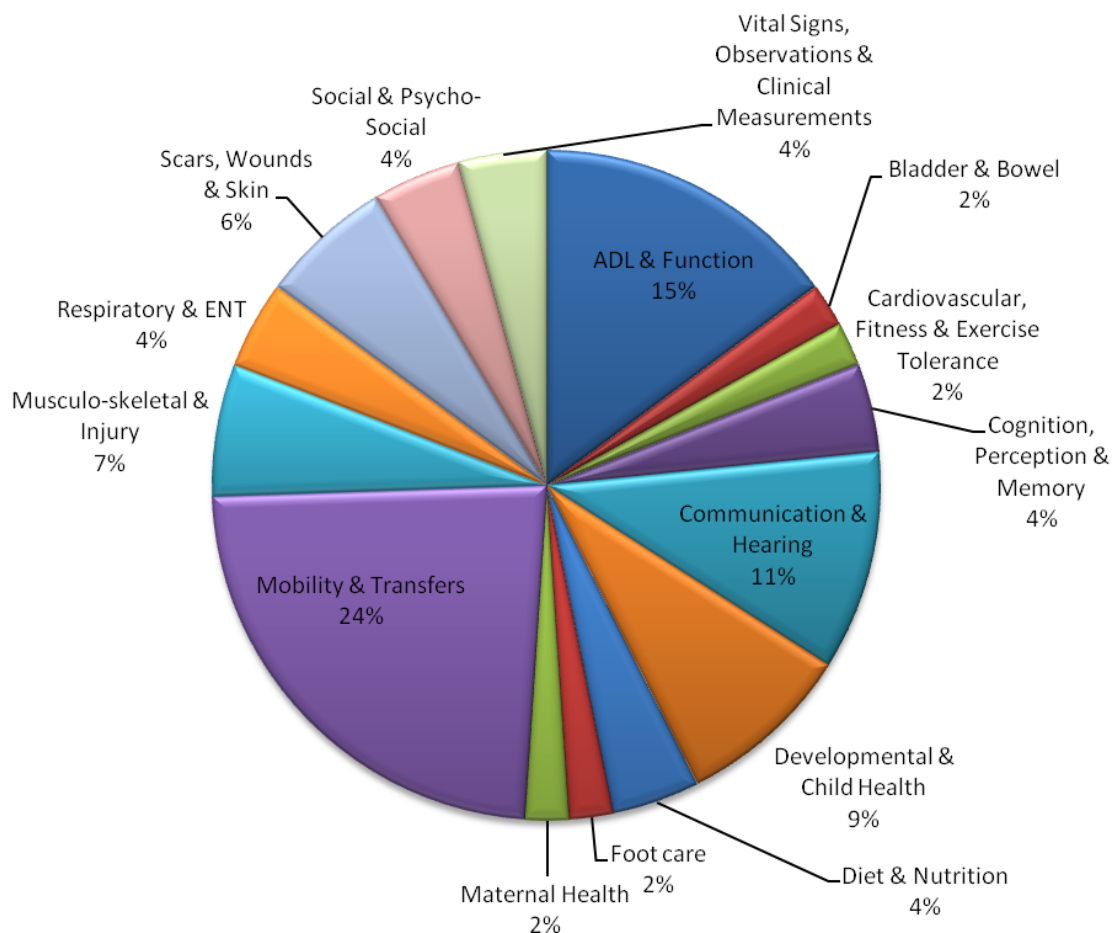
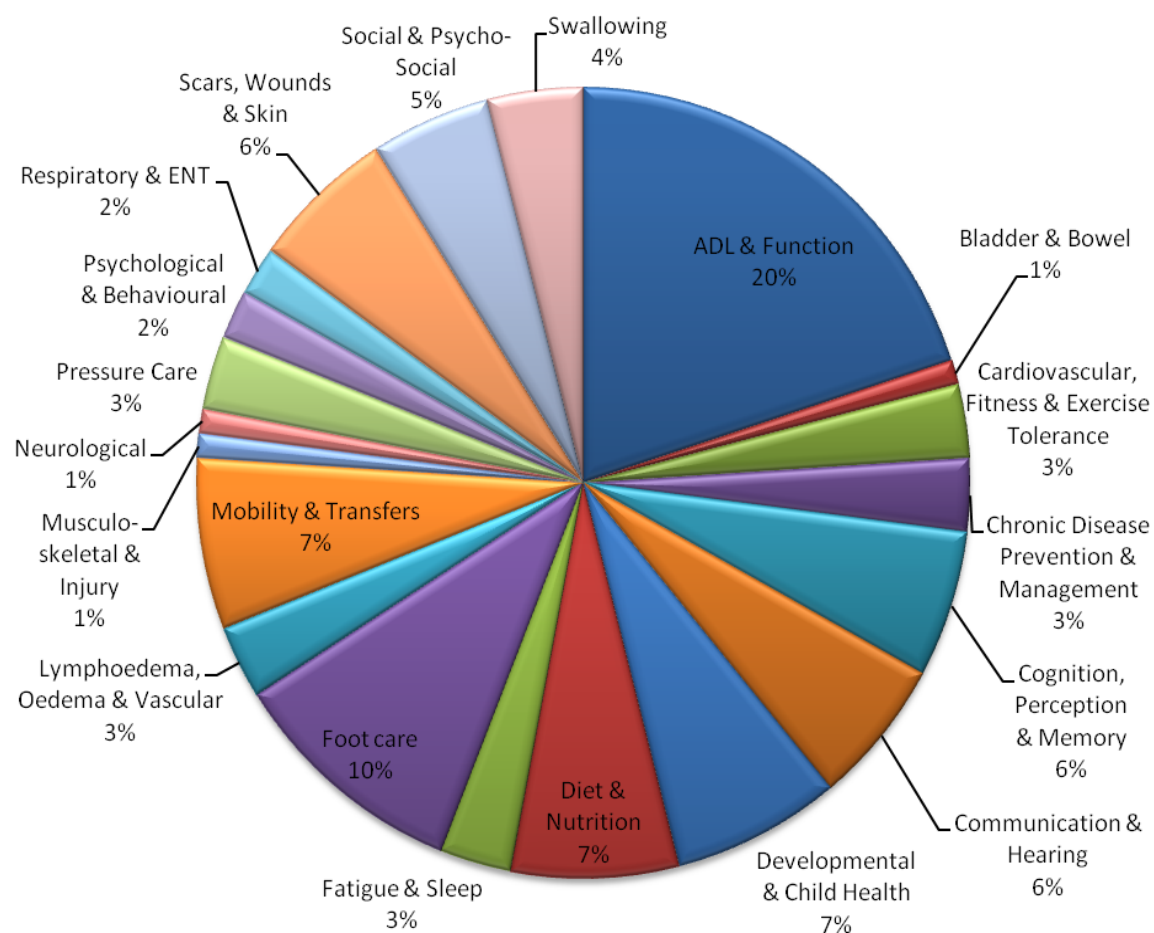


Figure 19. Tasks proposed for delegation to AHAs by clinical area (n=100)



Appendix N - other professions findings

Although not a focus of the project, some project sites included team members from the following non-allied health workforce groups:

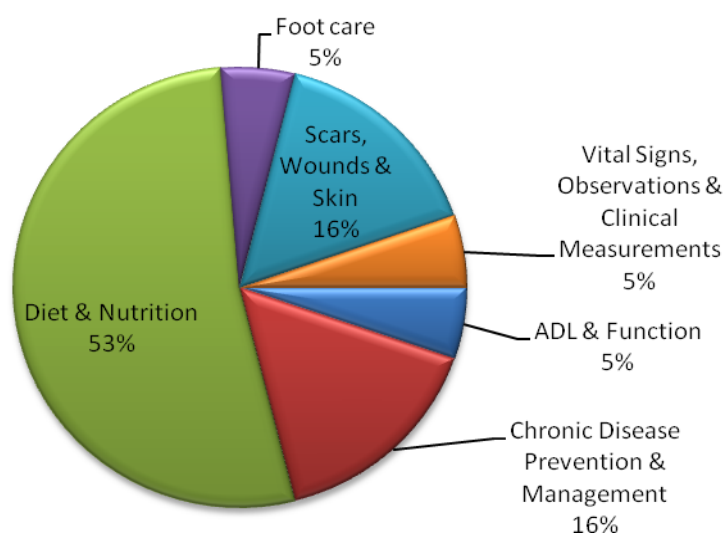
- Indigenous Health Worker (1 site)
- Aboriginal and Torres Strait Islander Health Practitioner (1 site)
- Disability Coordinator (Registered Nurse) (2 sites)

These team members participated in the Service and Task Analysis processes undertaken in the project site. This information was compiled in the aggregated task list and is presented as an opportunistic output of the project. Limited checking or review of this data was undertaken and it represents only a small number of participants. It is not suggested to be broadly representative of these workforce groups. The information may be useful to health services and training providers examining potential skill sharing between allied health professions and the broader multi-disciplinary team, although further scoping would be required. The findings are presented in this report as there is currently very little published information on skill sharing between allied health professions and these workforce groups.

Indigenous health workers

The potential for skill sharing allied health tasks to community-based Indigenous Health Workers was examined in one site. The summary outcomes are shown in Figure 20 and in Attachment 12.

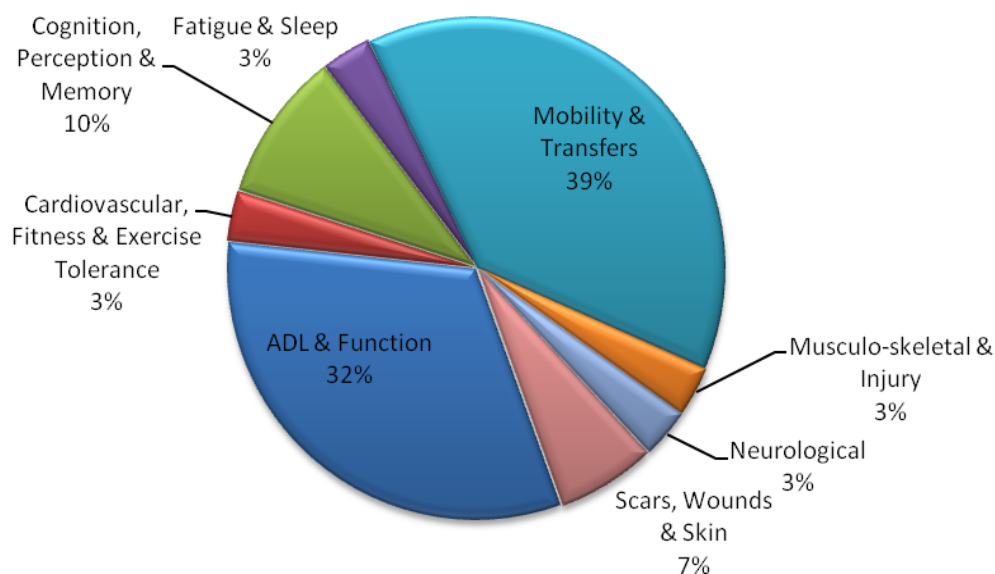
Figure 20. Potential skill share tasks from allied health profession/s to Indigenous Health Workers (full or component of task) (n=19)



Aboriginal and Torres Strait Islander Health Practitioners

The potential for skill sharing allied health tasks to Aboriginal and Torres Strait Islander Health Practitioners was examined in one site. The summary outcomes are shown in Figure 21 and in Attachment 12.

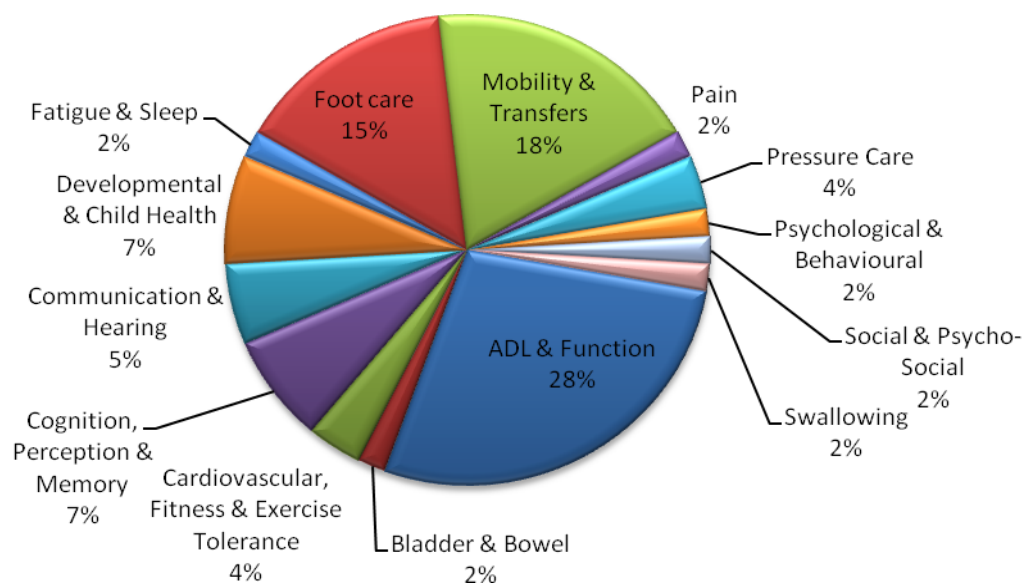
Figure 21. Potential skill share tasks from allied health profession/s to Aboriginal and Torres Strait Islander Health Practitioners (full or component of task) (n=31)



Disability Coordinators (Registered Nurses)

The potential for skill sharing allied health tasks to Disability Coordinators was examined in two sites. Disability Coordinators are generally non-profession specific roles working within disability service models of care in the Northern Territory. The data presented here relates to skill sharing decisions to Disability Coordinators with a Registered Nurse professional qualification. The summary outcomes are shown in Figure 22 and in Attachment 12.

Figure 22. Potential skill share tasks from allied health profession/s to Disability Coordinators (full or component of task) (n=52)



Appendix O – validity of findings

Internal validity

Internal validity relates to whether the project design and execution actually measured what was intended, and includes consideration of errors and bias. The following points should be noted in relation to internal validity:

1. The project aimed to map the clinical tasks undertaken by northern Australian rural and remote teams. The design drew on the expertise and experience of actual rural and remote allied health practitioners to map and describe their current scope of practice, and make decisions regarding professions responsible for providing clinical tasks. This is seen to have advantages over project designs that fail to engage with clinicians, or only do so superficially. The project design broadly supports the veracity of the data.
2. The review activity (see [Appendix P](#)) identified only one clinical task that had not been captured by the project teams, indicating comprehensiveness of the clinical task data.
3. Extensive training and support of the project site coordinators and use of a common, tightly prescribed process, and use of a common data collection template supported consistency of project site data collection. However, variation in application of the method between teams, and the representation of task information and decisions in the data collection template are expected to have occurred.
4. Minor data errors were noted in the analysis. Approximately a dozen tasks in one site's data sheet had become corrupted and needed revision by the project site coordinator and GNARTN project officer. A further five tasks in this site's task list had internal consistency errors. The total impact of these errors is likely to be small considering the extent of the total data set.
5. Although limitations of small sample size and selection bias are to be expected, the five project sites represented different service models seen in rural and remote allied health practice including inpatient hospital, outpatients, urban community practice and remote outreach. This range supported the examination of allied health rural and remote practice using the small number of sites.
6. The aggregation and analysis phase involved interpretation of project site data by the GNARTN project officer. Some level of bias in integrating site tasks into the aggregated task list is likely. It should be noted that the project officer is a physiotherapist which may introduce bias in terms of assumptions made from her own clinical practice experiences in physiotherapy, and by the disparity between her knowledge of the clinical practice of this profession relative to the others included in the project. Timeframe and resource constraints did not allow for the data aggregation and analysis stage to be undertaken by more than one individual. Strategies used to address this potential for bias included follow-up interviews or email communication with project site coordinators and specific team members from project sites, and providing the aggregated task list to project site teams for feedback. The timeframe for sites to review the draft aggregated task list was only one week due to delays receiving data from one project site. No specific feedback was provided from sites on the draft aggregated task list.

External validity

External validity relates to the generalisability of findings to groups beyond those examined in the project. The project design included an attempt to quantify generalisability of project findings by recruiting rural and remote northern Australian allied health teams, additional to the project sites, to undertake a review activity of the draft aggregated task list. The findings from the review activity are presented in [Appendix P](#). The key finding with regard to external validity was that there was generally good agreement between the project and review site tasks for the professions of physiotherapy, speech pathology and podiatry. Social work showed lower consistency. Greater inter-site variation in clinical tasks undertaken by social work between project sites and between the project sites and review sites was noted. No occupational therapists participated in the review activity.

Other points to note in relation to external validity are as follows:

1. All professions except podiatry were represented in more than one project site. Generalisability is expected to be greatest in professions with larger numbers of individuals contributing to the data, across more than one team i.e. physiotherapy and occupational therapy.
2. The project sites were located and/or provided services primarily to remote areas. Generalisability of results to rural areas was tested to some degree in the review activity, which included rural as well as remote practitioners.
3. The generalisability of findings to southern Australian services and also to organisation types not included in the project site data collection and review activity is uncertain. The review activity demonstrated reasonable agreement between the task list findings and Medicare Local allied health teams, although the review activity did not examine the skill share or delegation decisions made by the project sites. Only one community controlled health service was included in the project site cohort and no other non-government organisations participated in the project.

Appendix P - review activity findings

Interpreting review activity findings

The method used to conduct the review activity is discussed in [Appendix C](#). The purpose of the review activity was to investigate the representativeness of the data aggregated from project site task lists for other rural and remote allied health service providers. Note: the review activity related to the descriptive aspects of the task and not the decision to skill share or delegate the task.

Interpretation of the review versus project site tasks must be done cautiously. Differences between the two task groups may reflect:

- actual differences in service model and resultant breadth of clinical tasks performed by the practitioners i.e. consistent with the purpose of this activity,
- differences in methods of capturing task data i.e. review sites picked from an extensive pre-prepared list, whereas project sites needed to reflect on their practice and generate their own task list,
- differences in interpretation of the component activities involved in the tasks. The project sites, having generated their own task descriptions are likely to have been much more cognisant of the scope of task activities, compared with review sites reading short task descriptions, and
- low number of practitioners involved in both project sites and review sites.

Summary findings – generalisability of project data

Accepting the considerable methodological limitations of the review activity, it generated some findings for noting. Details of the consistency between project site and review site tasks are described in the profession-specific appendices. Summary findings were:

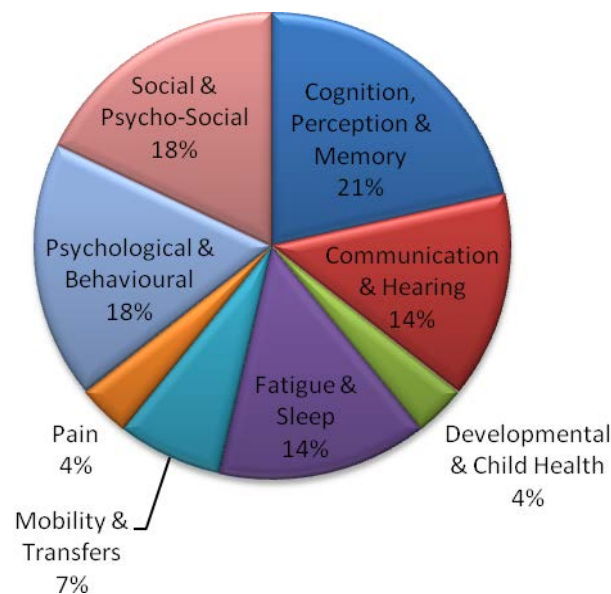
- Physiotherapy, podiatry, speech pathology and dietetics & nutrition showed reasonably high consistency between project and review sites in terms of tasks undertaken (>80% consistency). Considering the impacts of service model, casemix, community needs and expectations, practitioner experience and training and a range of other factors, this outcome is indicative of good representativeness of the task list for these professions.
- Social work showed greater variation in tasks undertaken both between the project sites and between aggregated project site data and review sites.
- Very few clinical tasks were identified by reviewers that were not captured in project site data. Analysis showed that only one task from dietetics & nutrition was not included on the final aggregated task list, nutrigenetics.
- Note: no occupational therapists participated in the review sites.

Psychology

Psychology was not included in the full data collection as none of the five project site teams included psychologists in their staffing establishment. One review site had 3FTE psychologists in the team and agreed to collect task information and record it against the draft aggregated task list. The tasks identified by psychologists from the draft aggregated

task list are shown in Attachment 11 and in Figure 23 by clinical area. One additional clinical task was also recorded, “providing cognitive assessment to a child”. This may be appropriate for inclusion in an existing task in the Cognition, Perception and Memory clinical area but would require further professional input to determine this. It is not possible to ascertain the extent to which the tasks recorded by psychology are currently delivered (full task or components of task) and there is no data available regarding skill sharing to or from psychology. Further work would be required to develop the rural and remote generalist psychologist task list and investigate current and potential skill sharing.

Figure 23. Tasks identified in the review activity as being delivered by psychology (n=28)



Diabetes educator

Diabetes educators (not from allied health professions) were present in the staffing establishment of two of the five project site teams, but for operational reasons did not participate in these projects. One diabetes educator provided data for the review activity using the draft aggregated task list. Three tasks were identified, all being completed with high frequency; [CD05] Education – diabetes, [VS02] Weight, Height, BMI & Waist Circumference, and [VS04] Vital signs and observations.

Appendix Q – evaluation survey

SECTION 1 These questions relate to your team's current services.	Summary % Responses - Before Project						Summary % Responses - After Project					
	Strongly Disagree	Disagree	Unsure	Agree	Strongly Agree	Total Responses	Strongly Disagree	Disagree	Unsure	Agree	Strongly Agree	Total Responses
1. Clients find it easy to access our services.	0%	0%	36%	64%	0%	11	0%	27%	18%	45%	9%	11
2. Clients receive benefit from our services.	0%	0%	0%	45%	55%	11	0%	0%	0%	55%	45%	11
3. The team coordinates client/patient care effectively.	0%	9%	9%	64%	18%	11	0%	9%	9%	82%	0%	11
4. Referrers (e.g. doctors, other AHPs) are able to engage the team's services without difficulty.	0%	9%	45%	45%	0%	11	0%	0%	9%	64%	27%	11
5. Communication within the team is effective.	0%	0%	18%	82%	0%	11	0%	9%	9%	64%	18%	11
6. Clients can access the team's services in a timely way.	0%	27%	36%	36%	0%	11	0%	36%	36%	18%	9%	11
7. Waste is not a major issue for the team (e.g. duplication of clinical tasks, unnecessary travel, unproductive time, inappropriate referrals).	0%	9%	36%	55%	0%	11	0%	27%	36%	36%	0%	11
SECTION 2 These questions relate to your team's workforce.	Summary % Responses - Before Project						Summary % Responses - After Project					
	Strongly Disagree	Disagree	Unsure	Agree	Strongly Agree	Total Responses	Strongly Disagree	Disagree	Unsure	Agree	Strongly Agree	Total Responses
8. In general, new staff have no difficulty adjusting to the team's model of care	9%	27%	36%	27%	0%	11	9%	45%	18%	18%	9%	11
9. In general, new staff have no difficulty meeting the clinical requirements of their role in the team.	9%	27%	36%	27%	0%	11	9%	36%	9%	45%	0%	11
10. I have a good understanding of the role and functions of other disciplines in the team.	0%	9%	27%	55%	9%	11	0%	0%	9%	45%	45%	11
11. Health professionals in this team work to their full scope of practice at least most of the time.	9%	0%	9%	64%	18%	11	0%	45%	0%	45%	9%	11
12. The role of each team member is clear.	10%	40%	20%	30%	0%	10	0%	45%	9%	45%	0%	11

Questions to be answered only if team includes an allied health assistant (or similar support worker)	Strongly Disagree	Disagree	Unsure	Agree	Strongly Agree	Total Responses	Strongly Disagree	Disagree	Unsure	Agree	Strongly Agree	Total Responses
13. Team members demonstrate good understanding of the scope of practice of support workers.	0%	40%	10%	50%	0%	10	0%	55%	18%	27%	0%	11
14. I understand the scope of practice of support workers in this team.	0%	20%	20%	60%	0%	10	0%	27%	9%	55%	9%	11
15. Support workers in this team work to their full scope of practice at least most of the time.	0%	20%	40%	20%	20%	10	0%	55%	9%	36%	0%	11
16. Health professionals in the team delegate appropriately and effectively to support workers.	0%	18%	36%	36%	9%	11	0%	45%	9%	45%	0%	11
SECTION 3												
These questions relate to the project your team is undertaking to review their model of care (i.e. the way services are delivered including who performs which tasks in the team).	Strongly Disagree	Disagree	Unsure	Agree	Strongly Agree	Total Responses	Strongly Disagree	Disagree	Unsure	Agree	Strongly Agree	Total Responses
17. I feel there is value in undertaking the project.	0%	0%	0%	45%	55%	11	0%	0%	0%	36%	64%	11
18. I support the use of the Calderdale Framework in this project.	0%	0%	0%	55%	45%	11	0%	0%	0%	55%	45%	11
19. I feel my team's clients/patients will benefit from the project.	0%	0%	9%	64%	27%	11	0%	0%	18%	36%	45%	11
20. I support investigating greater opportunities for delegation in the team.	0%	0%	9%	64%	27%	11	0%	0%	9%	27%	64%	11
21. The project is being driven from within the team.	0%	9%	18%	55%	18%	11	0%	9%	27%	27%	36%	11
22. I feel I have the skills to participate fully in the project.	0%	0%	9%	73%	18%	11	0%	0%	0%	64%	36%	11
23. I support investigating greater opportunities for skill sharing in the team.	0%	0%	9%	45%	45%	11	0%	0%	0%	55%	45%	11

24. The rationale and drivers for the project are adequately understood by the team.	0%	0%	36%	55%	9%	11	0%	0%	18%	45%	36%	11
25. There are adequate resources available to support the project.	0%	9%	36%	45%	9%	11	9%	18%	55%	18%	0%	11
26. I feel my team will benefit from the project.	0%	0%	10%	60%	30%	10	0%	0%	0%	55%	45%	11
27. I feel that the project will produce benefits that extend beyond my team (e.g. other parts of the organisation, other organisations, other rural/remote services).	0%	0%	10%	50%	40%	10	0%	0%	9%	55%	36%	11
28. I feel I have the time and capacity to participate in the project.	0%	20%	10%	70%	0%	10	0%	36%	27%	36%	0%	11
29. Management supports this project.	0%	0%	10%	60%	30%	10	0%	18%	9%	64%	9%	11
30. I feel the project will positively influence recruitment and retention in the team.	0%	0%	40%	50%	10%	10	0%	0%	27%	64%	9%	11
31. Use of the Calderdale Framework will enhance the outcomes of the project.	0%	10%	0%	50%	40%	10	0%	9%	0%	73%	18%	11
32. Risks associated with undertaking the project are manageable and acceptable.	0%	0%	40%	50%	10%	10	0%	0%	18%	73%	9%	11

Comments (pre-project):

- This is an exciting project and can have significant benefits for this team - which is the reason it was supported when the team was already short staffed. I hope that the outcomes will provide better training and processes for new staff and better definition of roles and frameworks for undertaking the shared roles (skill sharing without supports / processes in place) that we currently do.
- Excited to participate in something that could initiate positive changes in the workplace and as a generalist remote therapist!
- Within the context of current reforms to (work area), this project has come at the ideal time to ensure a more holistic service to our clients, job satisfaction to the staff involved and foundation in the workplace for future planning
- Given the (organisation's) history of going in 'circles' in terms of discussing and not actioning, I wonder whether the project will continue after GNARTN involvement. I think the project is a great idea, but do have some concerns over writing of competencies, who will oversee the process and how effectively the tasks will be completed once skill shared. I do hope the project will clarify the roles of staff better, rather than further blurring some of our vague roles

- One of the biggest challenges seems to be getting people to see past the initial increased workload and analysis and to see the end result, a more productive and skillful team. Reflected also talking with larger hospitals and the lack of time they have for such a project.

Comments (post-project):

- The process has been good for the team members to increase their understanding of others roles, and has been a good team building process. (Project Site Coordinator) has been an excellent project coordinator / facilitator and the team members, although very busy with client load, have responded enthusiastically. Training has been well presented. If taken through to implementation there will be significant benefits for clients, other service providers and staff. Overall an extremely positive experience which identified significant risks in the way we currently work.
- Time for completion of the project was a little too short. Not enough support with backfill to allow time / increased capacity to complete the project (more related to this end). Helpful to clarify roles, particularly for new therapy assistant roles. Very helpful to provide new staff with understanding of roles / responsibilities / usual tasks.
- I think participating in this project was a valuable experience for our team. It provides us with the opportunity and resources to reflect on our current practices and procedures. I think it has been a valuable tool in helping to improve our service.
- It was a pleasure participating in this project. I am looking forward to reading the final report. Many thanks
- The exercise so far has been a good team exercise and increased an understanding of the role and functions of other disciplines within the team.
- Enjoyed the experience – was difficult at times to qualify and quantify role but was a positive thing to do. Hope to see the next stages of the project implemented.
- Looking forward to the next step of the projects and anticipating improved retention of staff in the long term once the project is fully implemented.

Appendix R – validation of project outcomes

As described in [Recommendation 2](#), a validation process should be undertaken of the project findings.

The validation process may examine:

1. Any major gaps in the task list for the six allied health professions. This should not be an extensive mapping exercise, but instead a review of any broad tasks or functions omitted from the task list that are relevant to the profession in rural and remote generalist practice, with a focus on those that are potentially appropriate for skill sharing and those performed with high frequency.
2. Review the multi-professional and skill share tasks, particularly those in the thirteen skill share task clusters shown in Appendix F. Feedback should be sought from a range of allied health practitioners on the value and feasibility of skill sharing these tasks, with a focus on development of training and support resources for this purpose. Feedback would therefore encompass situations where the task is currently uni-professional in all/most services but would be valuable to share across two or more professions, or those which are inconsistently performed by more than one profession or require ad hoc on-the-job learning currently which would be strengthened by a more defined training pathway. For each task, participants in the validation process could be requested to provide the following information:
 - Is the full scope of the task commonly delivered by the respondent's profession in rural and remote practice (see point 1 above)?
 - If the task is commonly delivered by the respondent's profession in rural and remote practice (i.e. skill sharing is proposed from the respondent's profession to other profession/s), are there any legal, high clinical risk or operational barriers (e.g. some jurisdictions will only allow prescription of aids from specific professions for subsidy schemes, limiting the value of pursuing skill sharing) that were not present/relevant or adequately reflected in the decisions made by the project sites?
 - If the task is not commonly delivered by the respondent's profession in rural and remote practice (i.e. skill sharing is proposed to the respondent's profession from other profession/s), how extensive does the respondent expect the training and competency development to be to deliver the task (as a proxy measure of feasibility)?
3. Review the cluster of skill share tasks to identify those most likely to be value to rural and remote practitioners if converted to clinical training. This would be a small prioritisation exercise that may be of value if priorities for translation of project findings into training products is required.

Participants in the validation process should be targeted for their potential to contribute to the review of the project findings. In particular the following groups should be sought:

- experienced rural and remote practitioners and allied health leaders
- practitioners from southern Australia
- practitioners from rural areas (as the project sites were primarily remote services)
- practitioners from non-government organisations

- practitioners currently working or with extensive experience working in multi-disciplinary team-based care, as this is the most relevant to skill sharing models.
- social work and podiatry professions should be targeted for review of the data for the methodological reasons described in [Appendix L](#) and [Appendix K](#) respectively.

The validation process could use a survey, key informant interview or modified Delphi approach. Whichever approach is chosen, a comprehensive preliminary briefing of participants will be pivotal to achieving useful outcomes. The briefing would need to provide detail on the nature and assumptions underpinning skill sharing (See [Key Concepts section](#) of the project report). Inadequate briefing would undermine the validation process if participants take an absolutist view of skill sharing as a concept.

Additional work could also be undertaken to expand the usefulness of the project data to workforce groups beyond the six professions examined in the project. These activities could include:

- review of delegation task list and cross referencing to existing vocational training resources for allied health assistants to examine the consistency of training programs with rural and remote service needs,
- review by allied health professions beyond the six examined in the project, for relevance of skill sharing task clusters to the professions (e.g. psychology, exercise physiology, pharmacy).
- review by workforce groups beyond allied health to examine the value and relevance of skill sharing task clusters (e.g. Indigenous Health Workers, Aboriginal and Torres Strait Islander Health Practitioners, Registered Nurses).

Appendix S - project sites and review sites

Project sites

Project sites completed comprehensive task identification and analysis processes for all allied health professions in the team (including allied health assistants), and any other professions in the team that it was organisationally important to include.

Site	Organisation	Service	Participating disciplines	Base location
Katherine Hospital	Government	Hospital	Occupational Therapy (1FTE) Physiotherapy (1FTE) Aboriginal and Torres Strait Islander Health Practitioner (1FTE) Social Work (1FTE) Allied Health Assistant (1FTE)	Katherine, NT
Katherine Region Aged & Disability Service	Government	Urban (Katherine) and remote outreach	Occupational Therapy (2FTE) Physiotherapy (1FTE) Speech Pathology (1FTE) Disability Coordinators (3FTE) Allied Health Assistant (1FTE)	Katherine, NT
Top End Remote Disability Services	Government	Remote outreach	Occupational Therapy (5FTE) Physiotherapy (4FTE) Speech Pathology (2FTE) Disability Coordinators (RN) (2FTE) Therapy Assistant (1FTE)	Darwin & Gove, NT

Site	Organisation	Service	Participating disciplines	Base location
Apunipima Cape York Health Council	Community controlled health service	Remote outreach	Podiatry (2FTE) Dietetics & Nutrition (5FTE) Indigenous Health Worker (1FTE) Podiatry Assistant (1FTE) Tackling Smoking Healthy Lifestyle (1FTE team leader participated in project on behalf of TSHL team)	Cairns, QLD
WACHS, Mid-West Population Health	Government	Hospital, urban and remote outreach	Occupational Therapy (2FTE) Physiotherapy (2FTE) Speech Pathology (2FTE) Social Work (2FTE) Dietetics (1FTE) Therapy Assistant (1.5FTE)	Carnarvon, WA

Review sites

Review sites completed a two week data collection process using a draft task list aggregated from project site data. The purpose of the review was to examine the representativeness of task data from the project sites for allied health professionals in other rural or remote services.

Site	Organisation	Service	Base location	Participating disciplines (all sites)
Townsville Mackay Medicare Local	Medicare Local	Rural and remote outreach	Townsville, QLD	Dietetics / Nutrition (4) Social Work (2) Psychology (3) Speech Pathology (3) Podiatry (1) Physiotherapy (1) Diabetes Educator (1)
Central Queensland Medicare Local	Medicare Local	Urban and rural outreach	Emerald, QLD	
Central & North West Queensland Medicare Local	Medicare Local	Primarily remote outreach	Mt Isa, QLD	
WACHS – Derby allied health team	Government	Urban and remote outreach	Derby, WA	