

MINISTERIAL TASKFORCE ON HEALTH PRACTITIONER EXPANDED SCOPE OF PRACTICE

Consultation Paper

Background

The *Health Practitioners (Queensland Health) Certified Agreement (No. 2) 2011*, (HPEB2), Clause 50¹, indicates that:

A ministerial taskforce, including union representation, will be established to identify ways to address the following issues:

- a) advanced scope of practice areas/clinics in key occupational areas for health practitioners;*
- b) enabling patients/clients to begin treatments with health practitioners that do not require medical specialist oversight;*
- c) developing a framework to enable assistants to perform appropriate routine tasks to enable a greater proportion of health practitioners' time to be on the upper scope of practice end of the roles and duties within the classification level that they are employed, provided that such duties are in accordance with the relevant classification definitions and safe professional practice*

On 23 October 2012, The Hon Lawrence Springborg MP, Minister for Health, approved establishment of the Ministerial Taskforce on Health Practitioner Expanded Scope of Practice (the Ministerial Taskforce).

In February 2013 the Queensland Government released the *Blueprint for better healthcare in Queensland* as the action plan to transform the Queensland healthcare system into a model for productivity, care and efficiency. Core to this transformation will be redesign of service delivery and the workforce that delivers care and cultural change to support the new system.

Outcomes of the Ministerial Taskforce

The outcomes of the Taskforce will support the four principle themes stated in the *Blueprint for better healthcare in Queensland*²

1. Health services focused on patients and people
2. Empowering the community and our health workforce
3. Providing Queenslanders with value in health services
4. Investing, innovating and planning for the future

¹ Queensland Industrial Relations Committee (2011) 'Health Practitioners' (Queensland Health) Certified Agreement (No. 2) 2011 (HPEB2), available at www.qirc.qld.gov.au/resources/pdf/certified_agreements/cert_agreements/2011/ca_106_2011.pdf.

² Queensland public health system (2013) 'Blueprint for better healthcare in Queensland', Queensland Health, available at www.health.qld.gov.au/blueprint/default.asp.



Enabling *Health Practitioners* in the Queensland public health system to maximise their scope of practice has been identified by the Taskforce as the key focus to deliver outcomes for patients, the community, the workforce and the Queensland public health system. This is consistent with the *Blueprint* theme of *Providing Queenslanders with value in health services*.

'Clinicians need to work to their full scope of practice. We will challenge the 'myths' of what is possible and be open to new ways of working and models of care. We need to break down traditional barriers between professions, build clinician leadership and promote a culture of respect for each other's knowledge and skills.'

Blueprint for better healthcare in Queensland (2013)

Objectives of the Ministerial Taskforce

The objectives of the Ministerial Taskforce are:

- a) to identify opportunities for *Health Practitioners* to work to full scope of practice (including advanced clinical practice) and extend scope in appropriate contexts,
- b) to identify mechanisms to achieve effective delegation and therefore support better use of the *Health Practitioner* workforce,
- c) to identify an integrated education, training and clinical governance strategy to support effective introduction and integration of new roles, and
- d) to identify the funding implications of implementing the recommendations.

Scope

The scope of the Taskforce is the Queensland public health system *Health Practitioner* workforce. The focus of the Taskforce has been identified as the traditional allied health professional groups. Pathology, oral health, public health and technical workforces are excluded. See the Ministerial Taskforce Terms of Reference for more information on the background to the scope of the Ministerial Taskforce.

Deliverables

The Ministerial Taskforce will culminate in a written report with recommendations focussing on each of the Taskforce objectives.

More specifically, the deliverables of the Ministerial Taskforce will include identification of:

- a. evidence-based, patient-centred models regarding expanded scope *Health Practitioner* roles, that Hospital and Health Service Boards can consider for implementation,

- b. a contextually responsive framework of principles and processes to support implementation of expanded scope *Health Practitioner* roles in Hospital and Health Services, and
- c. the funding implications of implementing expanded scope *Health Practitioner* roles in the Queensland public health system.

Timeframes

The Taskforce Report will be submitted by 27 September 2013. Consultation will occur until 26 July 2013.

Principles to be met

Models and mechanisms for maximising the scope of practice of *Health Practitioners* must be:

- a. safe
- b. evidence-based
- c. equitable
- d. timely
- e. cost effective
- f. sustainable
- g. ethical
- h. enabling
- i. collaborative
- j. compliant with legislation and regulation
- k. relevant to the demographic and clinical context
- l. responsive to the multidisciplinary context

Question:

Are there additional principles that should underpin maximising the scope of practice of *Health Practitioners*?

Roles and tasks to maximise scope of practice

Where the above principles are met, opportunities exist to maximise scope of practice for each and every *Health Practitioner*; from the time of graduation and at every stage of their career.

Full scope of practice

For many roles and tasks, maximising scope of practice involves enabling the *Health Practitioner* workforce to work to the *full scope of practice* of their specific profession i.e. having the opportunity to work to the full extent of the profession's recognised skill base and/or regulatory guidelines. Culture and historical practice has meant that working to full scope is not always the

case, particularly within the context of the public sector. Full scope of practice is relevant across the full continuum of a *Health Practitioner's* career, from entry to the workforce through to more advanced practice skills. Advanced clinical practice³ involves high level clinical skills, knowledge and practice, closely integrated with clinical leadership skills, applied research and evidence based practice capacities, and competence in facilitating the education and learning of others.

Implementing an appropriate skill mix to deliver services will optimise productivity and sustainability through appropriate utilisation of the health workforce and through developing all members of the multidisciplinary team.

Facilitating change towards full scope of practice is primarily dependent on redefining organisational processes, reviewing team roles and functions, further education and training where necessary, and supporting changes in team culture.

Possible roles and tasks for full scope include (but not limited to):

- a. first contact in the care pathway (e.g. audiologist's autonomously receiving and triaging referrals; and assessing, diagnosing, treating and discharging patients from their care, within the scope of practice of their profession for patient's referred to ENT, and referring to others as appropriate in the multidisciplinary team),
- b. patient self-referral with appropriate triage mechanisms in place,
- c. making direct referrals to medical specialists within the Queensland public health system (e.g. podiatrist to an orthopaedic surgeon, psychologist to a paediatrician),
- d. requesting investigations (e.g. plain x-ray by podiatrists),
- e. prescribing equipment and consumables (e.g. home enteral nutrition, medical grade footwear),
- f. documenting findings by relevant diagnostic *Health Practitioner* on investigations they have performed (e.g. cardiac scientist providing provisional report on echocardiogram, radiographer providing written comment on plain x-rays),
- g. admission decisions (e.g. into subacute care; short stay),
- h. criteria-led discharge, and
- i. other location-specific roles and tasks.

Note: each item in the above list may apply differently to each *Health Practitioner* profession.

Extended scope of practice

A range of evidence-based roles and tasks that maximise *Health Practitioner* scope of practice involve *extending the scope of practice* of specific professions. *Extending scope of practice* describes a discrete knowledge and skill base additional to the recognised scope of a profession and/or regulatory context of a particular jurisdiction. These would be tasks usually undertaken by other

³ Queensland Department of Health (2013) 'Advanced Clinical Practice Framework', Queensland Department of Health, available at <http://qheps.health.qld.gov.au/ahwac/docs/advclinprac-fwork.pdf>

professions e.g. doctors, nurses or allied health professionals. Extending scope should be done where it would allow more efficient management and care of the patient and decrease the number of visits or transactions in the patient journey.

Requirements for implementing safe and effective extended scope of practice vary depending on the task, the profession, and the context in question. Examples of possible requirements include: formal and informal education and training; credentialing; clinical monitoring and audit systems; changes to legislation and regulation; and changes to funding models. Over time, as extended scope tasks develop into standard practice, evolution of clinical governance processes is also appropriate e.g. prescribing by optometrists' has evolved to form part of their entry level scope of practice.

These roles and tasks include (but not limited to):

- a. prescribing (e.g. prescribing by physiotherapists in the Emergency Department to better manage musculoskeletal presentations),
- b. requesting investigations (e.g. magnetic resonance imaging (MRI), plain x-ray, pathology),
- c. conducting procedures (e.g. simple suturing, percutaneous endoscopic gastrostomy (PEG) tube care, fiberoptic endoscopic evaluation of swallowing (FEES), suctioning by a speech pathologist),
- d. producing the final report on an investigation (e.g. plain x-ray, ultrasound), and
- e. skill sharing with other allied health professionals (e.g. either dietitians or speech pathologists assess both nutrition and swallowing ability in ED).

Delegation

Facilitating optimal utilisation of the *Health Practitioner* workforce will require effective delegation from *Health Practitioners* to the support workforce i.e. allied health assistant and administrative officers. It has been shown that allied health professionals under-utilise the allied health assistant workforce to support delivery of services. The reasons for this include a lack of clarity about what tasks could be safely delegated and uncertainty about how to delegate effectively. Strategies to maximise the scope of *Health Practitioners* need to consider education and training and other support tools for both the *Health Practitioner* and assistant workforces so to fully realise the contribution of the support workforce.

Question:

Are there other roles and tasks that reflect *full scope of practice* that should be considered for *Health Practitioners*?

Question: Are there other roles and tasks that reflect *extended scope of practice* that should be considered for *Health Practitioners*?

Question:

Are there roles and tasks that could be *delegated* that would support full scope of practice and/or extended scope of practice described above?

Priority areas

Maximising Health Practitioner scope of practice will support the achievement of the priorities and performance measures identified in the *Blueprint for better healthcare in Queensland* (2013).

Specific opportunities exist to contribute to the following priorities. Selected examples of initiatives relevant to contributing to these priorities are provided against each priority area. The examples included are illustrative only and a wide range of other initiatives and opportunities exist locally, nationally and internationally.

Reducing waiting times in the Emergency Department and achievement of the National Emergency Access Target (NEAT)

- ACT Health Directorate introduced an Extended Scope Physiotherapist (ESP) in-training to Canberra Hospital Emergency Department (ED), under the supervision and mentorship of an ED medical specialist. Patients attending the ED with musculoskeletal complaints are assessed and treated by the primary contact ESP-in-training. The role includes tasks supported by the literature, including limited prescribing, independent management of simple fractures and independent interpretation of x-rays. Over four months, 237 patients consulted the ED ESP-in-training, falling mainly into ED triage categories 4 and 5. The average length of wait was 46 minutes, with 81.9% seen within the national triage target times. The length of stay for 94.5% of patients was within the NEAT of 4 hours. Further investigation will occur into the benefit of training to undertake local anaesthetic injections^{4,5}.

Reducing waiting times for elective surgery and achievement of the National Elective Surgery Target (NEST)

- Orthopaedic Podiatry Triage Clinics were established at Logan Hospital, Ipswich Hospital and Townsville Hospital to respond to long wait times to see an orthopaedic surgeon for foot and ankle problems. A podiatrist screened all non-urgent (category 3) patients to determine their suitability for conservative treatment. If these treatments were beneficial, patients were discharged from the surgical wait list. Discharge rates with conservative podiatry treatment alone ranged from 21% to 46% across the sites. Reductions in the wait list ranged from 24% to 50%. At Logan Hospital, rates of conversion to surgery following specialist assessment increased from 29-35% to 41%-51%.⁶

⁴ Grimmer-Somers K, Hendry K, Morris J, and Murphy K (2012), 'Extended Scope Physiotherapy (ESP) – the new horizon for musculoskeletal presentations in the Emergency Department?', ACT Government, Health.

⁵ Morris, J (2011), 'Extending the scope of physiotherapists', Newsletter for Innovators in Healthcare and Beyond, Change Champions and Associates.

⁶ Queensland Health (2011), 'Innovations in models of care for the Health Practitioner workforce', Queensland Health, Queensland Government, available at <http://www.health.qld.gov.au/ahwac/docs/moc-finalreport.pdf>.

Reducing waiting times for specialist outpatient clinics

- The Royal National Throat, Nose and Ear Hospital, at Royal Free Hampstead NHS Trust, established an audiologist-led triage assessment clinic for new outpatient ENT referrals. Seventy five per cent of ENT otological referrals did not meet 'red flag criteria' and could potentially be managed by the diagnostic audiology department in a direct access service, by staff with appropriate skills and the ability to request MRI scans. In 95% of cases, audiologists and ENT were in agreement on the referral pathway to audiovestibular medicine or ENT. The new model released 45 outpatient appointments with ENT specialists per week.⁷

Improving patient flow

- Peninsula Health in Victoria introduced a Pharmacist-initiated E-script Transcription Service (PETS) for experienced pharmacists to generate electronic discharge prescriptions. Medical officers (MOs) refer patients to the pharmacist 24 hours before discharge. The pharmacist reconciles pre-admission and current medications and consults with the MO where needed. Prescriptions are prepared electronically and printed for confirmation and signing by the MO. The pharmacist electronically details medication changes and the reasons for changes. The complete medication list is populated into the electronic discharge summary which is sent to the GP once finalised by the MO. The changes have resulted in earlier patient discharge, reduced waiting times, improved education of Junior MOs, less prescribing errors and reduced clerical workload for MOs.⁸

Investing in effective sub-acute care

- The Bayside Rehabilitation Model of Care Project will focus on an advanced health practitioner providing clinical leadership and guiding multidisciplinary assessment, treatment planning and coordination of care of patients admitted to the rehabilitation beds at Redland and Wynnum Hospital. As well as working at full scope within their discipline, it is envisaged the project will explore extended scope tasks. The AH practitioner will be supervised by the visiting geriatrician. Specific duties are yet to be defined, however it is envisaged they will include playing a key role in identifying, assessing, coordinating and directing clinical management of patients when deemed medically stable. This would include authority to discharge from inpatient care and to ensure appropriate outpatient and community follow-up coordination and referral.⁹

⁷ NHS Improvement (2010), 'Audiology Improvement Programme – Pushing the boundaries: Evidence to support the delivery of good practice in audiology', NHS Improvement, United Kingdom, available at <http://www.improvement.nhs.uk/LinkClick.aspx?fileticket=zRsjLXTeCw%3D&tabid=56>.

⁸ Inventory of Innovation (2013), 'Pharmacist initiated e-script transcription project', Health Workforce Australia, available at <http://www.hwainventory.net.au/story/63-pharmacist-initiated-escrpt-transcription-project>.

⁹ Queensland Health (2013), 'Project plan: Bayside rehabilitation model of care project', Metro South Hospital and Health Service, Queensland Health.

Improving health services for regional, rural and remote communities

- The Sir Charles Gairdner Hospital in Perth established a telehealth initial assessment clinic for regional patients referred to the Neurosurgery Clinic with spinal pain. Using telehealth, an advanced physiotherapist guides a regional physiotherapist to perform a physical examination in real time. The initial assessment enables determination of the need for imaging and specialist assessment. Imaging can then be scheduled for the same visit as the specialist appointment, halving both the number of trips to the city and the number of specialist appointments.¹⁰

Improving health outcomes for Aboriginal and Torres Strait Islander people

- The Deadly Ears (Children's Health Queensland HHS) provides the opportunity for allied health professionals (and other health and community workers) to make direct referrals to ear, nose and throat specialists in Deadly Ears ENT outreach clinics. Removing the need for children to make a return visit from allied health to a general practitioner to access specialist ENT services removes a number of barriers to service access for this population of children.

Supporting recovery from mental illness

- *[Seeking further information]*

Question

Are there other priority areas where maximising *Health Practitioner* scope of practice will support achievement of priorities and performance measures?

Question

Please provide details of other existing or possible models involving Health Practitioner full scope or extended scope of practice?

Potential barriers and implementation issues

The following issues have been identified as potential barriers/implementation issues:

Organisational and cultural

- a. inadequate focus on client-centred practice
- b. a history of rigid and/or misconceived professional boundaries
- c. inadequate leadership from a multidisciplinary perspective
- d. inadequate application of evidence from other jurisdictions and contexts
- e. perceptions of legal impediments arising from delegated practice or changes in scopes of practice

¹⁰ Inventory of Innovation (2013), 'Assessment by advanced practice physiotherapists, using telehealth, of patients with spinal pain referred to Department of Neurosurgery' Health Workforce Australia, available at <http://www.hwainventory.net.au/story/78-assessment-by-advanced-practice-physiotherapists-u>.

- f. cultures which do not permit full scope and innovation to occur (within and external to the professions)
- g. perceptions of need for more resources to change
- h. penalties through redirection of resources when efficiencies are achieved
- i. lack of understanding of the concept of full scope of practice

Skills

- j. deskilling due to not working to full scope
- k. lack of skills in delegation

Funding models and regulation

- l. funding models
- m. legislation, regulation and accreditation standards

Question:

Are there any other barriers?

Question:

What are the strategies to overcome these barriers?

Implementation issues

A key outcome of the Taskforce is to identify processes that will effectively support maximising the scope of *Health Practitioner* roles in Hospital and Health Services.

Question:

What processes and tools would support a Hospital and Health Service to implement models that maximise *Health Practitioner* scope of practice?