Allied Health Professions' Office of Queensland

A Framework for Local Implementation and Support of Skill-sharing and Delegation Practice for Allied Health Services in the Queensland Public Health System

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Contents

Introduction

Publicly-funded healthcare in Queensland is undergoing major reform in an attempt to deal with "an ageing population, increasing demand on health services, higher consumer expectations, rising health care costs, technological advancements in patient care and an increase in chronic disease".[1] Effective utilisation of the allied health assistant (AHA) workforce in direct clinical care and reduction of duplication across professional streams have been identified as key strategies for sustainable Queensland public health allied health (AH) services.[2]

Since 1 July 2011, the Allied Health Professions Office of Queensland (AHPOQ) has funded 29 models of care projects designed to reform the way AH services are delivered through innovative approaches, structural and role reorganisation and development of advanced and extended roles.

To date, AH workforce redesign has been limited by the absence of targeted training, education and competencies to support the clinical practice change. Additionally, true engagement and reform in the AH professions is slow and difficult, particularly when there is no structured and formal way to approach the change.[3]

The Calderdale Framework (CF), developed by Effective Workforce Solutions in the United Kingdom provides structure for service and task analysis with a particular focus on clinical competencies and a process for determining tasks that can be skill-shared between professions or delegated to assistant staff. It is a transformational tool to enable service and skill mix review which engages frontline staff at all levels while assuring client safety and quality.[4]

The CF's broad applicability to the whole health workforce is consistent with the key Queensland public health strategy of workforce redesign and productivity. It provides the AH workforce with not only the tools to support workforce redesign but the skills to undertake this process.

Although the CF has the potential to involve nursing (in the context of the broader multidisciplinary team), the focus of this document is allied health. This resource has been developed by AHPOQ to guide and support the implementation of skill-sharing and delegation practice (SSDP) in AH services within the Queensland public health system.

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[1] SARRAH 2011, *Allied Health Assistants in Rural and Remote Australia Position Paper*, Services for Australian Rural and Remote Allied Health.
[2] Queensland Health 2011b, *Innovations in Models of Care for the Health Practitioner Workforce in Queensland Health*, Allied Health Workforce Advice and Coordination Unit, Queensland Government.
[3] Queensland Health 2011b, p.8.
[4] Smith R, Duffy J 2010, Developing a competent and flexible workforce using the Calderdale Framework, Int *J Ther Rehabil* 17(5); 254-262.

Calderdale Framework overview

The CF provides a formal, risk managed and structured framework to provide quality, efficient, responsive and clinically governed services. As a workforce development tool, it ensures safe and effective patient centred care and provides a clear and systematic method for reviewing skill mix, developing new roles, identifying new ways of working and facilitating service redesign by:

- identifying tasks carried out in teams
- deciding which tasks can be delegated or skill-shared across professional boundaries
- creating local clinical task instructions (CTIs) to standardise how tasks are carried out
- providing structured training and competence assessment for professional skill-sharing and delegation practice
- establishing governance processes to support clinicians
- establishing systems to sustain the model of practice in the long term.

The framework has been applied extensively to health services and is transferable to any setting. It can enable delegation to support staff or skill-sharing between professional staff. There are seven stages to successful implementation of CF (Table 1):

Table 1: Calderdale Framework

Stage	Title	Function/Purpose	Focus
1	Awareness raising	Engaging all staff at the outset	Engagement
2	Service analysis	Identifying tasks carried out in teams	Potential to change
3	Task analysis	Deciding which tasks can be delegated or skill-shared across professional boundaries	Risk
4	Competency identification	Creating local CTIs to standardise how tasks are carried out	Best practice
5	Support systems	Establishing governance processes to support clinicians	Governance
6	Training	Providing structured training and competence assessment for professional skill-sharing and delegation practice	Staff development
7	Sustaining	Establishing systems to sustain the model of practice in the long term	Embedding and monitoring

Implementation

The delegation of clinical tasks to AHAs and/or skill-sharing between AHPs will represent a new and potentially challenging way of working for many services within the Queensland public health system. In order to fully realise the benefits and opportunities afforded by this framework, services need to ready the workplace with systems (e.g. clinical governance, training and evaluation) that will support the new model of care.[5] Many of these supporting systems will already be in place (e.g. clinical supervision) while others will need to be established.

The CF entails deconstructing the model of care; then 'putting it back together' in a logical and planned way. It is not the intention of this document to provide an in-depth discussion about the CF per se, but to detail a number of steps (embedded in the stages of the CF) that guide the work unit as it integrates the SSDP framework into its existing model of care, from the perspective of the client and the task.

These steps will be explored in greater detail within Parts 1-3 of this document. Table 2 provides a summary of each step and the stage/s of the CF to which it predominantly relate/s and includes the tools available/generated in support.

Table 2: Steps to support implementation of SSDP

<table>
<tr><td colspan="3">Step A: Identify task and CTI [CF Stages 2/3/4]</td></tr>
<tr><td colspan="3">Written CTI to support identified tasks including developing new CTIs as necessary</td></tr>
<tr><td>Tools:</td><td colspan="2">– Clinical task integration algorithm
– Guidelines for Writing Clinical Task Instructions</td></tr>
<tr><td colspan="3">Step B: Supervise and monitor [CF Stage 5]</td></tr>
<tr><td colspan="3">• Method and frequency of supervision and monitoring tasks determined and enacted
• Reflective practice</td></tr>
<tr><td>Tools:</td><td colspan="2">– PAD
– Continuing professional development
– Reflective practice journal.</td></tr>
<tr><td colspan="3">Step C: Educate and train [CF Stage 6]</td></tr>
<tr><td colspan="2">Theoretical
• Embed the philosophy and principles of SSDP in the workplace – ensuring it is part of the orientation/induction process for new staff</td><td>Work-based training
• Training in the identified CTI and assessment of competence – AHAs
• Training in skill-sharing and assessment of competence – AHPs</td></tr>
<tr><td colspan="3">Learning to delegate (AHPs)</td></tr>
<tr><td>Tools:</td><td colspan="2">– WPI 1: Guidelines for allied health professionals developing delegation skills</td></tr>
</table>

[5] Smith R, Duffy J 2011, *Effective Workforce Programme Facilitators Manual,* Effective Workforce Solutions Ltd.

	– *WPI 2: Guidelines for delegation to allied health assistants* • *Learning Development Plan* – *WPI 3: Guidelines for skill-sharing between allied health professionals* • *Clinical Reasoning Record*
Step D: Allocate client [CF Stage 6]	
Prior to allocating the client ensure: • process for feeding back to delegating AHP has been established – including method, frequency and contingency planning • system of monitoring/supervision is established (i.e. method and frequency) for AHPs and AHAs The delegating AHP ensures client care plans are explicit regarding roles and responsibilities.	
Tools:	– *Allocation Analysis Tool*
Step E: Perform task [CF Stage 6]	
• Refer to client care plan and relevant CTI • Check client observation chart (acute sector) or measure vital signs before proceeding • Obtain client consent • Check three client identifiers before proceeding	
Tools:	– CTI: *'When to stop'*
Step F: Feedback following task [CF Stage 5]	
• Method, frequency and contingency planning for provision of post-task feedback to delegating AHP determined and enacted.	
Step G: Evaluation [CF Stage 7]	
Tools:	– Audit of CTIs – Audit of *CTI Training Registers* – Client and staff satisfaction surveys – Compliments and complaints register – Incident register – Annual credentials check as appropriate.

Delegated and skill-shared practice will be addressed separately.

Part 1: Delegated Practice

A number of Workplace Instructions (WPIs)[6] have been developed to support the process of delegating clinical tasks to AHAs and should be considered in association with this document:

- *WPI 1: Guidelines for allied health professionals developing delegation skills*
- *WPI 2: Guidelines for delegation to allied health assistants.*

Step 1A Identify the task and CTI	**CF Stage 2 Service analysis** **CF Stage 3 Task analysis** **CF Stage 4 Competency identification**

The task analysis stage of the CF will have identified a number of clinical tasks that can be safely delegated to an AHA i.e. delegated practice.

There can potentially be hundreds of tasks identified during this process and it will be up to the work unit to determine how and when to integrate them into the model of care. This will require a reliable system for determining the priority (and therefore order) in which tasks are reintroduced. A decision-making algorithm has been developed for this purpose (Appendix 1). It is based on a number of variables (listed below) against which a score is given:

- availability of an existing CTI to support the task
- frequency of task performance
- whether the task is currently performed in other parts of the service/facility/HHS and whether CTIs are used
- risk rating for the task (as determined by the *CF Decision Table 1* – Appendix 2)
- complexity of the training pathway:
  - availability of existing training programs
  - length of time required to complete the training program.

A higher score implies a higher priority for the task to be integrated into the model of care or into the first tranche of training. The minimum and maximum number of clinical tasks that can be potentially delegated will be determined by the afore-mentioned prioritisation process, staffing levels, the capacity to train and the ability to put adequate supporting systems in place.

Once identified, suitable clinical tasks must be transformed into CTIs. However, it is not expected that every discrete task undertaken by AHAs in the course of their day-to-day work will be or should be reflected in a written CTI and associated training and assessment process.

[6]The contribution of the AH team and Therapy Assistant Working Group, Townsville Community Health Service is acknowledged in the development of these WPIs.

Clinical tasks that potentially involve some risk to clients or other service users should have a written CTI. This would therefore exclude those administrative and operational duties typically performed by AHAs (e.g. confirming client appointments, opening/closing clinics, etc.) which are better suited as local workplace instructions.

Before developing new CTIs, determine whether one already exists locally, nationally or internationally. AHPOQ maintains a database through which all existing and newly developed CTIs for delegated tasks can be sourced. The CTI database is accessible to all CF Facilitators via the AHPOQ website at: http://qheps.health.qld.gov.au/ahwac/content/calderdale.htm.

If an existing CTI is not identified, one needs to be generated by the service. The resource *Guidelines for Writing Clinical Task Instructions* available at: http://qheps.health.qld.gov.au/ahwac/docs/MOC/clinical-tasks.pdf has been developed by AHPOQ to assist work units with this process.

Step 1B Supervise and monitor	**CF Stage 5 Support systems**

Guidelines have been developed by AHPOQ to ensure consistency in the way governance activities support AHAs employed by the Queensland public health system.[7] In addition to delineating the roles of management, supervision and delegation, these governance guidelines also:

- provide a framework in which AHAs can safely practise, ensuring clients receive safe, high quality care
- recognise and meet the support and development needs of AHAs to ensure they are appropriately resourced to undertake their roles
- value development of the existing AHA workforce to boost retention and morale
- enhance awareness of AHPs and line managers in regards to AHA roles and responsibilities.[7]

The different types of supervision and the person/s primarily responsible for their application have been summarised in Table 3. Please refer to *WPI 2: Guidelines for delegation to allied health assistants* for more information.

[7]Queensland Health 2010a, *Governance Guidelines for Allied Health Support Staff,* Allied Health Workforce Advice and Coordination Unit, Queensland Government http://qheps.health.qld.gov.au/ahwac/content/modcareprojects3.htm

Table 3: Types of supervision[8]

Type	Definition	Responsibility
Managerial	The process of line management including: • administration • mandatory training • HR management.	Team Leader
Task (also known as monitoring)	The process of supervising delegated tasks: • can be direct or indirect • tasks may be delegated to an AHA by a number of AHPs (same or different professions) within the team • each AHP is responsible for supervising (i.e. monitoring) their delegated task • AHA should discuss concerns about tasks delegated with the relevant AHP.	Usually an AHP
Clinical	The formal process of support and learning that involves: • developing a mutual commitment between the AHA and AHP to reflect on the clinical practice of the AHA • developing knowledge and skills competence • clarifying boundaries and scope of practice • planning and utilising personal and professional resources • identifying training and educational needs • developing accountability for their work quality.	Usually an AHP [May be a senior AHA in a co-supervisor role with an AHP]

"A delegated practice model of care cannot operate within a team without a co-existent formal notion of clinical supervision".[9]

Step 1C Educate and train	**CF Stage 6 Training**

Prior to implementing a delegated practice framework within the work unit, all AHP and assistant staff are required to have a thorough knowledge and understanding of the definitions, underpinning principles and philosophies of the framework as outlined below and in *WPI 1: Guidelines for allied health professionals developing delegation skills* and *WPI 2: Guidelines for delegation to allied health assistants.*

[8]Queensland Health 2010b, *Supervision & Delegation for Allied Health Assistants* [PowerPoint presentation], Allied Health Workforce Advice and Coordination Unit, Queensland Government.
[9]Department of Health 2013b, *Delegated practice: Basic concepts* [PowerPoint], Queensland Government.

1C1 Accountability and delegated activities

In the *Training in Delegation Practices* training package, Robinson (2013)[10] has defined responsibility and accountability as it applies to delegated practice as follows:

Responsibility	• AHP is responsible • Responsibility cannot be wholly delegated • Authority to perform tasks can be wholly delegated
Accountability	• Can be transferred or shared between team members • Authority to undertake tasks/functions is delegated • Accountability comes with authority

Other references in the literature to accountability and responsibility related to delegation include the following:[11,12,13]

- The delegating AHP is responsible for:
  - the overall management of the client and for the decision to delegate
  - the provision of verifiable "reasonable direction" regarding the delegated therapy program/plan content to the AHA.
- Accountability for delegated tasks is shared between the delegating AHP, the AHA and the employer:
  - The AHP is responsible for the process of delegation and for ensuring standards are maintained by monitoring the outcomes of the delegation. Therefore the AHP must be familiar with the assistant's capabilities and clearly communicate the task being delegated. The AHP must also provide the appropriate level of supervision.
  - AHAs are accountable for their own actions and should only undertake clinical tasks that have been properly delegated and that they are legally authorised and competent to perform.
  - The delegating AHP will not be accountable for the decisions and actions of those to whom he or she delegates, particularly if they choose to work outside the supplied "reasonable direction".
  - If the AHA is not comfortable accepting a delegated task they should discuss this with the delegating AHP.

[10]Department of Health 2013b, p.8.
[11]Physiotherapy Board of Australia 2012, *Code of conduct for registered health practitioners*.
[12]NSW Health 2012, *Allied Health Clinical Supervision Guidelines*, South Eastern Sydney Local Health District, NSW Government.
[13]Queensland Health 2010a, p. 7.

1C2 CF training methodology

The nature of the delegated tasks identified for integration into the model of care will determine the work-based training requirements. Work-based learning forms the basis of the CF training methodology (Table 6) which also provides a theoretical component as part of its two-strand approach.

Table 6: CF training – delegation[14]

Strand	Focus	Elements
Theoretical Evidence of knowledge	What the worker knows and understands as part of the learning experience	• Background knowledge: – SSDP framework – responsibility/accountability – abilities of AHAs – communication and other local support systems • Underpinning clinical knowledge • Delegation training (AHPs)
Work-based Evidence of performance	What the worker can do	• Clinical task training

Work-based training using the CF is provided for both AHA and AHP staff according to the TMC methodology[14] as follows:

Taught (T)	Classroom setting +/- self-directed underpinning theory
Modelled (M)	Observation of other competent workers performing the task followed by practise until competent (i.e. simulation)
Competent (C)	Supervised practice until the assessor deems that the trainee is competent

1C3 Principles of training

Duffy and Smith (2011)[14] describe a number of principles that underpin the CF training methodology for delegating clinical tasks to AHAs:

- Investing in staff development and training benefits the staff, clients and service
- All staff need training to understand the communication system regarding what, when and how to feedback and when a task is to be stopped
- AHAs need to understand the reasons for undertaking the task
- AHAs need to be trained in the relevant clinical tasks so they are competent to undertake them
- Training must follow the CTI in order to ensure consistency for both staff and clients
- Training must be delivered by staff competent in the task

[14]Smith R, Duffy J 2011, p.120-124.

- All AHPs need training to ensure they understand:
  - how the CTIs have been developed
  - what the AHA is competent and capable of doing
  - that renegotiation of the boundaries of practice in the service has taken place in order to make the change successful.

"The AHP's assessment of the individual AHA's capabilities is the critical determining factor to ensure the safe delegation of specific therapy tasks (irrespective of qualifications the AHA has attained)".[15]

1C4 Qualifications

In order to support delegation to the assistant workforce, the Department of Health has invested significantly in the development and delivery of standardised formal qualifications. These qualifications underpin local training to ensure assistants are able to meet individual service needs.

An AHA working at the 003 level is currently not required to have any qualifications to work in the Queensland public health system. However, the Certificate IV in Allied Health Assistance has been identified as the qualification best aligned with AHA roles within the Queensland public health system.[16] Advanced AHAs have the capacity to build on the Certificate IV in Allied Health Assistance and complete further units in order to focus their skills on profession or service-specific areas.[17]

AHPOQ has developed a number of resources for AH elective units (contextualised to the Queensland public health system) that align with the national competencies to allow for formal recognition of the training by registered training organisations (RTOs).[18] AHAs not enrolled in the Certificate IV, and their supervisors, also have access to these elective unit resources.

For example, when a new employee commences they can begin working through the learning and assessment resources to build knowledge and skills (i.e. competency) to enable them to perform their job to the accepted industry standard. If the employee subsequently enrols in the Certificate IV, they will be able to seek recognition of prior learning for the study they have done using the completed activities and assessment tasks to demonstrate competence with the RTO (e.g. TAFE).[19]

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[15] NSW Health 2012, p. 20.
[16] Queensland Health 2011a, *Completion report: Allied Health Assistant Project Phase II*, Allied Health Workforce Advice and Coordination Unit, Queensland Government, Brisbane. http://qheps.health.qld.gov.au/ahwac/content/modcareprojects3.htm
[17] Department of Health 2012, *Supervision and delegation framework for allied health assistants*, Workforce Leadership and Development Branch, Victorian Government.
[18] http://qheps.health.qld.gov.au/ahwac/content/modcareprojects3_2.htm
[19] http://www.tafe.qld.gov.au/students/rpl/index.html

These resources are available at:
http://qheps.health.qld.gov.au/ahwac/content/modcareprojects3_2.htm.

CTIs do not replace attainment of a Certificate IV but can be used in conjunction with the AHPOQ-developed AH electives within the Certificate IV as part of a recognition process with RTOs.

Step 1D Allocate client	**CF Stage 6 Training**

Once the decision to delegate a clinical task has been made, the AHP must still safeguard the client. The five rights of delegation (Table 7) as described by Robinson[20,21] define the essential responsibilities and procedures that ensure that the client receives the appropriate care and consideration:

Table 7: The five rights of delegation[20, 21]

Right Task	The delegated task is: • within the AHP's regular practice (i.e. the AHP is competent in/and able to appropriately supervise the task) • within the AHA's scope of practice.
Right Circumstances	The fundamental scaffolding to support a delegated practice model is provided: • Macro-scaffolding – legislation, regulation and central policy • Meso-scaffolding – organisational policy, credentialing, role descriptions, lines of accountability, standards of supervision • Micro-scaffolding – policy and procedure manuals, protocols and care plans, quality activities, teamwork processes, supervisory relationships • Situational factors – workload e.g. multiple reporting lines – complexity e.g. client, location, other factors – availability of appropriate support.
Right Person	To perform the delegated activity, the assigned AHA must possess: • the appropriate qualification/s i.e. documented and/or validated knowledge • demonstrated competency or skills.

[20]Adapted from Department of Health 2013c, *Delegated practice: 5 'rights' of delegation* [PowerPoint], Queensland Government.
[21]Adapted from Department of Health 2013d, *Delegated practice: Structural delegation* [PowerPoint], Queensland Government.

Right Communication	• The AHA understands and accepts: – the goals and outcomes of the care process – the exact and explicit nature of the tasks/processes delegated – timeframes – other expectations. • Reciprocal (two-way) process to allow negotiation • The AHA is provided with clear direction, concise description and complete information that avoids ambiguity.
Right Feedback	• The AHA is provided with the opportunity to participate in: – a courteous and respectful, reciprocal (two-way) process – timely communication (either booked or following episodes of variance) • Feedback should be specific, explicit, positive and constructive.

Step 1E Perform task	**CF Stage 6 Training**

Before performing the task, the AHA must refer to the client care plan and the relevant CTI. It is also essential to check the client's observation chart (where appropriate) or measure vital signs before proceeding. AHAs shall apply the AHPOQ CTI *"When to Stop"* at all times when working with clients. Please refer to *WPI 2: Guidelines for delegation to allied health assistants.*

This CTI will direct AHAs to clearly recognise danger or warning signs in a client, assess when to safely proceed and when to stop a task with a client.

The AHA is required to seek informed consent according to the *Queensland Health Guide to Informed Decision making in Healthcare*.[22]

Additionally, it is a National Safety and Quality Health Service Standard that at least three approved client identifiers are checked before providing care, therapy or services.[23] These include date of birth and full name together with one of the following: Hospital UR number, Medicare number or address.

Step 1F Feedback following task	**CF Stage 5 Support systems**

Prior to allocating any clinical task, the delegating AHP must ensure that an effective process for the communication of post-task feedback (i.e. from the AHA to the delegating AHP) has been established including:

[22] http://www.health.qld.gov.au/consent/documents/ic-guide.pdf
[23] http://qheps.health.qld.gov.au/psq/safetyandquality/standards/standard-five.htm

- Training for assistant staff on what feedback to give and how and when to give it.
- Agreement on the method and frequency with which the AHA reports back on the status of the client after the task is performed including a determination of minimum reporting requirements e.g. consistent with the CTI; weekly for ongoing exercises or following a session where a task is added or modified.
- Giving due consideration to the nature of the post-task feedback and whether it is routine or urgent. For example, urgent feedback may need to be provided daily compared to routine feedback which may only need reporting weekly.
- A contingency plan should the delegating AHP not be available to receive this feedback.

"All therapy tasks delegated to an AHA need to be clearly and unambiguously documented including an effective post-therapy feedback process".[24]

Step 1G Evaluation	CF Stage 7 Sustaining

Evaluation is regarded as an integral part of the SSDP framework that requires consideration at multiple levels including task performance, the process involved and client outcomes.[25] Table 8 describes the outcome of evaluation at each of these levels and the method of evaluation that might be employed.

Table 8: Outcomes and methods of evaluation[22]

	Evaluation outcome	Method of evaluation
Performance	Allows for review of competence, refinement of skill, further development of learning and development plans if necessary, and the identification of influences/considerations for other tasks.	Observation, de-brief and feedback with AHA/AHP, clinical notes etc.
Process	Allows for consideration of the delegation process itself (not the task). This allows the AHP/AHA to reflect on what worked well or didn't work well, and how can these issues be rectified in the future.	Self reflection and feedback from AHA/AHP.
Client Outcome	Assess appropriateness and impact of the task on the client (e.g. outcomes and progress).	Through client review, outcome measures and clinical notes.

[24] NSW Health 2012, p.20.
[25] Adapted from Department of Health 2009, *Delegation, monitoring and evaluation of Allied Health Assistants*, WA Country Health Service, Government of Western Australia.

More specifically, evaluation should be linked to the outcomes articulated in the awareness raising stage of the CF[26] in order to provide quality, efficient, responsive and clinically governed services.

The supporting systems essential for safe, effective and efficient implementation of the SSDP framework at the work unit level have been summarised in Appendix 3. A robust orientation/induction process for all new starters (both AHP and AHA) must be considered a fundamental supporting system. An example orientation/induction plan for both delegated and skill-shared practice has been provided in Appendix 4.

[26]Smith R, Duffy J 2011, p.131.

Part 2: Skill-share Practice

An additional WPI has been developed to support the introduction of skill-sharing between AHPs and should be considered in association with this document: *WPI 3: Guidelines for skill-sharing between allied health professionals.*

Step 2A	**Identify the task and CTI**	**CF Stage 2** **CF Stage 3** **CF Stage 4**	**Service analysis** **Task analysis** **Competency identification**

The task analysis stage of the CF will have identified a number of clinical tasks that can either:

- remain with the current profession (i.e. uni-professional practice)
- be shared with another AHP of a different profession (i.e. skill-share or transprofessional practice).

The same decision-making algorithm for clinical task reintegration described for delegated tasks also applies to skill-shared tasks (Appendix 1). It is based on a number of variables (listed below) against which a score is given:

- availability of an existing CTI to support the task
- frequency of task performance
- whether the task is currently shared in other parts of the service/facility/HHS and whether CTIs are used
- risk rating for the task (as determined by the *CF Decision Table 1* – Appendix 2)
- complexity of the training pathway:
  - availability of existing training programs
  - length of time required to complete the training program.

A higher score implies a higher priority for the task to be reintegrated into the model of care or into the first tranche of training. The minimum and maximum number of clinical tasks that can be potentially shared will be determined by the afore-mentioned prioritisation process, staffing levels, the capacity to train and the ability to put adequate supporting systems in place.

Once identified, suitable clinical tasks must be transformed into CTIs. Before developing new CTIs, determine whether one already exists. AHPOQ maintains a database through which all existing and newly developed CTIs for shared tasks are sourced. The CTI database is accessible to all CF Facilitators via the AHPOQ website at: http://qheps.health.qld.gov.au/ahwac/content/calderdale.htm

If a suitable existing CTI cannot be identified, one will need to be developed by the local service in consultation with the senior professional delegate/s.

This process is supported by the local CF Facilitator. The resource *Guidelines for Writing Clinical Task Instructions* available at: http://qheps.health.qld.gov.au/ahwac/docs/MOC/clinical-tasks.pdf has been developed by AHPOQ to assist work units with this process.

Step 2B Supervise and monitor	CF Stage 5 Support systems

The Allied Health Professional Support Implementation Standard specifies minimum requirements for professional support for AHPs working within the Queensland public health system including a stipulation that AHPs must participate in professional (clinical) supervision, peer group supervision or mentoring.[27] It is anticipated that all work units that adopt the SSDP framework will already have robust mechanisms in place to support this and it will not be addressed any further within this document. Additional information and resources are available at: http://qheps.health.qld.gov.au/cunningham-centre/html/ah-psp.htm.

In addition to standard supervision arrangements, AHPs undertaking to perform clinical tasks across professional boundaries require additional "supervision and mentoring from a suitably qualified and experienced AHP from the relevant professional background".[28] Please refer to *WPI 3: Guidelines for skill-sharing between allied health professionals* for more information.

Step 2C Educate and train	CF Stage 6 Training

Prior to implementing a skill-shared practice framework within the work unit, all AHP staff are required to have a thorough knowledge and understanding of the definitions, underpinning principles and philosophies of the framework as outlined below and *in WPI 3: Guidelines for skill-sharing between allied health professionals.*

Skill-sharing

Skill-sharing between AHPs is synonymous with transprofessional practice considered by Thylefors et al (2005) to include the "transmission of expertise to other team members" (i.e. role expansion) and "blurring of traditional profession boundaries" (i.e. role release).[29]

Transprofessional teamwork implies cross-training and flexibility in accomplishing tasks.[30]

[27] Queensland Health 2011c, *Professional Supervision Factsheet: Allied Health Professional Support Program,* Cunningham Centre, Queensland Government.
[28] Department of Health 2013a, *Allied Health Advanced Clinical Practice Framework*, Allied Health Professions Office of Queensland, Queensland Government.
[29] Thylefors I, Persson O, Hellström D 2005, Team types, perceived efficiency and team climate in Swedish cross-professional teamwork, Journal of Interprofessional Care, 19(2): 102-114.
[30] SARRAH http://www.sarrahtraining.com.au/site/index.cfm?display=144985

Skill-sharing can occur both within and beyond the recognised scope of clinical practice for the professions involved:

- Within professional scope (i.e. role overlap) – performance of a clinical task that is within the recognised scope of practice of more than one AH profession but as a result of workplace culture and historical practice has been 'adopted' by one profession in particular (e.g. OT might routinely manage referrals for upper limbs and hands in a particular clinical setting). In this instance, a PT may require minor upskilling to competently manage upper limb and hand function.
- Beyond professional scope (i.e. extended scope practice) – performance of a clinical task is outside the currently recognised scope for a particular AH profession and will require acquisition of clinical prerequisites, training and possibly legislative change and credentialling (e.g. dietitians or SP assess both nutrition and swallowing ability in Emergency Departments). In this example the training (i.e. underpinning knowledge and clinical skills) required for the dietitian to assess swallowing ability and conversely, for the SP to assess nutrition must be provided outside their professions.

In the context of the SSDP framework, skill-sharing refers to two or more AHPs sharing knowledge, skills and responsibilities across professional boundaries in assessment, diagnosis, planning and/or intervention. The requirement for a particular role to practise in a transprofessional way must be embedded in the role description. There are significant clinical governance and supervision considerations associated with these roles.

Step 2D Identify client	**CF Stage 6 Training**

Prior to the clinician using shared skills, it is essential that:

- the AHP has the underpinning clinical knowledge and has undertaken sufficient training and/or qualifications to demonstrate competence in the task/s being shared
- appropriate support systems (e.g. supervision strategies) are in place and operational.

Step 2E Perform task	**CF Stage 6 Training**

Before performing the task, the AHP must:

- refer to all relevant documentation including the CTI
- seek informed consent according to the Queensland Health Guide to Informed Decision making in Healthcare.[31]

Additionally, it is a National Safety and Quality Health Service Standard that at least three approved client identifiers are checked before providing care, therapy or services.[32]

[31] http://www.health.qld.gov.au/consent/documents/ic-guide.pdf

These include date of birth and full name together with one of the following: Hospital UR number, Medicare number or address.

Step 2F Feedback following task	CF Stage 5 Support systems

While developing competence in the shared task, skill-share supervised AHPs should provide regular post-task feedback to the lead AHP using a tool such as the *Clinical Reasoning Record*. Once competent, the supervisee should only need to provide feedback to the lead AHP on those occasions where a situation develops that they consider outside their clinical reasoning and/or acquired skill set. In this instance, the client should be referred back to the lead clinician.

Step 2G Evaluation	CF Stage 7 Sustaining

Evaluation is regarded as an integral part of skill-shared practice that requires consideration at multiple levels including task performance, clinical decision-making and client outcomes. More specifically, evaluation should be linked to the outcomes articulated in the awareness raising stage of the CF[33] in order to provide quality, efficient, responsive and clinically governed services.

The supporting systems essential for safe, effective and efficient implementation of the SSDP framework at the work unit level have been summarised in Appendix 3. A robust orientation/induction process for all new starters must be considered a fundamental supporting system. An example orientation/induction plan for both delegated and skill-shared practice has been provided in Appendix 4.

[32] http://qheps.health.qld.gov.au/psq/safetyandquality/standards/standard-five.htm
[33] Smith R, Duffy J 2011, p.131.

Part 3: Sustainability	CF Stage 7 Sustaining

Sustainability can be described as having occurred "when new ways of working and improved outcomes become the norm".[34] With reference to the SSDP initiative, sustainability involves:

- embedding the new model of care into competency-based role descriptions that can be used for recruitment[35]
- local induction and PAD for new team members and regular PAD for existing staff
- maintaining a database of training and competence assessment
- standardised process for the development of new CTIs and easily accessible CTI database
- formalising supervision, monitoring and evaluation processes.

Nancarrow et al (2012) identified a number of workforce change elements and facilitators that can influence the success of new role implementation. It is recommended that these strategies are considered during the preliminary planning phase of service redesign including:

- matching the overall implementation plan with national, state, local, and professional strategic directions
- identifying key attributes required of the AHA, team, and specific team members such as the change leader and those responsible for training the AHA
- a targeted recruitment strategy
- adequate and appropriate resourcing e.g. protected time and/or backfill to allow staff to perform all stages of implementation
- relationships with training organisations and professional bodies
- the need to engage key stakeholders in identifying context specific facilitators and barriers to successful implementation
- objective and consensus-based decision making on the scope of new roles
- robust governance arrangements to make new roles safe.[36]

The NHS Institute for Innovation and Improvement has developed a *Sustainability Model and Guide* comprising ten factors (relating to process, staff and the organisation) that play a key role in sustaining change in healthcare. This resource provides a diagnostic tool that identifies strengths and weaknesses in implementation planning and predicts the likelihood of sustainability for service improvement activities. Please refer to Appendix 5 for a summary.

[34]NHS 2010, *Sustainability Model and Guide*, Institute for Innovation and Improvement.
[35]Nancarrow et al 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.
[36]Nancarrow et al 2012, p.314.

Abbreviations and Acronyms

AH	Allied health
AHA/s	Allied health assistant/s
AHP/s	Allied health professional/s
AHPOQ	Allied Health Professions' Office of Queensland
AQF	Australian Qualification Framework
CF	Calderdale Framework
CTI/s	Clinical task instruction/s
HHS	Hospital and Health Service/s
PAD	Performance appraisal and development
RTO/s	Registered training organisation/s
SSDP	Skill-sharing and delegation practice
WPI/s	Workplace instruction/s

Supporting resources

Allied Health Professional Support Program available at: http://qheps.health.qld.gov.au/cunningham-centre/html/ah-psp.htm
Governance guidelines for allied health support staff available at: http://qheps.health.qld.gov.au/ahwac/content/modcareprojects3.htm
Guidelines for writing clinical task instructions available at: http://qheps.health.qld.gov.au/ahwac/docs/MOC/clinical-tasks.pdf
Training in delegation practices: A guide for allied health professionals and allied health assistants available at: http://qheps.health.qld.gov.au/ahwac/content/modcareprojects3.htm
WPI 1: Guidelines for allied health professionals developing delegation skills available at:
WPI 2: Guidelines for delegation to allied health assistants available at:
WPI 3: Guidelines for skill-sharing between allied health professionals available at:

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Appendix 1: Clinical task integration algorithm

Variable	Score					
Is there an existing CTI for the delegated/shared task?	Yes – AHPOQ		Yes – Internal/other		No or not applicable	
	5		**3**		**0**	
How frequently is the task performed?	Daily	2-3 /week	Weekly	Fortnightly	Monthly	Once/ 2-6 months
	10	**8**	**6**	**5**	**3**	**1**
Is the task currently performed by AHAs/AHPs in other parts of the service/facility/HHS?	Yes – with CTIs		Yes – without CTIs		No	
	5		**3**		**0**	
What is the risk rating for the task? (Decision Table 1)	0-1	2	3	4	5-6	≥7
	5	**4**	**3**	**2**	**1**	**0**
What is the complexity of the training pathway?	Existing training program/takes minimal time to complete		Existing training program requires adaptation/takes moderate time to complete		Extensive training and/or expensive resource investment required to implement	
	10		**5**		**0**	

Appendix 2: CF Decision Table 1[37]

Task Analysis Decision Table 1				
Task:	**Team:**		**Context:**	**Date:**
FOR EACH TASK DISCUSS AND GAIN CONCENSUS ON THE FOLLOWING STATEMENTS	**GO**	**RISK IDENTIFIED** consider the risk & how it can be managed	**DESCRIBE THE RISK**	**HOW CAN THIS BE MANAGED?**
Is the task carried out frequently? (Skill)	**YES**	**NO →**		
Is the Task procedure complex? (Rule /Knowledge)	**NO**	**YES →**		
Does the task require skilled manual adjustment throughout? (Skill/Rule/Knowledge)	**NO**	**YES →**		
a) If error occurs is there an **immediate** negative consequence?	**NO**	**YES →**		
b) Is this reversible? (Rule/Knowledge)	**YES**	**NO →**		
Is ongoing assessment and clinical reasoning required throughout the task in order to adjust input? (Knowledge/Rule/Skill)	**NO**	**YES →**		
Is information collection involved? (Rule/Knowledge)	**NO**	**YES →**		
Is decision making involved based on this information? (Knowledge/Rule)	**NO**	**YES →**		
Are protocols available to follow or Can they be written to support? (Rule/Knowledge)	**YES** **YES**	**NO** **NO →**		
a)Is consequence of error serious (0-5) b) Is likelihood of error high(0-5)	**Score =** **Score =**			
DECISION:				

[37] Smith R, Duffy J 2011

Appendix 3: Supporting Systems checklist[38]

Supporting Systems	Date achieved
Orientation/induction process for all new starters	
Training Register (including clinical work instructions)	
Task allocation process	
Client care plans are explicit	
When to stop – clinical work instruction developed	
Training for all team members (including new starters) : • AHAs • AHPs	
Frequency/means of post-therapy feedback established: • Routine • Non-routine – Urgent – Non-urgent • Contingency plan established if delegating AHP is unavailable to receive post-therapy feedback	
System of clinical supervision and monitoring (i.e. task supervision) established – frequency and methods	
System of reflective practice established	
Organisational system of evaluation (e.g. review and objective setting) established	

[38] Adapted from Smith R, Duffy J 2011, p.119.

Appendix 4: Example Orientation/Induction Plan – Delegated (D) and Skill-sharing (SS) practice

Elements	D	SS
Philosophy and principles of SSDP: • Generic – *A Framework for Local Implementation and Support of Skill-sharing and Delegation Practice for Allied Health Services in the Queensland Public Health System* including Calderdale Framework overview and tools.	✓	✓
• Service-specific Workplace Instructions (WPIs) – *WPI 1: Guidelines for allied health professionals developing delegation skills* – *WPI 2: Guidelines for delegation to allied health assistants*	✓	
– *WPI 3: Guidelines for skill-sharing between allied health professionals*		✓
Allied Health Delegation Training available at: http://qheps.health.qld.gov.au/ahwac/content/modcareprojects3.htm	✓	
Relevant clinical task instruction (CTI) workbooks: • *Learning Development Plan* • *CTI Assessment Grid*	✓	
• *Clinical Reasoning Record*		✓
Supporting systems: • Governance structure • Accountability • Supervision and monitoring: – PAD (linked to Role Description) – CPD – Reflective practice • Communication systems • Evaluation tools	✓	✓

Appendix 5: Sustainability[39]

Factor	Description	Level
Organisation	Fit with the organisations' strategic goals and culture	There is a history of successful sustainability and improvement goals are consistent with the organisations' strategic aims
	Infrastructure for sustainability • Adequate staff trained • Facilities and equipment to support the process • New requirements built into role descriptions • Policies and procedures support the new way of working • Communication systems in place	Staff, facilities, job descriptions, policies, procedures and communication systems are appropriate for sustaining the improved process
Staff	Staff involvement and training to sustain the process • There is a training and development infrastructure to identify gaps in skills and knowledge and staff are educated and trained to take change forward	Staff have been involved from the beginning of the change and adequately trained to sustain the improved process
	Staff behaviours toward sustaining the change	Staff feel empowered as part of the change process and believe the improvement will be sustained
	Senior leadership engagement	Organisational leaders take responsibility for efforts to sustain the change process. Staff generally share information with, and actively seek advice from, the leader
	Clinical leadership engagement	Organisational leaders take responsibility for efforts to sustain the change process. Staff generally share information with, and actively seek advice from, the leader
Process	Benefits beyond helping patients • There are other benefits apart from helping clients • The change reduces waste, duplication and added effort • Things run more smoothly • Staff notice a difference in their working lives	The change improves efficiency and makes jobs easier
	Credibility of the evidence • There are visible benefits to clients, staff and the organisation • Staff believe in the benefits • Staff are able to describe the benefits clearly • There is evidence that this type of change has been achieved elsewhere	Benefits of the change are obvious, supported by evidence and believed by stakeholders
	Adaptability of improved process • The process is able to overcome	The process can be adapted to other organisational changes and

[39] Adapted from NHS 2010, *Sustainability Model and Guide*.

Factor	Description	Level
	internal pressures and continually improve • The process continues to effectively meet ongoing needs • The change does not rely on an individual, group of people, technology, finance, etc. to keep it going • The change continues when these factors are removed	there is a system for continually improving the process
	Effectiveness of the system to monitor progress • Does the change require special monitoring systems to identify improvement • Is the data already collected and easily accessible • Is there a feedback system to reinforce benefits and progress and initiate action • Are the results of the change communicated to clients, staff and the organisation	There is a system in place to identify evidence of progress, monitor progress, act on it and communicate results