

Novel Coronavirus: Allied health workforce flexibility and clinical governance

Purpose

Hospital and health services (HHSs) preparing for and responding to the novel coronavirus (COVID-19) pandemic will seek to increase the availability and flexibility of the allied health workforce to support critical service delivery. Strategies may include:

1. redeploying existing HHS staff from one facility or clinical area to another,
2. using the skills of the allied health workforce flexibly including implementing skill sharing of clinical tasks between professions or formalising areas of shared practice held by two or more professions, or
3. sourcing allied health professionals from other organisations and sectors, either through recruitment to a temporary position, or an inter-agency service partnership, and recruiting students to allied health assistant and HP1 positions.

The purpose of this document is to support HHSs to implement clinical governance processes during the mobilisation of the allied health workforce for the COVID-19 health system response. Recommendations may be applied at the discretion of HHSs and should be based on individual HHS requirements and analysis of associated risks.

Principles

1. HHSs are responsible for delivering safe, high quality clinical care to consumers. Allied health professionals, support staff, managers and leaders share this responsibility.
2. Core mechanisms for implementing clinical governance for the allied health workforce include:
 - recruitment and selection,
 - credentialing and defining scope of clinical practice,
 - performance development processes and
 - supervision (professional support).
3. As part of preparation and response activities, HHSs should ensure clinical governance policies and procedures are current and fit for purpose, including that they:
 - support the mobilisation of the allied health workforce in a service demand surge,
 - reflect local service needs and context,
 - meet the minimum requirements for credentialing and defining scope of clinical practice as described in the:
 - [Credentialing and Defining the Scope of Clinical Practice Health Service Directive](#) (#QH-HSD-034: 2014)¹ (the “Directive”),
 - [Guideline for Credentialing, Defining the Scope of Clinical Practice and Professional Support for Allied Health Professionals](#) (#QH-HSDGDL-034-1:2015)² (the “Guideline”),

- [Allied Health Clinical Governance Framework in Queensland Health](#) (the “Framework”)³, and reflect the intent of the [Australian Commission on Safety and Quality in Health Care’s Standard for Credentialing and Defining the Scope of Clinical Practice](#) 2014⁴, and
- in order to maximise workforce flexibility and responsiveness, do not impose requirements on the service or health professionals that are in excess of the minimum needed to ensure safe allied health services in the relevant facility or clinical area.

1. Increasing the available allied health workforce

Recruitment of allied health professionals

Recruitment of temporary employees will be undertaken in accordance with [HR Policy B1: Recruitment and Selection \(QH-POL-212\)](#)⁵.

Credentialing: newly recruited allied health professionals

Credentialing and defining the scope of clinical practice of allied health professionals in Queensland Health occurs at the point of employment through the recruitment process³. The recruitment process must include an employee of the same profession as the applicant. This enables credentialing requirements to be met including the verification of qualifications, status of registration (verified via the appropriate Australian Health Practitioner Regulation Agency register) and/or eligibility for membership/accreditation/certification of a relevant professional, employment history, evidence of practice history and ongoing professional development, and reviewing an application and other information sources to examine suitability for the advertised position including referee reports³.

Development and supervision: newly recruited allied health professionals

A newly recruited allied health professional may require workplace-based training to refresh knowledge and skills in the clinical area and to align practice to local requirements e.g. local clinical pathways. The training plan should be concisely documented. An example training plan format is available in Appendix 2 of the [Return to practice guide for the allied health workforce](#)⁶.

Supervision sessions provide an opportunity to monitor and support development needs. Supervision arrangements should be proportionate in frequency and approach (direct, remote or telehealth-supported) to the level of upskilling required by the health professional and risks associated with practice in the clinical area. Supervision activities that support development are described in the Return to practice guide⁶.

Recruitment of allied health students

Recruitment and employment of allied health pre-entry students is described in Guidance Notes AH002320 Novel Coronavirus: Allied Health Workforce Planning and AH002338 Novel Coronavirus: Professional support for health practitioner level 1.

External allied health service providers

HHSs may source additional allied health service capacity through engaging individual providers or agencies to deliver services on behalf of the HHS. This includes services delivered to clients face-to-

face and via telehealth. External providers include other HHSs and government agencies, non-government organisations, community-controlled health services and private practices. Allied health professionals working outside the acute care sector will generally be most suited to continuing the delivery of priority community and outpatient services. This in turn will release workforce capacity to enable HHS staff to be redeployed to acute care settings. Examples include community services for clients requiring post-orthopaedic surgery rehabilitation, lymphedema management, diabetes diet and foot care, and grief and loss support. Use of existing and new service agreements and referral pathways, and strong collaboration between HHSs and external providers will be required to fully utilise the allied health workforce capacity in each region. General practice support will also be required to ensure that all eligible community members have a current GP management plan and team care arrangements in place to enable primary care sector providers to use Medicare Benefits Schedule (MBS) items.

Credentialing considerations: external providers

The Directive does not prescribe any specific credentialing requirements for external allied health professionals¹. The Guideline identifies that HHSs can elect to implement credentialing processes for external allied health professionals². External allied health professionals are defined in the Guideline as allied health professionals who are providing services to current patients of the HHS within HHS facilities who have not undergone a Queensland Health or similar recruitment process².

The Guideline recommends that HHSs do not need to implement formal credentialing processes for allied health professionals employed by an organisation that has a recruitment process of similar rigour to Queensland Health. This may include allied health professionals currently employed by other government departments such as Education Queensland or the Australian Defence Force Service². As all HHSs are required to implement Queensland Health human resource policies and directives, allied health professionals who are employed by one HHS and provide services to another HHS via telehealth should not require credentialing². For allied health professionals employed by non-government agencies, the HHS may have existing service agreements that include credentialing responsibilities of the external provider.

2. Redeploying allied health professionals between clinical areas

Allied health professionals may be required to work in different clinical areas or facilities during the coronavirus response. This may include moving between work locations within a HHS or between HHSs, or providing telehealth services between HHSs.

Credentialing considerations: redeployed allied health professionals

For existing employees, credentialing requirements have been met through the recruitment process that has allowed the individual to practice in their HHS role. The Guideline does not identify any additional formal credentialing processes for an allied health professional who intends to perform practices that are recognised as being within the scope of their profession². This would include an allied health professional moving to a clinical area that is different from their usual role, as long as the clinician's intended practice is consistent with the scope of practice of their profession. For example, a physiotherapist in a community rehabilitation role is seconded to a physiotherapy role in a general medical ward.

The Guideline recommends that additional formal credentialing processes are not required for “allied health professionals who are employed by one HHS and provide services to another HHS, for example providing services through a relief pool, exchange or rotation program or via telehealth.”²

Development and supervision: redeployed allied health professionals

An allied health professional moving to a different clinical area may require workplace-based training to refresh knowledge and skills. See Development and supervision: newly recruited allied health professionals (above).

3. Implementing skill sharing and shared practice

Skill sharing in a service model refers to two or more health professionals sharing knowledge, skills and responsibilities across professional boundaries in assessment, diagnosis, planning and/or implementation⁷. It involves a health professional safely and effectively delivering a clinical task that would traditionally be provided by another profession, or that is not explicitly aligned to the health professional’s own entry-level standards.

Shared practice refers to two or more professions, within their accepted scope of practice, possessing the knowledge, skills and competencies to deliver substantially similar clinical tasks and functions. Shared practice is underpinned by content knowledge and skills that are common to multiple professions. Limited workplace-based training may be required to align profession-specific approaches to the team’s agreed, best practice procedure for a clinical task.

Credentialing considerations: skill sharing and shared practice

The credentialing process for skill sharing should be determined at a local level and reflect consideration of the risks outlined in AH002334 Summary Guide: Allied health skill sharing and shared practice. The Allied Health Professions’ Office of Queensland (AHPOQ) recommends that:

- Skill sharing that is a modest change to a health professional’s existing scope of practice, and aligns well to their underpinning professional knowledge, may be approved by the work unit or service delegate. The delegate must confirm evidence of competency assessment. Competence in the task must be assessed by an occupationally competent assessor, and endorsed by relevant profession delegate/s. See AH002334 Summary Guide for further details on training and competency assessment.
- Skill sharing that is substantially different to a health professional’s existing scope of practice, and requires significant development of knowledge and skills, may require formal credentialing as an extended scope of practice. The Directive and Guideline, along with the HHS credentialing policy/procedure, should be applied to manage the formal credentialing process.

As shared practice tasks are consistent with the accepted scope of practice of the relevant profession, formal credentialing and approvals should not be required.

Development and supervision: skill sharing and shared practice

Training, competency assessment and supervision for skill shared tasks are described in AH002334 Summary Guide: Allied health skill sharing and shared practice.

Reference documents

1. Queensland Health, 2014. Credentialing and Defining the Scope of Clinical Practice Health Service Directive (#QH-HSD-034: 2014), 2014 at https://www.health.qld.gov.au/__data/assets/pdf_file/0021/155505/qh-hsdgdl-034-1.pdf.
2. Queensland Health, 2015. Guideline for Credentialing, Defining the Scope of Clinical Practice and Professional Support for Allied Health Professionals (#QH-HSCGDL-034-2:2015), 2015 at https://www.health.qld.gov.au/__data/assets/pdf_file/0021/155505/qh-hsdgdl-034-1.pdf.
3. Queensland Health, 2018. Allied Health Clinical Governance Framework at https://www.health.qld.gov.au/__data/assets/pdf_file/0030/143895/clingovframe.pdf.
4. Australian Commission on Safety and Quality in Health Care, 2004. Standard for Credentialing and Defining the Scope of Clinical Practice at <https://www.safetyandquality.gov.au/publications-and-resources/resource-library/standard-credentialling-and-defining-scope-clinical-practice>.
5. Queensland Health, 2019. Human Resource Policy B1: Recruitment and Selection (QH-POL-212) at https://www.health.qld.gov.au/__data/assets/pdf_file/0034/635893/qh-pol-212.pdf.
6. Queensland Health, 2015. Return to Practice Guide for the Allied Health Workforce at https://www.health.qld.gov.au/__data/assets/pdf_file/0023/140666/rtpguide.pdf.
7. Queensland Health, 2013. Guidelines for Skill-Sharing between Allied Health Professionals at https://www.health.qld.gov.au/__data/assets/pdf_file/0020/155513/wpi-three.pdf.