

# **Bridging allied health roles for better patient outcomes: Developing recognised authorising mechanisms to manage procedures that span professional clinical roles**

## **Executive summary**

Increasing complexity in health care needs are placing extreme pressure on existing, and limited, resources. Complacency about the way we organise work in health care is no longer acceptable. Liberating and enhancing the skill sets and knowledge of allied health practitioners are critical levers to shifting the way health services are delivered.

Relying on good will, and pockets of innovation will not create the momentum that is needed. This includes to shift attitudes and conventions about who *can and should* perform certain tasks. Debunking the myths surrounding health role delineation is imperative and allied health is well placed to lead work in this space. Practitioners, managers and the public need confidence that the person providing care has the skills and competence to do so. That's a given. They also need confidence that precious and finite health system resources are being utilised in the most effective way possible.

Recognising that workforce reform remains vital to the ongoing sustainability and productivity of Victoria's health system, the Ministerial Advisory Committee for Allied Health (MAC:AH) has identified registration and the regulation environment as one of three priority streams to progress the reform agenda in allied health (**Appendix One**). The Bridging Allied Health Roles for Better Patient Outcomes project has been established in response.

The project found that many allied health practitioners already share skills, but that these are generally at low-level or basic, not planned for in any systematic way, and not transferrable across clinical settings or service providers. The project also found that a range of mechanisms to guide practice already exist, for a range of different purposes, but none have been explicitly designed for the purpose of skill sharing. This project has identified that retro-fitting existing mechanisms is not an option - although components of best practice should be included in the model for authoring skill sharing. Importantly, the project did not identify any legal impediments to skill sharing at an advanced practice level, providing there is adequate training and oversight, and compliance with relevant licences.<sup>1</sup>

Authorising mechanisms to recognise skill sharing are “chicken and egg”. When developed, and in place, they can act as a catalyst for changing the norms and practice of sharing skill sets across clinical domains, and create demand for this role by employers. They will also help to tell a positive story about allied health, the breath of expertise available now, and the potential for an even deeper set of skills in the future, that will further encourage interest and uptake by practitioners now.

A three-pronged approach to develop a mechanism to authorize skill sharing is suggested. The first phase, outlining the rationale and scoping a process to develop the model, has already been completed, and is presented in this report. The second phase is to identify and engage stakeholders, and to design the model and the appropriate mechanisms within it. This phase has in

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<sup>1</sup> e.g. Use Licences and Management Licences under the Drugs and Poisons Act of Victoria.

effect already commenced, with the Scenario Forecast Group workshops, and broader stakeholder conversations. The third phase is to implement the model, beginning with demonstration in selected sites for the clinical situations outlined in this report, and following with broader roll out across settings, services and professions.

The premise for all three phases is to start with the end goal in mind - an agile allied health workforce that works seamlessly and safely across clinical domains, respectful of the clinical expertise and paradigms of others, but confident to draw upon the collective wisdom and knowledge of the allied health care spectrum. Iterative evaluation across all phases of the project is imperative. So too is exemplary coordination and proactive communication.

## 1. Introduction

In common with most other countries, people in Australia today are living longer than ever before. Once fatal diseases can now be cured or managed, adding years or even decades to a person's life. But progress brings challenges. People may be living for longer, but often they are living with several, life-long, complex conditions. This growing burden of chronic disease, coupled with the challenges of cost containment, is already putting significant pressure on Australia's health system. This pressure will deepen into the foreseeable future, and compel us to think and act differently about the the nature of work in health care.

A bigger proportion of older people in our population, means a smaller labour force, challenging economic productivity and health care facilities.(1) Advances in science and technology, different work and career preferences, new models of care, and increased awareness (and expectations) by consumers about how health care should be provided, are amplifying these challenges. At the same time, roles have also become more complex, specialized, and non-routine, and can no longer be performed independently or sequentially.

Strengthening health systems so they are more sustainable, is everyone's business.(2) It requires a major re-orientation towards value and outcomes, the involvement of a broader set of stakeholders in a more effective governance structure, and greater engagement and responsibility of patients and citizens.(3) For organisations, it's about better managing the resources they use, reducing waste, *and* improving quality of health care, as part of their normal business operations.(4)(5)

Despite plentiful commentary about expanded scopes, and extended or advanced roles in allied health, and a plethora of pilots, there has been little demonstrable evidence of a real change in the way people work. Evidence examined for this report shows that there is an urgent need to dispel the myths<sup>2</sup> about ownership of roles, and to encourage practitioners to reach across into the clinical domains of others. Information also shows that without a formal mechanism, practitioners are largely reluctant to bridge what is, in reality, a shared clinical space, despite there being no legal impediments to do so. Serendipity has proven to be an ineffective mechanism.

This report briefly outlines the premise for skill sharing, and why authorising mechanisms are necessary to enable practitioners to safely bridge two or more allied health professional roles, whether or not they are regulated under the National Health Practitioner Accreditation Scheme

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<sup>2</sup> The Merriam-Webster Dictionary defines myths as "a popular belief or tradition that has grown up around something or someone; *especially* : one embodying the ideals and institutions of a society or segment of society."

(NRAS)<sup>3</sup>, or unregistered.<sup>4</sup> The report outlines a process to develop and implement a model and authorising mechanism to recognise and endorse advance-practice skill sharing. The report proposes that the initial focus is on clinical situations relating to specific tasks for dietetics and speech pathology, and speech pathology and radiography, however it is recommended that the model be developed so that it is replicable across other allied health care professions and settings.

## 2. The approach

A tripartite approach was used to examine how allied health practitioner roles and scopes of practice in Victoria are currently organised, and to identify potential mechanisms to recognise and authorise skill sharing. A rapid review of published material on extended roles and authorising mechanisms from Australia and internationally,<sup>5</sup> was augmented by interviews with stakeholders, and two scenario planning workshops. (**Appendix Two**) Discussion documents were developed to support deliberations at each of the workshops. The findings of the three phases were analysed and consolidated into a one report - which you are reading now.

### Scenarios

Evidence shows that scenarios can help to illuminate issues, and identify how current and alternative paths might affect the future. Scenarios can also help break impasses, making them extremely effective in revealing uncertainties, opening lateral thinking, strengthening leadership, and enabling strategic decisions. (6)

The following two scenarios tell a story about what *could* happen for a patient (Jo) under current approaches to how the allied health workforce is organised (Scenario one), and for another patient (Alex) under new configurations and roles (Scenario two). The scenarios focus on skill sharing and role overlap for dietitians and speech pathologists providing swallowing assessment/fluid diets, and radiographers and speech pathologists providing videofluoroscopy in swallowing assessment.<sup>6</sup>

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<sup>3</sup>The health professions regulated under the National Scheme are: Aboriginal and Torres Strait Islander health practitioners; Chinese medicine practitioners (acupuncturists, Chinese herbal medicine practitioners, Chinese herbal dispensers); Chiropractors; Dental care providers (dentists, dental hygienists, dental therapists, oral health therapists, and dental prosthetists); Medical practitioners; Medical radiation practitioners (diagnostic radiographers, nuclear medicine technologists, radiation therapists); Nurses and midwives; Occupational therapists; Optometrists; Osteopaths; Pharmacists; Physiotherapists; Podiatrists; Psychologists.

<sup>4</sup>The term 'unregistered health practitioner' is defined to include any person who provides a health service and who is not registered in one of the 14 professions regulated under the NRAS. Unregistered professions in Australia generally operate under well-developed self-regulatory frameworks.

<sup>5</sup>The literature is referenced throughout this report, rather than comprising a separate literature review document. Consumer representatives and advocates were a key part of the scenario forecast working group.

<sup>6</sup> The scenarios are hypothetical. Scenario 1 deliberately ignores the fact that there are established guidelines for the management of stroke. Had these been followed, the pathways and outcomes for Jo may have been different. It is also worth noting that guidelines for the management of other conditions / clinical presentations are generally not as well developed as those for stroke and the scenario attempted to capture this variation.

<sup>7</sup>The clinical situations in the scenarios were chosen by the MAC:AH because they are illustrative of the work commonly performed by practitioners in three allied health professions (NRAS regulated and non-registered or self regulated) in a typical large metropolitan hospital, and where the potential for skill-sharing could reasonably occur.

## Scenario 1

*Jo is an older person who has arrived in the emergency department of a large metropolitan hospital with a neighbour. The neighbour became concerned after Jo hadn't turned up to the RSL for their regular Friday night darts session. On investigation the neighbour found Jo slumped in an armchair. Jo seemed pretty groggy, and the neighbour wasn't able to understand Jo's reattempts at speaking.*

*It is midnight on a Friday evening and the ED is very busy. The administrator asks Jo's neighbour a few questions about Jo's address and age. An ED nurse in the waiting room asks the neighbour a few more questions about Jo. Once in the ED itself, another ED nurse conducts a rapid assessment using the hospital-based ED screening checklist. She notes that Jo has some paralysis, is drowsy, and cannot speak clearly. Jo also has a nasty head abrasion. She tells the neighbour that a registrar will be along shortly. While they are waiting, the neighbour pops out to the hospital cafe to get a coffee and something to eat, including for Jo, as he is unsure when Jo last ate, and it has been a long wait in ED for everyone.*

*Eventually Jo is seen by the registrar. The registrar runs through his own checklist and considers a stroke as the possible explanation for Jo's loss of movement and slurring speech, but that this will need further confirmation by the consultant in the morning. It is now 5 am and Jo is to be transferred to the general ward as soon as a porter is available. The ED is still busy. Speech pathologists (SPs) are not rostered on in the weekend, however there is usually a dietician on call. Jo's neighbour has gone home.*

*It is 7 am by the time Jo gets to the ward, and breakfast has just been delivered. A nurse looks at the ED notes and also notices that Jo may have difficulty swallowing. She notes this on his chart, and asks the dietician on call (who is visiting another patient in the ward) about what food Jo should be on. The dietician recommends nil-by-mouth until Jo is seen by the consultant on Monday. She recommends assessment by a SP as well.*

*The consultant sees Jo on Monday morning, and refers Jo for a scan for the possible stroke. He is also concerned about Jo's cough, and pallor, and that it is possible that Jo may have other underlying conditions. He recommends Jo is seen by the SP. The SP assesses Jo on Monday afternoon. Jo is by now very weak, confused and not looking too good. The SP identifies some swallowing difficulties, but that the extent of this will need to be confirmed by videofluoroscopy, which must be performed by a radiographer. Jo is booked in for a videofluoroscopy on Wednesday (the videofluoroscopy room is closed on Tuesdays).*

*Jo is in hospital for three weeks, and treated for aspirational pneumonia and malnutrition. Jo's stroke is mild but diabetes is also diagnosed. Jo is referred on discharge to the social work and physiotherapy departments for ongoing care, but is readmitted to hospital 2 weeks later after collapsing at home.*

## Scenario 2

*Alex is an older person who has been brought into the emergency department of a large metropolitan hospital. It is midnight on a Friday evening and the ED is very busy. Alex's neighbour became concerned after Alex failed to show up at the club for their usual Friday night darts evening. On investigation, the neighbour found Alex slumped in an armchair. Alex was very pale, groggy, and wasn't able to talk to tell the neighbour what happened.*

*The ED is designed around what it is there for, rather than what health care workers need to do in it. There are health care teams - workers are "grouped" according to health care conditions, not professions. Specialization is around client groups.*

*Alex is immediately part of the older persons team, and a range of skills are linked to care at the outset. Dieticians, speech pathologists, and radiographers are supported and authorised to share specific skills, across roles / traditional domains of care, providing seamless care for Alex. Performance and accountability is both individually and team based. Alex will be able to contribute to this.*

*Assessment processes and treatment protocols are systematised across conditions, building on existing resources and operationalising what already exists. e.g. a standardised, electronic, hospital screening checklist; guidelines for stroke / diabetes.*

*Processes are streamlined, information is accurate and timely, and available. An iPad stays with Alex for the entire duration of stay. All screening, assessment and treatments are documented on a real-time basis.*

*Health care worker peak bodies have evolved to form multi-profession networks to provide expertise, advocacy, and advice on education, training, credentialing and accreditation.*

*Multi-profession governance arrangements support formal mechanisms to assess health care worker competency and conduct, aligned with the National Code of Conduct for Unregistered Health Professions.*

*The new authorising model and mechanisms for enabling skill-sharing are responsive, recognised, embedded, and routinely evaluated.*

*Staff recruitment processes incorporate softer skills, including communication and decision making as well as conventional technical and clinical skills. Continuing professional development for skill-sharing includes accredited in-service training and partner hospital and community secondments, as well as conventional education routes. Motivation and retention of allied health staff is high.*

*Student cohorts and graduate characteristics reflect emerging health care system needs. The workforce is dynamic, flexible, and sustainable.*

*Alex's care journey - into hospital, during hospital stay and home - is safe, high quality, and participatory. Alex recovers at home, supported by the health care team liaison, and returns to Friday darts in the following two weeks. Alex becomes a volunteer community advocate with the older persons team.*

### 3. Findings

- a) Stakeholders who participated in this project, including through interviews, and as members of the scenario forecast group, provided crucial insights that would not have been visible otherwise. Their *willingness to be involved*, engaged and collaborative in the processes of information gathering and debate, provides a sound platform to advance the recognition of skill sharing across clinical domains.
- b) The process used for this project highlighted the importance of acknowledging the strength and influence of existing norms, networks, relationships, values and informal sanctions that shape the interactions between and within professions. Harnessing and building on this *social capital* rather than dismantling it, will enable new arrangements and approaches to emerge, and be sustained.
- c) Moving from a single-profession focus for identity and recognition, to a model that recognises skills across professions, will also require a cultural adjustment. Good *clinical governance* would help clarify issues such as professional identity and eligibility criteria, shared responsibility, title and shared risk, as well as provide the practical and logistical steps to make it happen.
- d) Consistent with international literature, this project found that both formal *levers and mechanisms*, and informal levers and mechanisms (e.g. engagement), are needed to activate a shift in the attitude, and generate actions. These levers are needed at national, local, organisational, team and individual levels.
- e) Importantly, this project found that while many *mechanisms already exist*, e.g. protocols, credentialing and accreditation, and are important, they were designed to serve the needs of individual professions, be applied on a profession-specific basis, and/or for particular patient cohorts, contexts and settings. Thus many only have authority within single professions, single sites or single organisations.
- f) *National mechanisms* that have been developed (such as the National Code of Conduct for Unregistered Health Professions, and the Clinical Care Standards being developed by the Australian Commission for Safety and Quality in Health Care) focus on the delivery of safe, standardised and appropriate clinical care regardless of where people are treated in Australia. These mechanisms also do not explicitly, or formally, recognise or authorise skill sharing.
- g) The project also found that external *triggers* will be required to create the impetus for advanced practice skill sharing, the requisite streamlined processes and frameworks. The shift will not occur by serendipity, despite the emerging willingness by some practitioners, professions and organisations to embrace the concepts. An authorising mechanism is both catalyst and support. Chickens and eggs.
- h) The project found that although the notions of interdisciplinary and trans-disciplinary care are well advanced in the literature, and increasingly, in practice, the message that patients benefit from collaborative, integrated approaches to health care needs to be *communicated widely* to the public, patients and carers, as well as the health care workforce. The establishment of an authorizing mechanism for skill sharing will help raise the profile of connected care.
- l. The literature review yielded numerous related publications including on: the concepts of collaborative, inter-disciplinary, ways of working; studies of advanced and expanded scopes of

practice for allied health; credentialing frameworks for best practice health practitioner regulation; and options for organising non-registered allied health practitioners. The literature review *did not find* published material specifically related to the focus of this project. i.e the development and application of models or mechanisms that recognise, endorse or authorise skill-sharing across allied health professional clinical domains.

## 4. Discussion

This project was initiated by the MAC:AH to scope a process for developing an authorizing mechanism for roles that span two or more clinical domains. Conversations with stakeholders and a review of relevant literature, confirmed that before a process or model could be developed, the rationale (i.e. evidence and assumptions) for the project needed to be explored. These included looking at *why* there is a compelling need for skill sharing, whether skill sharing is *possible* (e.g. from a legal or regulatory perspective), *why an authorizing mechanism is required* ( i.e. what's stopping allied health professions from working in this manner already), and whether *existing mechanisms* are sufficient for this purpose. These issues, which were also explored by the Scenario Forecast Group workshops, are discussed below.

A number of broader contextual issues were also identified during the information gathering phase that are outside the scope of this project. Other issues, such as terminology, will require more attention as the project progresses, and hence warrant a brief commentary in this report.

### a) Terminology

Nomenclature, i.e. the names / terms we use, can vary considerably across health care settings, between health care professions, across disciplines, and in the literature. Difference in terminology is inevitable, given the complexity of health care. For some activities, particularly novel ones, terminology can also exert a powerful influence over buy-in and engagement, and to the place, and pace, of change.

This project identified a range of terms that *could* be used to describe roles that bridge clinical domains, including: skill sharing, hybrid roles, expanded or extended scope, role reallocation and role overlap, and transdisciplinary care. For the purposes of this report, the term *skill sharing* has been chosen, however it is acknowledged that a more suitable term, or common set of language *that people can live with*, may emerge over the duration of this project.

Similarly, the project also identified a range of terms that could be used for recognising practitioners who are assessed as competent to share particular, advanced-level skills. These terms include authorized, endorsed, accredited, and credentialed. For the purposes of this report, the term authorized has been chosen, noting that preferred or more appropriate terminology may emerge as the project progresses, and the practice is embedded over time.

### b) Why sharing skills is needed

In the context of health system sustainability, multi-disciplinary care and teams and expanded scopes of practice have been identified as best practice and cost effective across a range of conditions. The concept of *role overlap*, has also been the subject of debate for at least forty years, and recognised as inevitable within collaborative health care.(7) Information examined for this project, and explored in the scenario forecast workshops, identified that:

- Patients benefit from more timely, connected care (8)
- There is capacity to up-skill all participants in the health care team, including patients (9)

- Competencies and skills should be easily accessed from anywhere in the system (10)
- Skill sharing can *free-up* clinicians, create headroom- e.g. for existing / new skills, research, life-style, time, learning, teaching, governance, mentoring (11)
- Greater skill sharing contributes to building more resilient organisations that can better adapt to a changing environment (12) (13)
- Technology is rapidly evolving, facilitating better access to, as well as information about health care. Procedures that currently require more than one health care worker, may be able to be performed by only one practitioner, or be superseded by technology altogether. The robots are coming, but we do not have sufficiently forward looking mechanisms to monitor and plan for their impact. (14)
- Incentives and levers play a pivotal role in promulgating change in health care delivery (15)
- A range of legislation, regulations, codes and standards already influences the practice environment and protects the public (**Appendix Three**).

### c) *Can skills be shared?*

Many dieticians, speech pathologists and radiographers already routinely collaborate to assess and treat patients who require a combination of dietetic, speech pathology and radiography interventions. This collaboration may include *some* degree of skill sharing, whereby practitioners perform some tasks commonly associated with another profession or discipline within a profession. Many stakeholders described shared skills as like a Venn diagram, with sets of skills that could be common to one or more practitioners in the middle of the Venn. Examples of current practice included:

- insertion of PICC lines and IV cannulation by radiographers under ultrasound and video control
- dieticians assessing dysphagia (16) (17)
- speech pathologists modifying diet for people in aged care and rehabilitation settings
- nurses performing swallowing assessments and malnutrition screening.

Although these examples are encouraging, the type and extent of skill sharing varies significantly across clinical settings and organisations. It appears to be highly dependent on a few key factors, that include: existing collegial relationships, close day-to-day working proximity (e.g. in acute hospitals), and task level (generally low-level, or basic).

An examination of existing legislation and regulations identified that *skill sharing is possible* within current frameworks, providing there is adequate oversight and training. Stakeholders highlighted that a range of other barriers exist that, collectively, inhibit the willingness and confidence of allied health professionals to reach into and share aspects of another practitioners' clinical repertoire. Professional boundaries, turf tension, organisational culture and leadership, and established models of practice and various beliefs about the application of regulatory levers and licences, were just some of the reasons given as to why sharing skills and bridging roles for more advanced clinical practice, has not become routine and embedded practice.

### d) *Why are authorizing mechanisms necessary?*

There is a need to unbundle and tackle some of the myths that permeate the discourse around *allowable* roles and scopes of practice, and the perceived *entitlement* to tasks by one profession over another. Despite many examples of skill sharing being well established in other countries, such as the United Kingdom and United States, literature reviewed for this project suggests that, in Australia, skill sharing has not transitioned much beyond single-centre or multi-centre studies. (18) (19) (20) And while there are system-level differences between countries, nonetheless there appear to be some fundamental issues that prevent the spread of skill sharing beyond the concept



or pilot stage in Australia. (21) These issues could be collectively described as the presence, or absence, of an *authorizing environment* (discussed further in section five) that includes formal levers and mechanisms, as well as informal levers such as engagement, organisational culture and leadership.

Authorising mechanisms would help legitimise the practice of skill sharing across organisational boundaries. Stakeholders for this project confirmed that having new skills or advanced roles recognised across organisations and contexts, would make a significant difference to their interest and willingness to invest in the additional training, upskilling, and clinical or practice challenges that may be required to perform these roles.

Ultimately, the catalyst for skill sharing at an advanced practice level should be demand from employers, service providers and funders. Its a chicken and egg situation. Formal mechanisms to recognise practitioners who are competent and authorised to perform particular tasks in this space, may give employers and others confidence in the efficacy and safety of these roles for their organisations. At the same time, formal mechanisms would provide practitioners with the confidence they need to reach into the clinical domains of others, and for peak bodies, the mandate to advocate for these roles. They would also encourage education institutes to re-orient their programmes of learning towards developing more permeable roles.

#### **e) Are existing tools and mechanisms sufficient for authorizing skill sharing?**

Every day, health care workers make decisions that influence, for example, the number and type of tests, treatments, procedures and care pathways, and the number of days a patient stays in (or out of) hospital. Multiple tools, frameworks and protocols (i.e. mechanisms)<sup>8</sup> to guide these decisions, and shape or control the parameters of work for allied health practitioners have been in place for some time. (22) (23) (24) These mechanisms include:

- Department- or ward-level conventions - e.g. the way we do things around here
- Employer led arrangements - e.g. service-level agreements, standard operating procedures
- Profession-led protocols - e.g. codes of conduct, scopes of practice, competencies, standards
- Formal recognition processes, led by employers - e.g. credentialing; or by peak bodies - e.g. accreditation
- National frameworks and codes for unregulated practitioners— e.g. Accredited Registers (UK), National Code of Conduct for Unregistered Health Professionals (e.g. Australia)
- Negative licensing
- Voluntary self-regulation
- Statutory Regulation - e.g. NRAS

#### **(Appendix Four)**

Existing mechanisms were, however, designed for existing professions, existing roles, and existing services. None were designed explicitly for the purpose of skill-sharing, or to enable future development in health care. Stakeholders generally agreed that even with the best intentions, tools and protocols are not always followed. They may be overly complex, out of date, or lack credibility with clinicians who are expected to use them. Furthermore, busy workloads and different levels of training and experience, can mean that even where protocols are in place, some patients still fall through the net.(25) (26)

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<sup>8</sup>NHMRC estimates there are over 1000 clinical guidelines in Australia, produced by more than 130 developers. NHMRC 2014.

Getting the basics right, including in the rigour, use and streamlining of existing tools and protocols, is important, and many stakeholders suggested that this should occur regardless of the development of authorising mechanisms for skill sharing. They also stressed that the end result should be a complementary suite of easily accessible, relevant tools, that reduce duplication, and increase the overall benefit for users and beneficiaries, especially patients.

## 5. A targeted mechanism to authorize skill sharing

As the previous section highlights, skills should, and can, be shared at an advanced practice level, and that an authorizing mechanism is necessary. A number of elements will be critical to moving from concept to action. These elements, which are fundamental to good system design, and were endorsed by stakeholders, include having a clear purpose, sound principles and transparent processes. Stakeholders also emphasised the need to ensure mechanisms are targeted and relevant, with clear, measurable outcomes that benefit patients, and that strengthen practice into the future. These elements are expanded below.

### a) Purpose

Fundamentally, mechanisms for authorising roles and practice must be relevant and fit-for purpose. For skill sharing, the purpose of an authorizing mechanism includes to:

- Improve timely access to quality care for patients
- Support new roles and models of care that utilize the full suite of practitioners' skills and clinical knowledge
- Provide confidence to organisations and other professions that practitioners have requisite skills and competencies to reach across clinical domains
- Embed skill sharing as business as usual, across professional and organisational boundaries
- Support the development of more sustainable health care delivery and systems
- Reduce the duplication of activity and costs relating to multiple, location-specific endorsements or certifications
- Generate some real, tactical and sustained momentum in the reform agenda.

### b) Principles

International evidence relating to good system design, including for effective authorizing mechanisms, identifies a number of key elements that need to be present, and that help determine the type of mechanisms that will best give effect to policies.<sup>9</sup> These elements, or principles, include:

- Clear purpose - start with the end goal in mind
- Clear, measurable outcomes - that can be evaluated
- Well defined criteria - for what (or who) needs to be authorised
- Responsiveness and agility - in the face of changing health care and system needs
- Sound governance and clear accountabilities - for who "owns" model and how is their performance in implementing the model evaluated
- Transparent, simple and effective processes - including for activating the authorization mechanism, and managing risks or concerns
- Clear sources of financing - sustainable, proportionate to benefits of the mechanism
- Alignment with other relevant, mandated, standards, codes, regulations and legislation

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<sup>9</sup> For example Right Touch Regulation. Professional Standards Authority, UK

- Routine evaluation of the performance of the model and mechanisms, and, critically
- Engaged and involved stakeholders - visibility and participation of patients and carers, clinicians, non-clinical workforce, health service managers and senior executives, and policy makers.

### c) Process

A three-pronged approach is recommended to identify a process, and develop and implement the model and the mechanisms within it, as follows:

- i) **Phase one** - scoping a process to develop an authorizing mechanism
  - Completed and documented in this report
  
- ii) **Phase two** - designing the model. This phase includes:
  - *Coordination* - Identify what functions need to be coordinated, at what level and the expertise required. This is a critical role, requiring dexterity, pragmatism and fortitude, to harness opportunities, minimise risks, and generate momentum
  - *Stakeholder engagement* and socialisation of the concept. This has already commenced, through scenario forecast group workshops and stakeholder interviews. Build on the existing goodwill and support for the concept, expand this engagement, ensuring consumers / patients are actively involved throughout the project
  - *Governance* - of the process. This includes identifying who (e.g. expertise from peak bodies, clinicians, consumers, health care organisations, employers, funders, and policy makers) and how (e.g. network, shared, frameworks, guidelines, accountabilities). Seeds of clinical governance already exist in work of the scenario forecast group and through broader stakeholder engagement. A suggested clinical governance approach is attached as **Appendix Five**
  - *Communication* to debunk the myths and generate interest. This is also a critical role, and includes identifying who (e.g. practitioners, peak bodies, the department), for what (e.g. to communicate or socialise the process, respond to issues, concerns and risks) and how (e.g. newsletters, emails, social media, stakeholder fora)
  - *Design* - includes agreeing: the principles, criteria for which skills are in the Venn diagram; processes for initiating and maintaining authorization; education pre-requisites; CPD; and managing concerns
  - *Evaluation* should be iterative and occur throughout all phases of the project.
  
- iii) **Phase three** - demonstrating and implementing the model and mechanisms. This phase includes:
  - Identifying which *clinical situations* e.g. similar to those in this report
  - Identifying a range of *potential sites* through an expression of interest process, to demonstrate the utility of the model across settings and services and locations.
  - *Demonstrate and evaluate* the model and mechanisms
  - Encourage an authorizing environment i.e. by identifying the building blocks (described below), who is responsible for these, and how do they align / intersect / influence this project.

### d) An authorizing environment

New mechanisms or approaches are especially needed where roles are novel, or where there are competing agendas. A concurrent and connected process that strengthens the acceptance, applicability and benefit of skill sharing roles and mechanisms across professions and contexts and domains is also needed. This *authorizing environment*, consists of a number of building

blocks, that include: understanding the drivers and incentives –that is the value proposition; collaborative education and training; and good data and information. These are briefly described below.

Good design and successful integration of any new initiatives depends on how familiar we are with current policies, frameworks, key drivers and incentives. (27) Understanding and clearly articulating the *value proposition* i.e. what will be better for patients, consumers, practitioners, professions, managers and services, is essential. In Australia and elsewhere, new funding models are being explored, focusing on outcomes rather than outputs, and there is emerging interest in more Individualisation of services, and *specialization* around client groups.<sup>10</sup> There is also a shift in the balance of public to private provision of health care, and a corresponding increase in choice for consumers.

Historically, health professions education and healthcare practice have developed and functioned separately, with little recognition that the two are inextricably linked (28). Given that advanced roles that use skill-sharing are premised on team-based care, it follows that a more collaborative approach to *education for skill sharing* is needed. This includes from government departments, authorising “agencies”, peak bodies, and education institutes. The latter have a key role in fostering the values, skills, opportunities and professional role-socialisation, and an understanding of the paradigms that are underpin transdisciplinary learning and practice.(29)(30)

For authorising systems to be effective, the outcomes being sought, and the impact of the mechanisms on these outcomes, must be able to be quantified and evaluated. A wealth of data already exists across the system, but is disconnected and poorly utilized. A good data system to underpin this project is essential, as evidence shows that good data helps to improve the rigour and transparency of decision making, and to target limited resources where they are most needed.(31) Indicators<sup>11</sup> that reference, align with, or build on, existing national and/or state based systems, will support the integrity of the model and the sustainability of the mechanism. **Appendix six** lists some of the indicators that could be considered for this project.

## 6. Conclusions

Information from the literature and stakeholders shows that allied health is well positioned to lead the way to more integrated approaches in the way health care is delivered. A wealth of clinical, science and therapy skills exist across multiple professions, paradigms, disciplines and roles. Importantly, allied health practitioners already play a pivotal bridging role, linking assessment, treatment and care, across contexts and settings, and professions.

There remain, however, a number of obstacles to developing roles that transcend traditional clinical domains, and that enable practitioners to utilise the full range of their skills and higher levels of clinical reasoning. These obstacles may, to a large extent, be addressed through the development and application of mechanisms that endorse and authorize the practice of higher-level skill sharing.

A three pronged approach is suggested to develop the authorizing mechanism. The first phase has been to scope a process - and this phase is presented here, in this report. Phase two includes

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<sup>10</sup> For example, The National Disability Insurance Scheme (Australia); Integrated Health and Social Care Budget (UK); the New Model, including for Enhanced Individualised Funding (NZ); and Integrated Care Pathways (UK)

<sup>11</sup> *Indicators* are instruments which are used to measure or determine what is happening over time, measure progress made or establish benchmarks for judgement. Indicators are an important element of performance measurement to strive for good practice and ensure continuous quality improvement.

engagement with stakeholders, initial socialisation and testing of the concepts, and design of the model. This phase has also already commenced with the establishment of a Scenario Forecast Group, and through interviews with a broad range of stakeholders. Importantly, the response from stakeholders to the concept has affirmed the need for a mechanism to be developed, and that there are no legislative barriers to doing so. It has also generated considerable interest from a range of individuals, and a desire to continue to be involved as the project progresses. This augurs well for the third phase, which is to implement the model in selected sites, focusing firstly on the clinical situations described in this report, but with the intention of rolling it out across clinical settings and allied health professions.

Iterative evaluation is a critical component of all three phases, to ensure the model is agile, relevant and integrated. Clearly articulated outcomes, appropriate measures, and robust data are fundamental. And finally, the success of the process, and to an extent, the model, is dependent on exemplary coordination; not only of process, but to nimbly, and strategically, position the project phases where they have best chance of success. This requires being attuned to the broader reform agenda, incentives, policies, politics, risks and opportunities, and a competent communicator who can traverse the many dimensions of this work.

## 7. Recommendations

1. A cross-profession, pan-organisation, streamlined and efficient approach for advanced practice skills sharing is imperative. This will not occur by serendipity. An authorizing mechanism to formally endorse advanced practice skill sharing should be developed, building on the clinical engagement already generated through the scoping phase.
2. Good *coordination* of the entire process to develop the model is essential. This should span the initial scoping work (this report), establishing a clinical governance network and framework, (for developing the mechanism), and progressively embedding the authorising mechanism through demonstration to business as usual.
3. Getting the basics right, including debunking the myths is essential. The coordination function should include proactive *communication* about the concept, the process of developing the model and mechanisms, demonstration and implementation. The ability to competently, and concurrently manage expectations from a range of stakeholders, and maximise opportunities is essential.
4. Establish a *clinical governance network / group*, drawing on the membership of the project scenario forecast group, to develop the model. This group should reflect expertise drawn from practitioners, clinicians, peak bodies, consumers, employers, funders, and policy. It should be agile, progressive and time-limited.
5. A *clinical governance framework and guidelines* should be developed to support the design, demonstration and implementation of the model. This framework should include: clearly stated governance and accountability; how the model will be financed; an agreed set of principles and outcomes; skills to be included in the shared space (i.e. the venn diagram); criteria or thresholds for skills or practitioners that require authorization; processes e.g. to initiate and monitor authorization / endorsement; education and CPD; HR considerations; and what is in and out of scope. It will also include identifying the measures and indicators for evaluating the mechanism and model.

6. Demonstration of the model should initially focus on *clinical situations* similar to those illustrated in this report, and that involve speech pathology, dietetics and radiography professions.

7. Care should be taken to avoid this project concluding as “yet another pilot”. *Iterative evaluation* of the model (coordination, clinical governance, development and demonstration) is essential, and will support progressive implementation and integration as business as usual. The evaluation should identify, at the outset, what outcomes will be measured, what data is required and its sources, and how performance of the model will be measured and reported over time.

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## Appendices

Appendix One: MAC:AH - priority projects

Appendix Two: Scenario Forecast Group - role and membership

Appendix Three: Related legislation and regulations

Appendix Four: Examples of existing authorising mechanisms

Appendix Five: Proposed Clinical Governance framework for authorizing skill sharing

Appendix Six: Suggested indicators



## Appendix One: MAC:AH priority projects

The Ministerial Advisory Committee for Allied Health (MAC: AH) was established in 2013 to provide advice and guidance to the then Minister for Health on issues that may be impacting on the quality of services and optimal utilisation of the allied health workforce including workforce reform; emerging issues and longer term opportunities informed by national and international trends; emerging technologies; and education and professional development and registration. The establishment of this strategic leadership group comprising thought leaders from across 27 allied health disciplines, across sectors and settings to work in conjunction with the Chief Allied Health Advisor, has provided a unique opportunity to initiate and progress work to articulate and optimize the value of allied health services in improving health outcomes for all Victorians.

The work program developed under the auspices of this committee and the Chief Allied Health Advisor, includes activity in three priority areas. These comprise: Strategically positioning allied health to have more influential/ meaningful contribution into the health dialogue and the health system reform agenda; demonstrating the capability of allied health to lead reforms including in the regulatory space that improve patient and health system outcomes (this project- *'Bridging allied health roles for better patient outcomes'*), Progress or achievement realized in any of the work streams will have flow on benefit into the other priority areas through increasing the visibility of the allied health contribution to better health outcomes, and more effective and cost effective health care delivery.

## Appendix Two: Scenario Forecast Group information sheet

### Role

The *scenario forecast group* is asked to:

- provide/refine perspectives on the current situation for roles or tasks that sit, or could potentially sit, between dieticians and speech pathologists (clinical situation 1), and between radiographers and speech pathologists (clinical situation 2)
- identify what is *already working well*, and the mechanisms that support this
- identify arrangements and mechanisms that currently inhibit workforce flexibility, and patient outcomes (recovery) i.e *the problem we're trying to solve*
- identify possible *solutions* to the problem - highlighting the role of "authorising" mechanisms
- provide examples of mechanisms and governance model/s in other jurisdictions that could be relevant in the Australian context and for the two clinical situations
- identify 3-4 scenarios or patient stories / journeys that could illustrate the solutions
  - Identify other potential credentialing and /or endorsement processes appropriate to the specified activity or procedure(s) in the scenarios.
- suggest possible structure/s and features of the authorising mechanism(s) and model, for 3-4 scenarios/patient stories, in each of the two clinical situations. This model will potentially be tested in demonstration sites.

### Scope and parameters

*Scenario forecast group* members will be encouraged to be creative, to challenge assumptions, and to think beyond their personal, professional, or institutional contexts. They will also need to be pragmatic. The scenarios need to recognise and respond to:

- a significant increase in service demand but limited increase in funding
- an increasing and ageing population, with more disease complexity and co-morbidities
- maintaining or improving the quality of, and access to, services
- a continued need to address inequalities
- reducing the duplication of services, mechanisms and processes
- the interface with other regulations, legislation, authorising mechanisms,
- simpler journeys for patients - triple aim
  - an improvement in individuals' experience of their health care and better individual health outcomes
  - an improvement in the health and well-being of communities
  - a reduction in the per-capita costs of health care
- consideration that the status quo is acceptable, if there are no superior alternatives.

### Membership

The Scenario Forecast Group membership draws on a broad range of experience, knowledge and expertise relating to the project. Members are not "representatives" of particular organisations or institutions - rather the intention is to gather multiple perspectives, tap into networks and create a dynamic interchange of ideas. Conversations with other stakeholders will continue throughout the project, to augment the groups discussions e.g. for specific technical, service, system level, or data related information.

### Meetings

The group will meet twice face to face, and if necessary, by teleconference and through email. A discussion document will be provided ahead of the first meeting on 28 May. This paper will explore issues and current context (situational analysis), and identify published material related to these issues (literature review). It will also provide information on various authorising mechanisms, as well as key principles relating to design, governance and accountability. A second discussion document will be provided for the second meeting on 17 June. The purpose of this meeting to respond to the revised situational analysis, literature review, and agree the scenarios and proposed model.

## Scenario Forecast Group members

## Scenario Forecast Reference Group members

Name	Title	Organisation	Profession
Alan Malbon	Director Radiography Department	St Vincent's Hospital	Radiography
Annette Byron	Senior Policy Officer	Dieticians Association Australia	Dietetics
Brenda Wraight	Director	BKWraight Consulting	Health Policy Consultant
Charlie Flynn	Practitioner Member	Physiotherapy Board Australia	Physiotherapy
David Collier	Chief Executive	Australia Institute of Radiography	Radiography
David Lescai	Senior Policy Advisor	Department of Health and Human Services	Allied Health Policy
Elisabeth Mount	Dietician	Monash Health	Dietetics
Fiona McKinnon	Group Manager, Allied Health and Community Programs	St Vincent's Hospital	Allied Health
Gail Mulcair	Chief Executive Officer	Speech Pathology Australia	Speech Pathology
Glenda Kerridge	Manager of Social Work	Eastern Health	Social Work
Kathleen Philip	Chief Allied Health Advisor	Department of Health and Human Services	Allied Health Policy / Physiotherapy
Marilyn Baird	Professor	Monash University	Medical Radiations
Mark Marcenko	Practitioner Member	Medical Radiations Practitioners Board Australia	Nuclear Medicine
Mary Anne Silver	Senior Manager	Monash Health	Dietetics
Mary Edwards	Consumer Advocate	AHPRA	Consumer Advocate
Rhiannon Begg	Manager Speech Pathology and Audiology	Melbourne Health	Speech Pathology
Russell Booth	Chief Nuclear Medicine Technologist	Medical Imaging Department	Nuclear Medicine
Tanya Gilliver	Associate Director of Allied Health	Northern health	Dietetics, Podiatry, Speech Pathology, Audiology, Orthoptics & Orthotics

## Appendix Three - Relevant legislation, regulations, standards and codes

### **Radiation Safety Act 2005, and Radiation Regulations 2007**

Radiation sources are regulated by the Radiation Safety Act 2005. Section 13 of the Act provides: Use of a radiation source prohibited unless licensed

- (1) A natural person must not use a radiation source unless the person—
  - (a) holds a use licence, that is in force, that allows that use; or
  - (b) is exempted under section 16 from the requirement to hold a licence in respect of that use and the person uses the radiation source in accordance with the exemption; or
  - (c) is an approved tester and uses the radiation source in accordance with a tester's approval he or she holds that is in force. Penalty: 1200 penalty units.
- (2) An offence under this section is an indictable offence.

Applications for a **Use Licence** must be made to the Secretary of the Department (s37) and the Act also sets out the form of the application and the information to be included (ss.38 & 40).

Applicants seeking a licence to use radiation sources must meet certain requirements prior to the issuing of a Use Licence. **Management Licences** must be held by organisations that use or possess radiation equipment.

*In relation to this project* - videofluoroscopy is a series of x-rays and hence, is a radiation source. A speech pathologist would need a *Use Licence* to use videofluoroscopy unless they were exempted from this requirement. The service in which the speech pathologist is conducting the video fluoroscopy would also need to hold a *Management Licence*.

### **Drugs, Poisons and Controlled Substances Act 1981**

Drugs and poisons controlled under the *Drugs, Poisons and Controlled Substances Act 1981* and the *Drugs, Poisons and Controlled Substances Regulations 2006* are defined under the Act as being in the Poisons Code or in the Commonwealth Poisons Standard 2015.

*In relation to this project*: Videofluoroscopic evaluation involves the administration of a barium solution (barium sulfate). Barium sulfate appears to be excluded from the list of poisons in Schedule 6 of the Commonwealth Poisons Standard

### **Health Practitioner Regulation National Law (Victoria) 2009**

Medical radiation practitioners must be registered under the Health Practitioners Regulation National Law, whereas speech pathologists and dietitians are not regulated as part of the National Registration and Accreditation Scheme.

*In relation to this project* - the National Law does not define what practice different types of health practitioners can and cannot do, with three exceptions – spinal manipulation, certain dental acts and prescribing of optical appliances.

### **Other legislation that could have relevance to the project includes:**

Occupational Health and Safety Act 2004

Health Services Act 1988

Health Records Act 2011; Health Records Regulations 2012

Public Health and Wellbeing Act 2008; Public Health and Wellbeing Regulations 2009

Food Standards Australia and New Zealand Act 1991

Healthcare Identifiers Act 2010; Healthcare Identifiers Regulations 2010

Personally Controlled Electronic Health Records Act 2012

Therapeutic Goods (Victoria) Act 2010

Equipment (public Safety) Act 1994

Workplace Injury Rehabilitation and Compensation Act 2013

National Standards and Codes in Australia, relevant to this project include, but are not limited to:

### ***National Code of Conduct for Unregistered Health Professions***

The National Code of Conduct (the National Code) was agreed by Ministers in 2015. It sets standards of conduct and practice and applies to the provision of health services by: a) health care workers who are not required to be registered under the Health Practitioner Regulation National Law (including de-registered health practitioners), and b) health care workers who are registered health practitioners under the Health Practitioner Regulation National Law and who provide health services that are unrelated to their registration. *In relation to this project:* The model should reference the National Code, and not seek to duplicate it or the structures that are being established to implement it. For example, a common web portal will be developed and a nationally consistent suite of explanatory materials to support the National Code, ed by the Australian Health Complaints Commissioners. There will also be a common framework for the collection and reporting of data and for annual performance reporting to the COAG Health Council.

### ***National Safety and Quality Health Service (NSQHS) Standards***

The NSQHS Standards were developed by the Australian Commission on Safety and Quality in Health Care (ACSQC) to drive the implementation of safety and quality systems and improve the quality of health care in Australia. The 10 NSQHS Standards provide a nationally consistent statement about the level of care consumers can expect from health service organisations. In September 2011, Health Ministers endorsed the NSQHS Standards and a national accreditation scheme. This has created a national safety and quality accreditation scheme for health service organisations.

*In relation to this project:* Standards developed within the model should reference and align with the NSQHS standards.

### ***Clinical Care Standards***

The ACSQC is working to formulate and monitor safety and quality standards and work with clinicians to identify best practice clinical care, to ensure the appropriateness of services being delivered in a particular health care setting.

*In relation to this project:* Clinical Standards developed for the model should reference Clinical Care Standards being developed by the ACSQS, and ensure they remain aligned over time.

## Appendix Four: Authorizing mechanisms - examples, and comment relevant to this project

- Departmental-level conventions
  - Description - the way we do things around here
  - Benefits include - can be more responsive to immediate context
  - Issues include- standards and approaches within a health service may vary considerably; may not be based on sound policy or evidence; can be controlled by individual behaviour and preferences
- Employer -led arrangements
  - Description - Includes service level agreements, contracts, Memoranda of Understanding, Standard Operating Procedures
  - Benefits include - formalises expectations around how services will be delivered; can enable outcomes and KPIs to be measured
  - Issues include - variability in standards, approaches between services; no continuity for practitioners if they change jobs; patients receiving treatment across a range of providers may experience quite different models of care.
- Scopes of practice
  - Description - Profession-led, generally defined by relevant professional association or peak body. Documentation usually outlines the practice of the profession, and the competencies or minimum requirements that the professional must meet in order to practice. The documentation may also describe additional training or education requirements that may be needed to move to a new area of practice, or to expand practice, and may incorporate principles of Continuous Professional Development.
  - Benefits include - consistent approaches across state and territory, and/or nationally
  - Issues include - interests of each profession may conflict; may not reflect new models of care, interdisciplinary practice etc, can be narrowly interpreted
- Competencies
  - Description - a cluster of related abilities, commitments, knowledge and measurable skills that enable a person (or an organisation) to act effectively in a job or situation
  - Benefits include - can be developed over time, can reflect the multifaceted nature of clinical practice, practice settings and cultural differences, enabling the person to act in a wide variety of situations
  - Issues include - approaches to ensure reliability and validity of competence indicators and assessment tools vary widely, may lack rigour; reporting methods may lack objectivity
- Structured competency attainment framework.
  - Description -. is used for advanced practice areas. Workplace implementation of competency processes follow a consistent framework, e.g. the the *National Office for Overseas Skill Recognition* competency-based standards.
  - Benefits include - by following a standard format for competency attainment, the credentials granted by one organisation may be more easily compared to those granted by another employer.
  - Issues include - Voluntary; difficult to assure objectivity, particularly for assessment of competency, may not reflect setting or cultural context

- Standards
  - Description - a common set of requirements, behaviours, ethics that are required for entry to a profession.
  - Benefits include - Generally published documents, they set out specifications and procedures designed to ensure health professionals practice is safe, reliable and consistent
  - Issues - may not be formally linked to education, curriculum, other assessment tools, or accreditation of education providers and programs.
  
- Accredited professionals
  - Definition - Some professional associations offer a mechanism to accredit, or endorse, the qualifications and skills that are required to provide expert professional advice, or as a practitioner in that profession.
  - Benefits include - can provide assurance to the profession, other professions and the public that the accredited practitioner has achieved the requisite skills and knowledge, and that there is (likely to be) a system of oversight for monitoring practitioner performance
  - issues - voluntary, cannot be enforced, generally only available to members of the professions peak body; may not be recognised by other professions, employers, patients.
  
- Credentialing
  - Description - formal processes used by a health care organisation (employer) to evaluate and verify qualifications, formal training and clinical and management experience of health care professionals.
  - Benefits include - can embed good practice; can protect clinicians in the event of an adverse outcome; can provide assurance to employers that staff have attained the requisite qualifications
  - Issues include - generally organisation specific, not transferable across organisations, multiple approaches and variation in rigour of processes.
  
- Voluntary / Self-regulation
  - Description - practitioners voluntarily choose to join a professional association, thereby subjecting themselves to the rules of the association. As a condition of their membership, they may agree to abide by a code of ethics, undertake CPD and meet other practice standards.
  - Benefits include - membership may be withdrawn by the association for breaches of professional standards. A variety of government and non- government organisations that fund or provide health services (such as Medicare Australia, workers compensation, transport accident insurance, and private health insurance funds) rely on such professional associations to regulate their members.
  - Issues include - whilst position papers and statements can guide the profession and its members, professional associations have no power to enforce their recommendations, act upon breaches of their Code of Ethics by non-members, nor govern the actions or behaviour of non-members.
  
- Accredited registers (UK)
  - Description - organisations that hold voluntary registers, ie self regulate, are accredited by a statutory body (e.g. the Professional Standards Authority UK) and hold a quality mark or endorsement after assessment
  - Benefits include - offers recognition and support by key stakeholders; the organisation can be rigorously assessed as having effective processes in place to assess standards, handle complaints, address poor performance of practitioners.
  - Issues include - UK model requires an independent statutory body to oversee and manage

#### Codes of Conduct

- Description - expected professional and clinical behaviour and ethical conduct. The National Code of Conduct for Australia has now been approved by COAG.
- Benefits include - sets a benchmark for practitioners; visibility for other professions and the public about expected behaviour and conduct;

- Issues include - for non-registered, profession-specific Codes, developed peak bodies, not enforceable for non-members of peak body; limits to the degree of and impact of censure - e.g. practitioners can still practice even if membership of peak body withdrawn
- Statutory Regulation
  - Description - set by legislation, defines mandatory standards for entry to a profession, can censure or remove from practice those who fall significantly short of those standards, and promoting and enforcing clinical competencies and standards of ethical conduct.
  - Benefits include - provides minimum, enforceable standards to protect the public; carries to most force
  - Issues include - carries the most cost; can be misinterpreted as providing professional “recognition”



## Appendix Five: A suggested approach for clinical governance

### Bridging Allied Health Practitioner Roles for Better patient Outcomes - Authorized Skill Sharing: Clinical Governance Guideline

1. **Purpose**
  - The guideline should provide recommendations regarding best practice and a standardised approach for clinical governance for authorizing mechanisms for advanced practice skill sharing in allied health
2. **Links / alignment with other processes**
  - The guideline should identify relevant legislation, regulations, standards, codes and policies.
  - It should define processes that support skill sharing and the delivery of safe, quality and sustainable health care for the people of Victoria.
3. **What / who the guideline covers - could include**
  - This guideline is relevant to allied health professionals practicing in the fields of Speech Pathology, Dietetics and Radiography.
  - It provides information for Victorian health system employees and others (including patients, carers, contractors, consultants and volunteers).
  - It does / does not cover the practice of allied health professionals working in the private sector
  - other considerations
4. **Related documents - for example, fact sheets on procedures and protocols such as:**
  - Employment arrangements
  - Quality use of medical imaging
  - Speech Pathology competencies / standards
  - Dietetics competencies / standards / accreditation
  - Radiography regulation / standards / accreditation
  - Authorised shared skills for allied health (SP, D, R)
  - Practice standards and competencies for authorised shared skills for allied health (SP, D, R)
  - Other
5. **Forms and templates - These might include:**
  - requests / application to initiate an authorization process
  - competency / skills assessment
  - education or practice plans
  - any supervision requirements
  - agreements for monitoring / oversight / review etc
6. **Guideline for allied health practitioners who are authorised / endorsed in skill sharing. This could cover:**
  - background or rationale for the shared skill role
  - the clinical governance framework
  - what practitioners are authorised to do
  - what's out of scope
  - what ongoing requirements are needed to continue to be eligible for authorisation / endorsement - CPD
  - professional responsibilities generally
  - how will concerns / complaints be managed

**7. Overview of the framework. This might include:**

- recommended minimum standards and processes for all clinically related aspects of the role
- how the framework aligns with other clinical governance, credentialing, accreditation, regulatory frameworks in the Victorian (public) health system.
- an outline of fundamental best practice for the role to ensure a systematic approach to managing, maintaining and improving the quality of patient care within the Victorian public health system.

**8. Prerequisites for consideration of authorization / endorsement as a shared skill practitioner - considerations might include:**

- Education and qualifications
- Employment, HR
- Indemnity
- Is the role likely to be classified in any awards
- Is the role likely to be classified in schedules and benefits (such as medicare)

## Appendix six: Potential indicators for evaluating of the model

Indicators measure the impact of the mechanism on the outcomes that have been identified and agreed. They should be signposts, not shackles. There are numerous indicators that could be relevant for this project include. A small sample of the type of indicators include:

- Patient reported experience of health care, services and outcomes
- Opportunity cost - lost time, lost productivity
- Trends over time - hospital bed days, admissions, readmissions, discharges
- Trends over time - Community / primary care visits, service utilization, referrals to secondary care
- Equity indicators - such as how well a service meets the requirements of particular groups in society e.g. older persons. people with disabilities
- Recruitment, retention and motivation of allied health professionals and other staff
- Costs
- Audit of efficiency
- Clinical outcomes
- etc