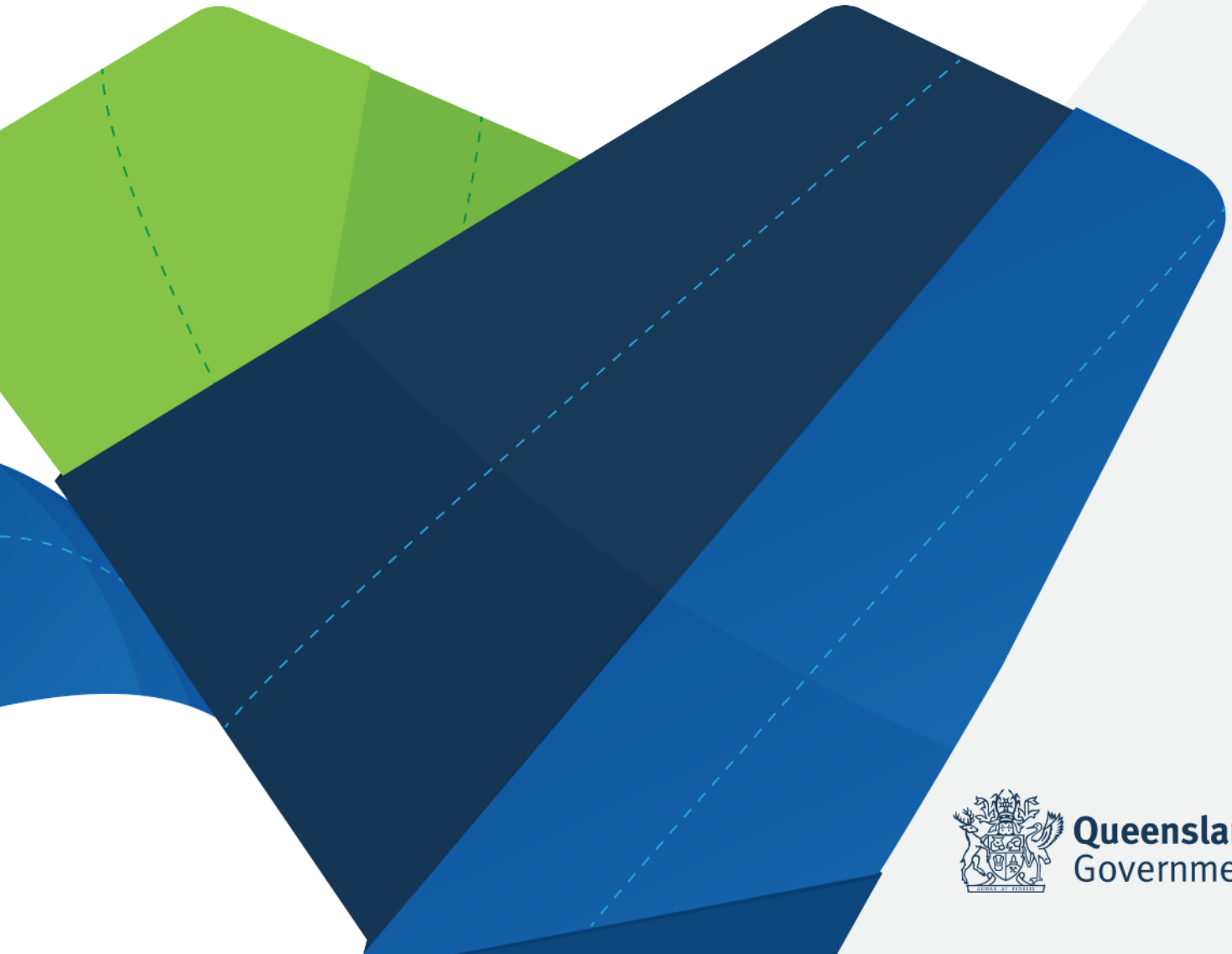
Queensland Health

Skill Sharing Framework

November 2022



Queensland Government

Terminology

The Office of the Chief Allied Health Officer acknowledges that terminology differs across the health system. The term 'client' is used throughout this document to refer to health service users in all health service contexts.

Skill Sharing Framework - November 2022

For further information contact Office of the Chief Allied Health Officer, PO Box 2368, Fortitude Valley BC QLD 4006, email allied_health_advisory@health.qld.gov.au, phone (07) 3328 9298. An electronic version of this document is available at: www.health.qld.gov.au/ahwac/default.asp

Disclaimer:

Foreword

It gives me great pleasure to present the Queensland Health Skill Sharing Framework. Increasingly there is a need to adopt new ways of working to improve efficiency and achieve coordinated care. The Optimising the allied health workforce for best care and best value: A 10-year Strategy 2019-2029 supports the allied health workforce to adopt service models that contribute to the broader healthcare team, and provide high value, efficient and person-centred services. Skill sharing between health professionals to improve health care delivery through workforce redesign, is one such model.

Skill sharing refers to two or more health professionals sharing knowledge, skills and responsibilities across professional boundaries in assessment, diagnosis, planning and/or intervention. Demonstrated benefits include reduced duplication, increased access to services and improved consistency in care. Health services recognise that skill sharing requires integration into clinical governance, training and supervision, and service delivery processes to be a safe and effective approach to delivering person-centred, high-value care.

More than a decade has passed since Queensland Health implemented the Calderdale Framework as a method to support the development of skill sharing between professional staff. I am extremely proud of the number of teams that have spent time implementing and evaluating skill sharing in practice. The Skill Sharing Framework has been collaboratively developed by allied health clinicians, teams and their managers across Queensland Health using the richness of their lived experiences in meeting service needs through skill sharing. The challenges, solutions and insights from their experiences with skill sharing have been interwoven into this Framework and provide encouragement and practical advice for those considering, developing or refining skill sharing to meet the health care needs of the communities they serve. Each service and community are unique, and so it is my hope that through applying this Framework, you will be supported to identify the opportunities for skill sharing that are relevant to your service needs.

I wish to thank those who shared their stories of successes and struggles, achievements and challenges. In being open to new ways of working together as a multi-disciplinary team to respond to your patients' needs, you have paved the way for others to examine skill sharing in their service. I encourage you to continue to embrace innovation, deliver clinical excellence, work collaboratively and use new technology to make a difference in the lives of Queenslanders.

Liza-Jane McBride
Chief Allied Health Officer
Clinical Excellence Queensland

Strengthening allied health. Strengthening healthcare.

Contents

Overview

The Skill Sharing Framework guides healthcare teams in Hospital and Health Services (HHSs) to examine, plan and implement skill sharing that addresses the needs of their clients and the community and reflects their service context, team structure, skills and experience, and strategic priorities. It is divided into three sections.

- **Section one** defines skill sharing and describes its contribution to high value care through client-centred, safe, efficient and effective service models. The principles that underlie the practice of skill sharing are presented and the accountabilities associated with skill sharing are discussed.
- **Section two** presents key considerations for scoping skill sharing in practice, including contextual factors that support successful skill sharing, the value of using a quality improvement approach, and factors affecting the integration of skill sharing into the wider service model, such as the assessment of benefits and risks, risk management strategies, and the potential outcomes for clients and the team. Advice on implementing skill sharing across teams and agencies is also covered.
- **Section three** covers the processes of embedding skill sharing within existing systems to support sustainability. Content includes the importance of documentation, systems for quality and safety management and monitoring, operational processes, and workforce development and support.

Using the Framework

As no two situations are alike, the Framework is not designed to be a prescriptive process but rather a guide to the issues that should be considered and the processes that can enable the implementation of skill sharing. Teams must use sound professional judgement and understanding of their local context to inform the decisions made and processes used to implement skill sharing. The potential benefits to clients, staff and the service need to be weighed against the extent to which any risks can be adequately managed and the resource demands of sustainable implementation. For some teams, designing and implementing skill sharing can be relatively simple and quick to progress, particularly when skill sharing is used for a small number of related tasks that represent a modest expansion of scope for a few health professionals. In other situations, that include complex redesign of roles and services, and innovative strategies to address risk, clinical governance and other challenges, the process requires detailed planning and effort over an extended period, which demands considerable investment and leadership.

This Framework, along with related skill sharing resources are available on the Office of the Chief Allied Health Officer website https://www.health.qld.gov.au/ahwac/html/extended-scope and provide a sound foundation for allied health professionals to integrate skill sharing into their service model and practice.

1. Understanding skill sharing

1.1 Defining skill sharing

1.1.1 What is skill sharing?

Skill sharing describes two or more health professionals sharing knowledge, skills and responsibilities across professional boundaries. The term is used in Queensland Health allied health services to describe health professionals performing clinical tasks (assessment, diagnosis, treatment planning and/or implementation) that are not generally performed by their profession.

Once training and competency requirements are met and relevant clinical governance is in place, skill shared tasks are implemented as part of an allied health professional's individual scope of practice and within an approved service model. The skill share-trained allied health professional is accountable for the decision to undertake the clinical task, delivering the task safely and consistent with best practice, interpreting outcomes and integrating findings into the client's care plan. [1]

1.1.2 Principles and characteristics of skill sharing

The Queensland Health allied health workforce has many years of experience designing and implementing skill sharing. Through this experience, Queensland Health has identified:

- **principles** that must be fulfilled when skill sharing is implemented (Figure 1), and
- **lessons** for successfully implementing and sustaining models of care that include skill sharing (Figure 2).

Figure 1

Principles of skill sharing

1. The primary motivation for skill sharing is to serve the **best interests of clients**.
2. Skill sharing must **enhance the performance of the service** through improved accessibility, continuity of care, effectiveness, efficiency and sustainability, and/or safety.
3. Skill share-trained professionals are **accountable for their decisions and actions** when undertaking skill shared clinical tasks.
4. Skill sharing must be **integrated into the clinical governance processes** of the service to ensure consistency with organisational standards of quality and safety.
5. Skill sharing requires robust and consistent **support and supervision** from the profession that has the skill shared clinical task in its accepted scope of practice.
6. Skill sharing is a **clinical task substitution model** not a profession or workforce substitution model.
7. Skill sharing depends upon a commitment to **collaborative care and the mutual respect** between all members of the healthcare team.

Figure 2

Lessons learned from successful skill sharing

Successful implementation of skill sharing in Queensland Health has most commonly occurred when:

1. Initial implementation begins with a small number of clinical tasks, and a series of **iterative quality improvement** cycles are used to progressively expand the range of tasks shared within the team.
2. It involves a **modest expansion of clinicians' existing scope of practice**, which enables training, skill maintenance and clinical governance demands to be sustainably managed.
3. It is implemented for **high frequency** clinical tasks that can have the greatest impact on timeliness and comprehensiveness of services.
4. Teams have a **cohesive and collaborative culture** and a relatively **stable workforce**.
5. The **clinical governance arrangements** are proportionate to the risks involved (i.e. not unduly complex for low-risk tasks, nor cursory where risks require mitigation).
6. It is implemented **alongside other clinical and operational strategies** that in combination optimise the model of care (e.g. telehealth, delegation to allied health assistants, and changes to administrative processes).
7. The design enables **optimal use of the skills and capabilities** of each team member, including new graduates, early career professionals and experienced practitioners.

1.1.3 Skill sharing and related practice approaches

Multiprofessional practice refers to team members from different professions liaising and working co-operatively, but in parallel, to deliver care. In this practice approach, individual health professionals engage separately with the client to develop and implement a care plan that is focused on goals from their own profession's perspective.[2]

Interprofessional practice (or interprofessional collaborative practice) refers to 'multiple health workers from different professional backgrounds providing comprehensive services by working with clients, their families, carers and communities to deliver the highest quality of care across settings'.[3] Interprofessional practice involves clinicians working collaboratively to optimise clinical and health outcomes. Health professionals share responsibility for developing and implementing a care plan with the client. Each team member applies their knowledge and skills and understands and acknowledges the contribution of other professions in the team, to support the goals in the care plan.

Transprofessional practice involves health professionals transcending profession-specific boundaries, and sharing knowledge, skills and decision-making.[4] In a transprofessional service model, each member of the team, irrespective of professional background, can work in partnership with a client to develop and implement a comprehensive care plan. Typically, clients experience highly integrated care and multiple professions in the team share a common or substantially similar scope of clinical capabilities.

1.1.4 Skill sharing along the continuum of different practice approaches

Although defined separately, the three approaches described above represent practice along a continuum of team collaboration, shared responsibility and decision-making, and integration of care across professions.

A team or service will have a predominant practice approach that is influenced by the needs of the client group, the service model, skill mix, structure and dynamics of the team, practitioner experience and preferences and a range of other factors. Skill sharing can be implemented within service models that are characterised by strong cross-professional communication and collaboration, and shared care planning and decision-making. Consequently, it is best aligned to interprofessional and transprofessional practice approaches.

Skill sharing provides a mechanism to safely extend the scope of practice of one or more team members to support the service model. Skill sharing can be a key enabler of a transprofessional practice approach, if the service model requires team members to deliver tasks that are not usually performed by their profession in other settings or contexts. Interprofessional health care teams may also implement skill sharing, where it has the potential to enhance clients' access, experience and outcomes and to improve service efficiency and responsiveness.

1.1.5 Skill sharing and scope of practice

The **scope of practice of a profession** refers to 'the full spectrum of roles, functions, responsibilities, activities and decision-making capacity that individuals within that profession are educated, competent and authorised to perform'.[5] An **individual practitioner's scope of practice** should strongly align to, but may not mirror, the scope of practice of their profession. An individual's scope of practice is influenced by client and community needs, the priorities of their service context, training and continuing professional development, professional interest and other factors. Over time, a health professional will typically lose recency of practice in some clinical areas that form part of the graduate standards for their profession. Health professionals will also gain capabilities, through work-based and formal training and experience, that are beyond those they possessed at entry to their profession. Skill sharing extends the scope of a health professional beyond the entry-level competencies of their profession, enabling the delivery of clinical tasks and functions that are more commonly performed by a different profession in other services or clinical settings.

1.1.6 Comparing skill sharing and shared practice

Shared practice refers to two or more professions possessing the knowledge, skills and competencies to deliver the same or substantially similar clinical tasks and functions. This may reflect common requirements in entry-level standards (e.g. physiotherapists and occupational therapists providing upper limb therapy; social workers and psychologists providing grief counselling and support; podiatrists and medical practitioners ordering and reviewing lower limb x-rays to inform diagnosis) or occur through post-entry/post-graduate accredited training programs that can be completed by multiple professions (e.g. lymphoedema; diabetes education; x-ray operator, cognitive behavioural therapy).

Skill sharing differs from shared practice in that a skill share-trained practitioner can implement clinical tasks and functions that sit outside the usual scope of practice of their profession. By comparison, a shared practice, although not necessarily aligned to entry level standards, is considered an accepted area of practice for the profession.

An individual clinical task can be both shared practice and skill sharing, depending on the professions delivering the task. For example, a home environment assessment may be considered a shared practice for occupational therapists and physiotherapists working in a community aged care services but would be skill sharing for the team's social worker.

Recognising shared practice

A metropolitan community child development service has two full time physiotherapists and only one occupational therapist. Manual wheelchair (MWC) prescription is usually done by the occupational therapist in the service, but the team recognises that having the physiotherapists also perform the assessment and prescription process would make better use of the team's resources and be more client-centred.

One of the physiotherapists has recently moved to the team from a disability service provider and routinely assessed clients and prescribed MWCs in that role. He has current competence in the task. The other physiotherapist last performed the task more than 15 years ago.

MWC assessment and prescription is shared practice for occupational therapy and physiotherapy. That is, the task is an accepted part of practice for both professions and is conducted by either or both professions in other HHSs and sectors. An individual practitioner's ability to deliver the task is influenced by their previous experience and training, rather than the professions' scope and entry standards. Although one physiotherapist in the team does not possess adequate recency of experience and current competency in the task, it is not skill sharing.

The physiotherapist makes a plan to upskill and re-establish her competence in MWC assessment and prescription, including accessing training resources through her professional association, completing a two day workshop available from an industry training provider, and participating in observations and case discussions over a two-month period with the occupational therapist and other physiotherapist with current competency in the task. Beyond upskilling the physiotherapist, implementing this shared practice task across the two professions requires no substantial changes to the service model, clinical governance or other team processes.

1.1.7 Comparing skill sharing and delegation

Delegation is the process by which an allied health professional allocates clinical and health related tasks to an allied health assistant with the appropriate education, knowledge and skills to undertake the task. The allied health professional identifies the need for the task and provides a delegation instruction to the allied health assistant who accepts and then performs the task with appropriate monitoring by the allied health professional and then provides feedback to the delegating allied health professional. The delegating health professional then integrates the findings back into the client's care plan.[6] This contrasts with the skill share-trained professional who is solely accountable for the decision to implement the skill shared clinical tasks within the care plan, interpret the outcomes and use this information to inform future care.

1.2 Why use skill sharing?

Allied health teams in Australia and overseas have been formally implementing skill sharing for over 20 years. Peer-reviewed research demonstrates that skill sharing is a safe and effective approach to delivering person-centred, high-value care.

Table 1 summarises evidence for skill sharing's contribution to positive outcomes for clients, professionals, and the service.

Table 1 Outcomes arising from skill sharing for clients, professionals, and services

Clients	Health professionals and services
• Improved client-centred practice [7] • Improved service access and reduced wait times [8-12] • Better care co-ordination and case management [7, 11, 13] • Greater consistency of care [14] • At least equivalent and in some cases better client outcomes and quality of life [8, 12, 13, 15] • Improved client experiences [8, 10, 12] • Reduced service duplication [11]	• Improved workforce flexibility [7] • Increased staff skills [16] • Increased staff satisfaction [7, 8, 10-12, 16] • More team collaboration [7, 11, 16] • Improved team relationships and culture [8, 13, 12] • Improved client flow through reduced length of stay and reduced readmissions [12] • Greater cost efficiency [10-13, 16, 17]

1.3 Skill sharing accountabilities

Questions of accountability are frequently raised by allied health professionals and service managers when skill sharing is being considered.

Each allied health profession has a broadly described scope of practice in professional competency frameworks and standards. These standards rarely define individual tasks as in or out of scope. Moreover, there are few allied health clinical tasks that are restricted to specific professions by legislation or regulation (see 2.4.1).

All allied health professionals are obliged to ensure their clinical practice aligns with relevant standards, their individual scope of practice and the approved local service model (see 1.1.5 above). Individual scope of practice is influenced by qualifications, formal and work-based training and professional experience. Once an allied health professional is trained and demonstrates competence in any clinical task - including skill shared tasks - the task becomes part of their individual scope of practice. As autonomous professionals, skill share-trained allied health professionals are accountable for decisions they make to conduct skill shared tasks, how they deliver the clinical tasks, and the way they interpret and use the outcomes to inform ongoing client care.[1]

As a natural extension of these accountabilities, issues relating to management of clinical incidents and associated questions about the validity of indemnity insurance for skill share-trained allied health professionals should be considered in the same way as any other task within a professional's individual scope of practice.

In the same way that local services have systems to support quality and safety for a professional workforce group, equivalent support for quality and safety is required for the skill share-trained allied health professional. Obligations by the local service system and the profession that has the task in its accepted scope of practice include, but are not limited to, providing appropriate training and competency assessment; ensuring access to ongoing support and supervision; defining clear limits to the scope of the skill shared tasks and establishing associated escalation pathways; embedding quality assurance and risk assessment and management processes into existing service systems; and implementing

mechanisms for monitoring, reporting on and refining skill sharing based on practice outcomes. Advice on how the service can ensure these obligations are in place is discussed in Section 3.

1.4 Skill sharing alongside other service development strategies

Skill sharing is just one of many strategies used to maximise value-based health care and is rarely implemented alone. Other clinical and operational strategies that might be implemented with skill sharing include:

- allied health workforce and service development options (e.g. delegation to allied health assistants, changes to the available skill mix such as increased hours of a specific profession, alternate service delivery modes such as video teleconferencing)
- internal organisational strategies (e.g. improving shared understanding of team roles; refining team processes; introducing new tools, resources and processes)
- partnerships with external providers (e.g. private-public partnerships, partnerships with non-government organisations).

Skill sharing in action - Improving client intake

Problem: A multi-site child development service was experiencing long waiting lists and high fail to attend (FTA) rates. The service included occupational therapists, physiotherapists, psychologists, social workers and speech pathologists, who believed that the service could be more client centred.

Process: Patient experience interviews indicated that children and families found the assessment process tiring, with appointments scheduled for up to 90 minutes; clinician's questions were often duplicated and following the assessment the child may not have need for further engagement with each professional.

Chart audits were undertaken to map the number and range of assessments performed and identified that sites used different service models and clinical approaches, and there was variation in the clinical assessments used. Significant duplication was present with practitioners of each profession implementing a range of tests independently, or collaboratively as a joint session in some cases.

Results were presented to the team and a 4-hour workshop with paediatricians, clinicians and consumers was conducted as part of developing the model. The team saw opportunities to streamline the administrative intake process and to investigate skill sharing with a focus on a two-part intake process including a carer interview and a comprehensive child development assessment.

The team agreed that for 6 months their service and quality improvement time would focus on this activity.

Challenges: Some team members and sites were more ready for change than others. Sites with high levels of trust in the team and that were already implementing some commonly agreed screening tools or outcome measures were observed by the project team to be more open to investigating skill sharing. Other team members reported concerns that skill sharing would result in professionals becoming de-valued or de-skilled and may negatively impact patient outcomes. Providing an understanding of the service from different perspectives maintained a consumer-centred service redesign approach.

Service Change: Administrative processes were standardised and streamlined. A transprofessional assessment tool for use by all clinicians was developed, including thresholds for escalation of identified problems and recommended actions (watch and wait, providing brief intervention, referral). With strong and supportive guidance across the teams and the involvement of enthusiastic change champions, momentum for implementation was achieved.

Outcome: Families reported positive experiences including having a clear plan at the end of the assessment and a better understanding of each clinician's role in their child's care. Patient flow improved and clinicians reported increased job satisfaction, working relationships and improved referral information for triaging.

Learning: By recognising the individuality of each service site, and maintaining a strong focus on clients and families, concerns were generally overcome. Participation of developmental paediatricians and consumers in some project activities was valuable. It was also important to explore concerns raised by clinicians regarding loss of professional identity and role clarity. Concerns about loss of professional skills were discussed in relation to the development of new skills by individual practitioners, the expansion of knowledge and capabilities across the team, and the importance of each profession contributing their profession-specific expertise for clients requiring assessment beyond the scope of skill sharing. The shared focus of the team in a single area for improvement contributed to team development.

Value of skill sharing: This team identified that most clients, irrespective of the profession indicated on the referral, engage with multiple professionals over the course of their care. Skill sharing was used to ensure that children and families would receive a comprehensive, best practice assessment process that assisted care planning. Skill sharing also formalised existing informal role expansion that the team later reflected was occurring 'organically' through exposure to the practice of others in the multi-professional team. The confidence of clinicians implementing these skills increased, and new team members were able to develop these skills quickly.

2 Scoping skill sharing

2.1 Planning for success

Like all changes to practice, successful implementation of skill sharing will be influenced by favourable contextual factors and effective change management. Five key elements are necessary for effective implementation and sustainability of skill sharing.

- **Support from senior leadership:** Skill sharing is understood and supported by senior service managers and clinical teams are empowered and trusted to lead change.
- **Alignment with local priorities:** Skill sharing is designed and implemented to respond to the specific needs and priorities of the local clients, community, team and service.
- **Shared understanding:** All stakeholders are engaged, a high level of trust is present in the team, and the team works collaboratively with stakeholders to design, implement and review the outcomes of skill sharing.
- **Access to resources:** The team has access to knowledge, skills and time to enable the design, implementation and sustainability of service model changes. Frameworks, implementation guides and other resources are available.
- **Sustainable systems:** Processes to support skill sharing are proportionate to the scale of the change and the level of risk involved and are integrated into organisational systems, including clinical governance, risk management, training and development, and quality improvement.

2.2 Using a quality improvement approach

Like other service development strategies (and as noted in section 1.1.2), skill sharing is most successful when implemented through a series of successive quality improvement processes that include deliberate reflection, review and refinement. Embarking on skill sharing design and implementation using the iterative process of the Plan-Do-Study-Act cycle (Figure 3) supports:

- early identification of whether skill sharing is likely to achieve the intended outcomes, or whether alternative and/or additional options should be considered
- development of a model informed by the team's evolving understanding of key issues
- progressive improvement of the model
- adjustments to respond to changes in local needs and context over time.

Figure 3 Plan-Do-Study-Act cycle

Plan:

Define the goal of the skill sharing and design an approach

Do:

Implement the skill share clinical task/s

Study:

Identify successes and areas for improvement

Act:

Adjust the goal and method

2.3 Understanding the current situation and potential for skill sharing

Health service improvement can be achieved through addressing an identified problem or responding to an opportunity for improvement. Each problem or opportunity will require a different response and the nature of the response will depend on whether the issue relates to clinical, administrative and/or operational tasks.

Skill sharing can contribute to service improvement that relates to clinical tasks and functions of the team. Administrative or operational challenges are better addressed through other strategies e.g. system review and process improvement, procedural changes.

The first step in determining the potential value of skill sharing is to conduct an assessment of the situation. Mapping provides a structured approach to this assessment process. The breadth and depth of the mapping process should reflect the scope of the problem or opportunity that the team is examining. It should also be proportionate to the changes being considered.

In broad terms, mapping involves

1) stakeholder identification and process selection,

2) data and information gathering,

3) map generation,

4) process analysis, and

5) action planning: [18]

- **Stakeholder identification and process selection** should identify:
  - all stakeholders - clients, their families and carers; professional and operational team leaders; clinicians; operational and administrative staff; and external service providers*
  - tools relevant to the situation and ensuring knowledge of their use and application
- **Data and information gathering** might include:
  - experiences of clients, families and carers; allied health, nursing and medical staff; administrative and operational staff and referrers, accessed through direct feedback, records of compliments and complaints, client surveys
  - client records and databases
  - risk registers and clinical incident reporting
  - other quantitative and qualitative data systems
  - established clinical pathways, Work Instructions, and Procedures
  - service and clinical outcomes data
  - funding and budget e.g. travel, outreach costs
  - emerging knowledge, information or practices relating to client safety, research evidence, client and community need, strategic priorities, service systems, administrative systems, financial imperatives, and technological advances.
- **Mapping** should include perspectives from all relevant stakeholders and consider client experiences, the clinical pathway, and operational processes that support care.
  - A map of the **clinical pathway/s** relevant to the problem or opportunity the team is examining including the sequence and timing of clinical tasks, any inter-dependencies between tasks, team members currently delivering the tasks, the location/setting and any other relevant clinical context information.
  - **Operational processes** associated with each stage of the clinical pathway should also be captured. Examples include referral processes; scheduling; waiting list management; client admission, discharge and transfer processes; client transport systems; provision of resources (e.g. medication, equipment); finance and billing; data capture; information exchange etc.
  - **Client experiences** should be mapped against each clinical and operational process. Examples include the experience of waiting for appointments and participating in consultations, for example repeating a medical history to different professionals, logistics for attending and co-ordinating multiple appointments, cost, use of telehealth etc.

* Consumer involvement should be guided by the Partnering with Consumers Standard within the National Safety and Quality Health Service (NSQHS) Standards from the Australian Commission on Safety and Quality in Health Care[33] local Hospital and Health Service consumer and community engagement strategies; and the Health Consumers Queensland Consumer and Community Engagement Framework for Health Organisations and Consumers.[34]

Validation of the map with the different stakeholders should occur before proceeding to analysis.

- **Process analysis** requires the team and stakeholders to explore the problem or opportunity to identify whether skill sharing is likely to be indicated. The process analysis should also include identifying the potential for any unintended, unwanted consequences for other parts of the service system. Skill sharing is likely to be a relevant service development response if the following circumstances arise due to issues related to the clinical tasks and processes of the team (rather than operational or administrative tasks and processes):
  - **wait times** that act as barriers to other processes progressing and result in bottlenecks in client flow (e.g. waiting for assessment, fitting, training and review of aids impacting discharge timeframes)
  - **duplication and overlap of clinical tasks** that place additional demands on clients, families and carers and result in resource waste (e.g. similar or repeated assessments delivered by different clinicians)
  - **gaps** where clinical tasks do not occur at all or do not occur at the optimal stage in the clinical pathway (e.g. delayed referral to allied health profession impacting outcomes or discharge timeframes)
  - **handovers** for a profession to deliver a minor component of the entire care plan or clinical pathway may introduce unnecessary risk of error.
- **Action planning**: Where the prior stage of process analysis suggests skill sharing is a relevant response, action planning can proceed. This includes planning to implement the changes to clinical tasks as well as related administrative and operational processes. As with all prior stages, all team members and relevant stakeholders should be included in action planning pertinent to their roles and the interface between roles.

Mapping processes and tools

NSW Government, Agency for Clinical Innovation:

- Mapping Diagnostics [19]
- How to Process Map: Clinical Program Design and Implementation [20]
- Journey Map [21]

UK NHS:

- Improvement Leaders' Guide – Process Mapping, Analysis and Redesign – General Improvement Skills [22]

Auckland District Health Board, NZ:

- Health Service Co-Design – Explore Patient Journey Mapping [23]

2.4 Integrating skill sharing in a service model

2.4.1 Confirming skill sharing as the right approach

Prior to progressing development of skill sharing, proposed skill shared tasks should be scrutinised for potential system-level barriers to identify whether skill sharing is an appropriate response or whether alternate strategies need to be identified.

- **Clinical tasks controlled by legislation or regulation**: Few allied health clinical tasks are explicit subjects of legislation or regulation. Exceptions include the supply and administration of medications[24], use of radiation for healthcare[25] and conducting involuntary examination, assessment or treatment under the Mental Health Act[26]. These clinical tasks have specific and established qualification, training and governance requirements.
- **Clinical tasks with business restrictions**: Clinical tasks may not be feasible to skill share if eligibility to claim reimbursement or charge fees is defined by a profession rather than task competence (e.g. funding for equipment or home modifications requiring prescription by a specific profession).
- **Clinical tasks are shared practice**: A task that is within the accepted scope of two professions is shared practice. It may be that a clinician in a team does not have a task in their individual scope of practice due to workload divisions in the local service model, teamworking arrangements, culture or preference. However, if the task is consistent with the scope of the profession, an upskilling program can enable the task to be delivered by the clinician. This will not require the extent of clinical redesign and clinical governance arrangements indicated by skill sharing. For example, a physiotherapist who has worked exclusively in musculoskeletal outpatients for many years may require targeted upskilling to prescribe manual wheelchairs.
- **Clinical tasks relevant to other workforce groups**: Skill sharing in an allied health team should be considered cautiously if the clinical issue or opportunity relates to the scope of practice of another workforce group in the multi-disciplinary team. Teams should consider if there are opportunities to achieve the desired outcome through supporting other clinical workers and teams to work to full scope and consistent with the service model. Examples include nursing staff implementing comprehensive intake tools at admission or allied health assistants delivering delegated therapy programs from multiple allied health professions within a single session.

2.4.2 Ensuring a balance between benefits and risks

The decision to implement skill sharing requires consideration of the likely 'return on investment'. The benefits for clients and the service must outweigh the:

- potential for quality, safety or efficiency to be compromised
- demands on time and resources to develop, implement and sustain the approach
- impacts on other service areas
- opportunities foregone by investing in skill sharing rather than alternative initiatives.

To integrate skill sharing into the service model:

- the scope of the tasks that will be shared need to be defined and agreed, including which professions and team members will be trained to deliver them
- strategies for maximising the quality and safety of the tasks and for managing and monitoring risks must be determined.

This includes determining:

- the indicators, limits and parameters for skill share-trained practitioners to implement the task/s
- any additional clinical governance arrangements, policies and procedures that need to be developed and implemented
- whether existing risk management systems are adequate to address the identified needs.

Quality and risk management is typically assessed for skill sharing by considering the needs of the 'average' client in the local service, but uncommon or rare clinical events also need to be reflected in the processes that support implementation of skill sharing in practice. The circumstances within which the team regard a task as generally safe, effective and efficient to skill share should be articulated within the approved model.

There are a range of strategies for maximising and managing safety and quality within a skill sharing service model. These factors and considerations are further discussed in Table 2 below. Skill sharing should only proceed if risk management strategies can maintain risks at an acceptable level and are feasible for the team to implement sustainably and consistently. Examples of approaches to maximising benefits and minimising risk in relation to these variables include:

- **Risk elimination**: Limit use of the skill shared task to defined situations (i.e. specific client presentations, circumstances, or contexts).
- **Task modification**: Deliver a prescribed part of the skill shared task; placing additional limitations on the use of the task; defining processes for timely referral.
- **Standardise processes**: Using standard information and data collection tools to support audit, review and continuous improvement of practice; establish systems for clear, consistent and timely communication.
- **Education and training**: Initial and ongoing education and training regarding responses to recognised and emergent risks.

These factors and considerations for integrating tasks into the skill share model are discussed in Table 2.

Table 2 Factors and considerations for integrating tasks into the skill share model

Factor	Considerations	Example strategies to maximise safety and quality
Clinical tasks	Consider the specific clinical activities, including their frequency and the level of knowledge, technical skills and reasoning required to perform the task.	Modify the scope of the task, use standardised decision making and information collection tools, use a consistent approach to training and competency assessment.
Clients	Consider the client group/s for which the clinical tasks are delivered within the local service model (including routine and less common presentation and co-morbidities).	Include training and resources that specify the indications and limitations for the skill shared task, guide adaptations of the task for common clinical presentations and co-morbidities, provide escalation pathways for clients whose needs are beyond the approved scope of skill sharing, etc.
Clinical pathways	The timing of the task within the client journey, the clinical pathway, the occasion of service, the admission or service event (including the interdependency of the clinical task to other clinical tasks or service events).	Ensure skill sharing of the task makes sense in the client flow and the proposed skill share-trained professional is accessible and available when the task is required.
Setting/ environments	The settings in which the clinical task is typically undertaken by the team, including the clinical context, the environment, the equipment and support available.	Ensure the skill share-trained professional is accessible and available, limit the contexts within which the clinical task is skill shared, establish mechanisms to support team collaboration and escalation etc.
Team	Characteristics of the team as a whole, including team culture and approach to collaborative team work, full time equivalent (FTE), mix of professions, knowledge and skills, workflow practices.	Training may include the entire team across numerous disciplines or be limited to one profession skill sharing with another, or two professions skill sharing with each other.

2.4.3 Considering impacts on clients and teams

A range of practical issues need to be considered and addressed in the planning processes of teams examining or progressing implementation of skill sharing. Table 3 presents a summary of variables that may need to be examined.

Table 3 Considerations for decision making regarding implementation of skill sharing

Impact	Associated area
Client experiences	Client perspectives on the impact and value of skill sharing tasks and the capacity of the team to understand, monitor and respond to feedback or concerns.
Demands on time and resources	Implementing the system changes (e.g. resource demands to: change staff recruitment, induction, and development, implement and monitor data systems across professions etc.)
	Feasibility within the staffing establishment and skill mix (e.g. available mix of professions, FTE of each profession, current commitments, etc.)
	Training and competency requirements are feasible and sustainable. A high training load is associated with tasks that have advanced knowledge or skill requirements, are substantially dissimilar to the underpinning knowledge and skills of the profession to be trained, or that will occur infrequently in practice, making competency maintenance difficult.
	Sustaining the changes (e.g. demands on human resource systems, operational systems, ongoing training and competency reassessment etc.)
Feasibility of clinical governance	Stability and capability of staff in the lead profession to provide support and supervision

2.5 Skill sharing arrangements with other teams, services and agencies

In some situations, clients may benefit from skill sharing being established between teams within the one HHS, between two different HHSs, or between an HHS and a non-government organisation (NGO). The potential for skill sharing is most likely to be included in an existing cross-agency service arrangement.

A cross-service or cross-agency process to address each of the considerations presented in this Framework will need to occur. The obligations and expectations of each team/service/agency should be agreed and documented, along with operational arrangements such as estimates of staff time allocation to training and supervision, specification of key roles and contact details, and communication methods. Where relevant, this should be incorporated and managed within an existing service agreement or similar documented arrangement.

As discussed in Section 1, a skill share-trained practitioner is responsible for the care they provide and a healthcare organisation is responsible for clinical governance, patient safety and practice standards for all facets of care provided by its workforce, including implementation of skill shared tasks. A skill sharing arrangement across teams, services or organisations does not imply shared care or shared clinical responsibility for patients between agencies, unless this is explicitly defined and agreed.

Skill sharing between a health service and NGO

A rural HHS works collaboratively with a local NGO to provide services to nine communities. The NGO employs two full time podiatrists to deliver services in the communities, including in-reach to two HHS multi-purpose health service (MPHS) through a service agreement. The HHS and NGO identify the opportunity to provide a foot screening service including the HHS physiotherapist, exercise physiologist, dietitian and social worker providing screening assessment and bridging intervention tasks across the communities and settings they work in.

The HHS and NGO negotiate and document in the existing service agreement the support functions the NGO will provide including training, supervision, telehealth-enabled case discussions, and operational arrangements such as which organisation is responsible for purchasing consumables for the skill shared tasks. The model uses existing referral arrangements from the HHS team to the NGO podiatry service and the new training, supervision, advice and other processes that support skill sharing.

Referrals to the NGO podiatrists now include additional detail of assessment outcomes and bridging interventions provided by the HHS skill share-trained professionals which support the client while awaiting podiatry telehealth or outreach review and assist the NGO to prioritise services.

Skill sharing in action - Improving client flow

Problem: A regional outpatient cancer care team was anticipating an increase in demand due to the introduction of local radiation services. Multiple service improvement initiatives to increase patient access and/or optimise the clinicians' time were included as part of the review, including telehealth booking processes and clinical tasks performed by the allied health assistant.

Skill sharing was proposed as a potential option for the speech pathologist and dietitian as the current model of care included shared appointments with both. This model had been developed to streamline the need for clients to attend two separate appointments. However, staff recognised that input requirements for each profession varied between clients and over a course of treatment.

Process: The HHS Workforce Development Officer provided support to the team for the service improvement activities, including planning, stakeholder engagement and implementation.

The team's dietitian and speech pathologist mapped the clinical tasks commonly provided by their professions across a typical head and neck cancer patient journey. The input of each profession varied depending on a number of clinical indications defined by the clinicians. It was found through a basic audit that indications were not consistently present for all clients and at all time points across a typical care journey. A risk-based assessment of clinical tasks identified that for some joint appointments, one profession provided limited input, although may provide a task that required as an enabler of an entire occasion of service (e.g. a task that is required for the other profession's intervention to progress).

Challenges: Early engagement with administrative staff was required to collaboratively work on a process for progressing triage outcomes to either a joint appointment or a single profession appointment. As the dietitian role was a 6-month rotational position, training investment and service sustainability were important considerations when defining the scope of skill sharing to be implemented. The clinicians involved reported that colleagues from other areas in the hospital had expressed concerns that skill sharing would devalue their respective professions and lead to loss of positions from the service.

Service Change: A small number of discrete tasks were identified for skill sharing, with a particular focus on tasks that were critical reviews or enablers for other tasks in a clinical care pathway. Tasks focused on periodic assessment or re-assessment of identified or anticipated problems, and recommended actions were identified (providing basic intervention, watch and wait, or referral). This included agreed, evidence-based triggers for escalation to the other profession.

Outcome: Evaluation showed that client access, clinical outcomes and experience were maintained. Findings were disseminated through local and state forums for consideration by other teams.

Learning: During the redesign process the clinicians involved found it important to communicate the drivers and rationale for the strategy with their professional peers, including the need to manage demand, maximise use of clinical time and to work to full scope of practice.

Planning for ongoing orientation (e.g. for rotational or new staff), training, assessment and professional support needs should be part of the development of skill sharing to ensure sustainability is adequately considered. By developing clear objective parameters (indications and limitations) and referral pathways for escalation to the other profession, clinicians felt confident that safety and clinical effectiveness was maintained.

Value of skill sharing: By skill sharing a single or small number of tasks provided by each profession in the flow of a service event, bottlenecks and delays in care can be avoided and clinicians are able to allocate their time and expertise optimally across the caseload. Skill sharing supports clinicians to work to full scope in a specific clinic type.

3 Embedding and sustaining skill sharing in existing systems

Effective and sustainable implementation of skill sharing requires that:

- all consultation, design, and implementation processes are documented and shared with all stakeholders
- the model is integrated into existing quality and safety processes; operational systems and processes; and workforce development and support systems.

The extent of system and process changes and associated documentation should be proportionate to the scope and complexity of the skill sharing implementation including team members involved, the number and nature of the clinical tasks that are shared, and the risks and quality management measures required.

3.1 Documentation and information sharing

Documentation and ready access to information about skill sharing arrangements by relevant stakeholders is needed to support effective implementation, continuous improvement and sustainability. Key areas for documentation include:

- the design process, including stakeholders consulted and their contributions; options considered; risk assessment outcomes; decisions made and written approvals
- the scope of skill sharing, including escalation pathways for clients with needs that are beyond the scope of skill share-trained practitioner
- implementation arrangements, including clinical governance, training and competency assessment, quality management, monitoring and evaluation.

3.2 Quality and safety

3.2.1 Clinical governance and approvals

Approval and governance arrangements for skill sharing must:

- align with and operate within existing legislation, professional regulatory requirements, Queensland Health policies, and local HHS policies and procedures.
- define the roles of Executive Directors and/or Directors of Allied Health, profession-specific managers, operational managers, and allied health professionals who will

become skill shared trained professionals as well as those who will be involved in their training and ongoing support and development

- be agreed and understood by all stakeholders.

Consistent approval and governance processes for skill sharing across an HHS or a facility will support operational efficiencies and reduce risk.

Governance processes must be established for:

- approving skill sharing tasks, including risk assessment and mitigation strategies. At a minimum, these processes will include approval from operational and professional delegates.
- identifying, developing and approving the training and competency assessment requirements, including consideration of the need for credentialing in the case of complex skill sharing (refer to the Queensland Department of Health Guideline for Credentialing, Defining the Scope of Clinical Practice and Professional Support for Allied Health Professionals.[27]
- ensuring availability of support from lead professional and alternate arrangements when regular support is not available for clients who have care needs outside the scope of skill shared tasks. If alternate arrangements are not available, skill sharing must be suspended. There must always be an option for clients to be referred to a clinician with expertise in the task if the client's needs exceed the capability of the skill share-trained professional. Lack of or inadequate access (i.e. excessive waiting list) to the profession with task expertise is a risk to clinical governance and safety. For this reason, skill sharing is not generally a viable option for vacancy or leave management. An alternative option for referral and for supervision and advice to the skill share-trained practitioner must be maintained.
- reflecting the skill share-trained professional's role in human resource processes such as role descriptions, induction, performance development planning, training and supervision.
- maintaining records, including tasks that can be skill shared, by which allied health professions, the tasks each team member has been trained in and assessed as competent to perform.

3.2.2 Ongoing management of risk

In section 2.4.2, risk was considered for the purpose of scoping the safety and feasibility of skill sharing as part of a team's models of care. These considerations from the scoping phase should inform decisions on any changes required to existing clinical and operational risk management processes that are required for implementation, including but not limited to:

- risk registers and risk management plans
- risk management committees
- team meetings
- accreditation processes
- Workplace Instructions and Procedures
- RiskMan reviews and reports - compliments and complaints, clinical incidents.

Risk identification must include clinical risks as well as risks that might arise across all areas of service operation. The Queensland Health Risk Analysis Matrix [28] provides a guide to risk identification across health service functions such as workplace health and safety, finances and reputation.

Arrangements for both scheduled and unscheduled reviews of risk and risk management strategies for skill sharing should be established. **Scheduled reviews of risk** should be carried out in a planned way at agreed intervals after the initial implementation. Systems to conduct **unscheduled reviews of risk** should be established to implement in circumstances where:

- something goes wrong and there is a need to consider whether skill sharing has contributed to the issue (e.g. clinical incidents, workflow issues, waitlist issues, funding issues etc.)
- the assumptions the skill share model was built on change (e.g. video-telehealth now becomes readily available, the available human resource options increase, decrease, diversify etc.).

The outcomes of a scheduled or unscheduled review of risks may inform changes to the approach to using skill sharing or the risk management strategies applied.

3.2.3 Quality improvement

A continuous process of monitoring and maintaining the quality of skill sharing processes, practices and outcomes and periodic evaluation is an integral component of skill sharing practice and is critical to establishing a safe and sustainable model of care.

Monitoring and review

Processes for monitoring and review should be established within and reported through the existing quality improvement systems of the HHS. The Plan-Do-Study-Act cycle (see 2.2 above) is a useful reference. A defined set of process and outcomes indicators directly relevant to the intended goals of the skill sharing approach should be agreed, collected and reported on from the outset.

Continuous improvement and monitoring of performance should be considered at multiple levels, including client outcomes, task performance, and clinical decision-making as well as focussing at the individual level, within professional support relationships, within a team, and at the manager level. Potential opportunities for review of processes and practice include:

- reflective practice by the skill share-trained professional
- peer support and clinical supervision for learning and development
- performance data – indicators such as access, efficiency, clinical outcomes (e.g. client demographics, occasions of service, length of stay, wait times)
- review of risks and risk mitigation strategies – including those identified in the design stage and other risks that emerge over time (see 3.2.2 above)
- satisfaction surveys – client and staff

- audits of skill share training, skill share activity and practice and clinical governance processes – competency register, use of clinical task instructions and other skill shared task protocols
- reviews of the quality, effectiveness and experience of training processes
- reviews of clinical governance – performance development plans, skill sharing support and supervision processes.

Evaluation

Periodically, an overarching evaluation of skill sharing should be undertaken through integrating and triangulating the findings of each of the processes listed above, in order to identify:

- the outcomes achieved for clients, carers, professionals and the service system, in particular, whether the original issues have been addressed
- the fidelity of the process relative to the original intentions
- any unintended consequences - including positive consequences that can be learnt from and possibly replicated and negative consequences that warrant attention
- changes in the wider service system that might inform the need for adjustments to the practice model (e.g. increased staffing, improved use of telehealth, employment of allied health assistants etc.).

3.3 Operational systems and processes

While the focus of skill sharing is on clinical tasks, the changes to clinical practices may affect both workflow processes and resources and business processes and resources. These impacts must be systematically identified, and appropriate responses implemented. The mapping activities undertaken in the scoping phase should inform these changes. Operational changes to support skill sharing may include using or adapting existing systems and tools or designing and developing new systems and tools.

3.3.1 Workflow

Client flow, team workflow and care coordination responsibilities may be affected by skill sharing. Changes may be required for referral processes, intake systems, client triage, workload allocation, and assessment, intervention and discharge. The associated operational processes must be systematically considered and responded to through team processes involving relevant stakeholders.

Business processes and resources

The potential for impacts on business processes and resources requires that all relevant support systems are reviewed, and necessary changes are accommodated in the model being implemented:

- policies, procedures, business rules and administrative processes
- record keeping, data collection, reporting, and billing
- human resources, e.g. role descriptions, orientation, training and competency records

- equipment and resources e.g. telehealth, consumables, clinical tools.

3.4 Workforce development and support

3.4.1 Training

To ensure safe, best practice care that is consistent in its approach and outcomes, allied health professionals starting out in a new skill shared task must undertake a program of training to acquire the knowledge and clinical prerequisites underpinning the clinical task to be skill shared.

Training documentation and processes must include:

- the agreed best practice approach to performing the skill shared task
- information on the training, skill and knowledge requirements of staff implementing the skill shared task
- information on safety and quality risks and mitigation strategies
- guidance on clinical reasoning in relation to when the task is in scope and when it is out of scope as a skill shared task
- a competency assessment tool and process.

The training approach and learning resources developed should reflect the demands of the task and extent of risks associated with the task. The training design and process should consider:

- the complexity of clinical reasoning, knowledge and skill requirements to implement skill shared tasks
- indications for credentialling considering the extent to which the task may constitute a complex practice for the practitioner to be trained (refer to the Queensland Department of Health Guideline for Credentialing, Defining the Scope of Clinical Practice and Professional Support for Allied Health Professionals [27]
- the level of risk associated with the task
- an individual's current level of experience and capability, pertinent to the task
- the need for ongoing skill development over time, rather than at a single point time.

There is no definitive or standard approach required for a skill share training program. Different options include:

- Work Instructions or Procedures for skill shared tasks that present low risk and are operational or procedural in nature e.g. implementation of a screening tool with limited clinical reasoning demands
- Clinical Task Instruction (CTI) for tasks that have a higher level of knowledge, reasoning and skills required
- completion of training to support development of knowledge.

Refer to the Queensland Health Guidelines for developing and writing clinical task instructions [29] for detailed information on developing CTIs.

An extensive range of statewide published CTIs are available, which include associated Performance Criteria Checklists and Learning resources. These CTIs are usually generated in local skill share implementation projects and are then proposed for statewide review and publication. Before being published these CTIs undergo a content validation and quality review process. Statewide CTIs still require a local review and approval process to ensure that they are fit for purpose and context.

Training programs for skill shared tasks must be developed by a professional with content expertise in the task and approved jointly by the profession with clinical content expertise and the profession/s to be trained to deliver the skill shared task. Work-based training in the skill shared task/s must be facilitated by a clinician who has expertise in the task, as approved by the relevant professional manager. Skills in training/ facilitating learning are desirable but not mandatory. Training and competency assessment must be documented. Records kept by the work unit should, at a minimum, list the skill share competencies each team member has completed.

An example skill sharing training plan template is available at:
https://www.health.qld.gov.au/__data/assets/word_doc/0035/706598/ss-training-plan.doc

3.4.2 Competency assessment

Competence in the skill shared task must be assessed by a health professional who is competent in the task and who is:

- qualified in the profession that has the task in its accepted scope of practice
- experienced in completion of the skill shared task according to the prescribed approach (i.e. as documented in the Workplace Instruction, CTI, or other formal documentation).
- has experience in teaching and training, supervision, competency assessment and providing feedback.

It is advantageous, but not mandatory, for the competency assessor to have qualifications in workplace training and assessment. Observation of task performance in the usual practice environment should be included in the competency assessment process, but other methods can augment observation including case reviews and simulated practice of technical skills.

Competency assessment processes should include details relating to the role that will conduct the competency assessment and sign off on competence, the performance criteria for competency attainment, including resource considerations.

Training and competency processes and resources must be reviewed on a regular basis to ensure they reflect changes to the local context or processes and clinical best practice. The professional lead should be accountable for ensuring these reviews occur and that the review process includes the professional lead and the operational lead of the skill share-trained professional.

3.4.3 Supervision, support, learning and development

Health professionals performing clinical tasks across professional boundaries must have access to reliable and ongoing support, mentoring and supervision from a suitably qualified and experienced health professional who is from the profession that has the skill shared task within their scope of practice and is competent in the skill shared task. This may be the

clinician who provided direct clinical supervision and monitoring (i.e. task supervision) during the training phase.

The characteristics of ongoing supervision (formal versus informal, who it is delivered by, frequency and context) are to be determined by the operational and professional managers relevant to the employee and task. Supervision arrangements in relation to the skill shared tasks should be outlined in the performance development plan of the skill share-trained professional and align to the recommended professional support Health Service Directive Guideline for Credentialing and Defining the Scope of Clinical Practice and Professional Support for Allied Health Professionals .[30] Examples of approaches to supervision and support include monthly case discussions, quarterly case reviews, chart audits and/or use of the clinical reasoning record. The frequency and format of the review will be influenced by the risk profile of the task, skills and experience of the skill share-trained professional and frequency of the task implementation.

Performance and development plan processes should be used to monitor and plan for ongoing training and development of the skill share-trained professional, including the need for reassessment of competence.

Protocols for managing concerns raised about the competence of a skill share-trained professional should be aligned to and embedded into existing clinical governance arrangements.

Skill sharing in action - Improving efficiency

Problem: A health service identified an increasing rate of older clients presenting to the emergency department within 28 days of discharge from hospital. The health service examined options for increasing the input of the older persons allied health team at the peri-discharge phase to support the transition for clients with frailty and risk factors for re-presentation.

Process: Led by the multidisciplinary allied health team leader, the team used a process map and chart audit to examine the clinical service requirements for frail older clients discharged from hospital. This identified that most emergency department presentations were associated with a fall or loss of mobility or decline in capacity to complete activities of daily living. The team recognised the multi-dimensional nature of frailty and functional decline including physical, perceptual and cognitive wellbeing and the influence of nutrition, medications, carer/social supports, living situation and setting. Clinical tasks required to address client needs were mapped by the team including identifying the optimal point that the task is delivered (i.e. prior to discharge or when in the community).

Opportunities for skill sharing were examined by assessing potential value for client care and access, risks and mitigation strategies and operational considerations including training requirements and workforce capacity.

Challenges: The team identified a large range of potential clinical needs for this client population. It was also recognised that there must be a balance in training time and investment and ensuring skill sharing would be sustainable during periods of leave of key positions.

Service Change: The professions selected to be trained in skill shared tasks were physiotherapy and occupational therapy. These professions had larger FTE allocation (than social work, speech pathology, dietetics and podiatry in the older persons service) and more tasks were identified in the physical/functional domain to be included in the model. Common underpinning knowledge and the number of shared practice tasks between the physiotherapist and occupational therapist was also viewed to create training efficiency.

Outcome: The physiotherapist and occupational therapist trained in skill shared tasks from the other profession, undertook some upskilling in tasks that were shared practice between these professions, and also trained in a limited number of skill shared tasks usually provided by the dietitian, social worker and podiatrist. These tasks included both assessment (malnutrition, carer strain, social supports and feet) and basic and bridging interventions (information provision on; high protein high energy diet, social supports and foot care). Opportunities for occupational therapy and physiotherapy staff to back-fill in the service were also prioritised by the departments.

Learning: Frailty and falls are multi-dimensional problems. The range of potential healthcare needs of clients is extensive. Determining factors that precipitate a poor clinical outcome or service presentation, and identifying critical clinical tasks to address these issues, enabled the team to focus on high value tasks for skill sharing. Skill sharing of a task may occur from one profession to another, without an expectation of reciprocation. Establishing systems for staff to provide backfill in the service model contributes to succession planning and sustainability of the approach.

Value of skill sharing: Skill sharing enables implementation of an expanded range of tasks by selected practitioners, which can improve the comprehensiveness and timeliness of intervention and efficiency for the team. This is particularly relevant for tasks related to discharge preparation or undertaken on outreach and home visits.

Glossary

Term	Definition
Capability	Capabilities are underpinning behavioural skills that characterise work being performed well.[35]
Competence	Competence is the combination of training, skills, experience and knowledge that a person has and their ability to apply them to perform a task safely.[31]
Competency	Competency is the demonstrated ability to provide healthcare services at an expected level of safety and quality.[32]
Credentialing	Credentialing is the formal process used to verify the qualifications, experience, professional standing and other relevant professional attributes of practitioners for the purpose of forming a view about their competence, performance and professional suitability to provide safe, high-quality healthcare service within specific organisational environments.[30]
Delegation	Delegation is the process by which an allied health professional allocates clinical and health related tasks to an allied health assistant with the appropriate education, knowledge and skills to undertake the task. The allied health professional identifies the need for the task and provides a delegation instruction to the allied health assistant who accepts and then performs the task with appropriate monitoring by the allied health professional and then provides feedback to the delegating allied health professional.[6]
Interprofessional practice	Interprofessional practice (or interprofessional collaborative practice) refers to practice where 'multiple health workers from different professional backgrounds provide comprehensive services by working with clients, their families, carers and communities to deliver the highest quality of care across settings'.[3] Interprofessional practice involves clinicians working collaboratively to optimise clinical and health outcomes. Health professionals share responsibility for developing and implementing a care plan with the client. Each team member applies their knowledge and skills and understands and acknowledges the contribution of other professions in the team, to support the goals in the care plan.
Multiprofessional practice	Multiprofessional practice involves team members from different professions liaising and working co-operatively, but in parallel, to deliver care. In this practice approach, individual health professionals engage separately with the client to develop and implement a care plan that is focussed on goals from their own profession's perspective.[2]

Term	Definition
Scope of practice	The **scope of practice of a profession** refers to 'the full spectrum of roles, functions, responsibilities, activities and decision-making capacity that individuals within that profession are educated, competent and authorised to perform'.[5] An **individual practitioner's scope of practice** should strongly align to, but may not mirror, the scope of practice of their profession. An individual's scope of practice is influenced by the priorities of their service context and client needs, training and continuing professional development undertaken, professional interest and other factors.
Shared practice	Shared practice refers to two or more professions possessing the knowledge, skills and competencies to deliver the same or substantially similar clinical tasks and functions. This may reflect common requirements in entry-level standards or occur through post-entry/post-graduate accredited training programs that can be completed by multiple professions.
Skill sharing	Skill sharing describes two or more health professionals sharing knowledge, skills and responsibilities across professional boundaries. The term is used in Queensland Health allied health services to describe health professionals performing clinical tasks (assessment, diagnosis, treatment planning and/or implementation) that are not generally performed by their profession.[1]
Supervision	Supervision is a formal process that provides dedicated time and an opportunity for learning and development within the context of an ongoing professional relationship with an experienced practitioner. In relation to skill sharing, the term is specifically used to describe the process of regular, supportive contact with a health professional with expertise in the skill shared task. As skill sharing is generally limited in most health professionals' role and scope, it is likely that this will be a minority component of regular clinical supervision as outlined in the Guideline for Credentialing and Defining the Scope of Clinical Practice and Professional Support for Allied Health Professionals.[30]
Transprofessional practice	Transprofessional practice involves health professionals transcending profession-specific boundaries, and sharing knowledge, skills and decision-making.[4] In a transprofessional service model, each member of the team, irrespective of professional background, can work in partnership with a client to develop and implement a comprehensive care plan. Typically clients experience highly integrated care and multiple professions in the team share a common or substantially similar scope of clinical capabilities.

References

1. Greater Northern Australia Regional Training Network (2013). Project Report: Rural and Remote Generalist - Allied Health Project. Retrieved from https://www.health.qld.gov.au/__data/assets/pdf_file/0025/656035/GNARTN-project-report.pdf
2. Chamberlain-Salaun J, Mills J, & Usher K (2013). Terminology used to describe health care teams: an integrative review of the literature. Journal of Multidisciplinary Healthcare, 6, 65-74. doi:10.2147/JMDH.S40676
3. World Health Organisation (2010). Framework for action on interprofessional education & collaborative practice. Retrieved from https://www.who.int/publications/i/item/framework-for-action-on-interprofessional-education-collaborative-practice
4. Van Bewer V (2017, Oct). Transdisciplinarity in Health Care: A Concept Analysis. Nursing Forum, 52(4), 339-347. doi:10.1111/nuf.12200
5. New South Wales Health (2011). Health Professionals Workforce Plan Taskforce: Discussion paper to inform and support the NSW Government's Health Professionals Workforce Plan. Retrieved from https://www.health.nsw.gov.au/workforce/hpwp/Publications/hpwp-dis
6. Queensland Health (2015). Allied health assistant framework – revised 2022. Retrieved from https://www.health.qld.gov.au/ahwac/html/ahassist
7. Kaltner M, Murtagh D, Bennetts M, Pighills A, James J, & Scott A (2017). Randomised controlled trial of a transprofessional healthcare role in an acute medical setting. Journal of Interprofessional Care, 31(2), 190-198. doi:10.1080/13561820.2016.1248237
8. Ryan D, Pelly F, & Purcell E (2017). Exploring extended scope of practice in dietetics: A systems approach. Nutrition and Dietetics, 74, 334-340.
9. Hall F, Gordon S, Hulcombe J, & Stephens C (2019). Compression garment service model: Facilitating access to compression garments through workforce and service redesign. Australian Journal of Rural Health, 27(3), 257– 261. doi:10.1111/ajr.12509
10. Queensland Health (2016). The Calderdale Framework implementation in Queensland Health 2011 – 2015 Part A Report: Summary and Recommendations.
11. Patterson S, Huang A, Kuipers P, Cornwell P, & Pain T (2016). Evaluation of the Queensland Health implementation of The Calderdale Framework Completion Report. Queensland Health.
12. Page L & Andrews R (2020). Literature Review: Research Ready Grant Program. Queensland Government, Central Queensland Hospital and Health Service.
13. Queensland Health (n.d.). Health Practitioner Models of Care Project: Acute Medical Services Model of Care - Toowoomba (Stage 1) Appendix A: Transdisciplinary Practice Literature Review.
14. Passfield J, Nielsen I, Brebner N & Johnstone, C (2017). Skill sharing and delegation practice in two Queensland regional allied health cancer care services: a comparison of tasks. Australian Health Review, 42, 656-660. doi:10.1071/AH16160
15. Pighills A, Bradford M, Bell K, Flynn LJ, Williams G, Hornsby D, Torgerson D & Kaltner M (2015). Skill-sharing between allied health professionals in a community setting: A randomised controlled trial. International Journal of Therapy and Rehabilitation, 22, 524-534. doi:10.12968/ijtr.2015.22.11.524

16. Pain T, Patterson S, Kuipers P, & Cornwell P (2018). Evaluation of the state-wide implementation of an allied health workforce redesign system: utilisation of the Calderdale Framework. Queensland Health.
17. Watterson D, Walter K, O'Brien L, Terrill D, Philip K, Swan I, & Somerville L (2019). Trans-disciplinary advanced allied health practitioners for acute hospital inpatients: a feasibility study. International Journal of J Qual Health Care, 1(31(2)), 103-109. doi:10.1093/intqhc/mzy127
18. Antonacci G, Lennox L, Barlow J, Evans L, & Reed J (2021). Process mapping in healthcare: a systematic review. BMC Health Services Research, 21(342). doi:10.1186/s12913-021-06254-1
19. NSW Agency for Clinical Innovation (ACI) (2021). Mapping Diagnostics. Retrieved from Mapping Diagnostics: https://aci.health.nsw.gov.au/resources/redesign/redesign-factsheets/redesign-methodology-for-improvement-and-innovation
20. NSW Agency for Clinical Innovation (ACI) (2015). Guide - How to Process Map: Clinical Program Design and Implementation. Retrieved from https://www.aci.health.nsw.gov.au/__data/assets/pdf_file/0007/279088/Guide_on_How_to_Process_Map.pdf
21. NSW Agency for Clinical Innovation (ACI) (2018). Journey Map. Retrieved from https://www.aci.health.nsw.gov.au/__data/assets/pdf_file/0010/419797/EBCD_Toolkit-Journey_Map.pdf
22. NHS (2005). Improvement Leaders' Guide – Process Mapping, Analysis and Redesign – General Improvement Skills. Institute for Innovation and Improvement. Retrieved from https://www.england.nhs.uk/improvement-hub/publication/improvement-leaders-guide-process-mapping-analysis-and-redesign-general-improvement-skills/
23. Auckland District Health Board (2021). Toolkit. Retrieved from Health Service Co-Design: https://www.healthcodesign.org.nz/tool-kit/
24. Queensland Government (1996). Health (Drugs and Poisons) Regulation 1996. Retrieved from Queensland Legislation: https://www.legislation.qld.gov.au/view/html/inforce/current/sl-1996-0414
25. Queensland Government (1999). Radiation Safety Act 1999. Retrieved from https://www.health.qld.gov.au/system-governance/licences/radiation-licensing/legislation/resources#radiation
26. Queensland Government (2016). Mental Health Act 2016. Retrieved from https://www.legislation.qld.gov.au/view/pdf/asmade/act-2016-005
27. Queensland Health (2015). Guideline for Credentialing, Defining the Scope of Clinical Practice and Professional Support for Allied Health Professionals. Retrieved from Queensland Health: https://www.health.qld.gov.au/ahwac/html/clin-gov
28. Queensland Health (2013). Risk Analysis Matrix. Retrieved from https://qheps.health.qld.gov.au/__data/assets/pdf_file/0028/413488/risk-matrix.pdf
29. Queensland Health (2018). Guidelines for developing and writing clinical task instructions – revised 2022. Available at: https://www.health.qld.gov.au/ahwac/docs/cti/Writing-Guidelines.pdf
30. Queensland Health (2014). Health Service Directive: credentialing and defining the scope of clinical practice. Retrieved from https://www.health.qld.gov.au/__data/assets/pdf_file/0038/670979/qh-hsd-034.pdf
31. Health and Safety Executive (n.d.). What is competence? Retrieved from https://www.hse.gov.uk/competence/what-is-competence.htm

32. State of Victoria (2016, December). Allied health: credentialling, competency and capability framework (revised edition): Driving effective workforce practice. Retrieved from file:///C:/Users/gretc/Downloads/Allied%20health%20%20credentialling%20competency%20and%20capability%20framework%20-%20PDF.pdf
33. Australian Commission on Safety and Quality in Health Care (2019). The National Safety and Quality Health Service (NSQHS) Standards. Retrieved from Australian Commission on Safety and Quality in Health Care: https://www.safetyandquality.gov.au/standards/nsqhs-standards
34. Health Consumers Queensland (2018). Guide to Consumer Partnerships. Retrieved from Health Consumers Queensland: https://www.hcq.org.au/guides/
35. Woods P, Gapp R, King MA (2015). Researching pharmacist managerial capability: philosophical perspectives and paradigms of inquiry. Research in Social and Administrative Pharmacy 11(2): 265-279, cited in, Martiniuk AL, Colbran R, Ramsden R, Edwards M, Barrett E, O'Callaghan E, Bullock R, Lowe EF, Karlson D, Curnow J, Gotch B, Kramer J, Bagnulo S, Rothnie IP, Hardaker L, Turner N, Wotherspoon A, Russell C. (2020). Capability … what's in a word? Rural Doctors Network of New South Wales Australia is shifting to focus on the capability of rural health professionals. Rural and Remote Health 20: 5633. https://doi.org/10.22605/RRH5633