Calderdale Framework: Large scale implementation in Queensland, Australia

Alison Pighills
Associate Professor Health Practitioner research
Describe Queensland Health’s (QH) processes, outcomes and learnings from strategically and centrally implementing the CF in allied health (AH) teams

Present outcomes of evaluation / research studies

Outline the role of the rural generalist (RG) AHP

Describe the implementation of a RG model of care (MoC) in the Mackay HHS Hinterland
Drivers for workforce redesign

- Increasing longevity and chronic disease
- Increasing patient demand for and expectations of health care
- Increasing fiscal constraints
- Workforce maldistribution and attrition (shortages)
Calderdale Framework & Qld Health

Need to redesign QH workforce identified

Previous MoC projects hampered by lack of structure to implementation and review

QH adopted the CF as 10 AH workforce redesign tool a state-wide level in late 2011
State-wide Implementation - Challenges

How does AH capitalise on work at a local level to spread the benefits more broadly (reduce duplication of effort and investment)?

How can QH generate resources to support state-wide delegation and skill sharing?
Key Terms

Delegation

• Authority to undertake tasks or functions is delegated from the AHP to the AHA, and with that comes accountability for the performance of those tasks or functions.

• The AHP retains responsibility for patient care. Responsibility cannot be wholly transferred from one team member to another

Skill Sharing

• A health practitioner undertakes a clinical task that historically sits outside the scope of their profession, by undertaking training and competency assessment and supervision

(Queensland Government, 2013)
## State-wide Implementation

### CF Expertise/Skills
- Effective workforce solutions
- Allied Health Professions Office of QLD
- CF Practitioner advisory group (QLD and New Zealand CF Practitioners) succession planning
- CF Practitioners (n=5)
- CF Network (CF Facilitators)
  - Share resources, peer support, buddy system, foundation training (VC)
- CF Facilitators (n=128)

### Resources for State-wide co-ordination
- **CF Officer (CF practitioner)**
  - Sustainability
  - Training
  - Resources
  - Shared drive
  - Website
  - CTI development
  - CTI Validation
  - CTI Publication
  - CF Network
  - CF guidelines
  - Links CF to AHPOQ initiatives (RFs, HPRS, MoC, RG)
- EOI Process for CFF training
  - Project outline
  - HoD Sign off
  - EDAH sign off
  - Webinars

### Health Service Context
- Directors of Allied Health – Professional Advisory Group (DAHPAG)
- State-wide Discipline Director groups
- Hospital and Health services (n=16)
- AH Workforce Development Officers
- AH teams

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## State-wide Implementation - Resources

### Governance
- Guidelines
  - Writing CTIs
  - Implementing the CF
  - Skill sharing delegation
- Standardised terms
- Standardised clinical task descriptions
- AH expanded scope strategy

### Training
- AHPOQ funded CF Facilitator training
- JCU/QUT AH Rural Generalist program
- Allied Health RG Education framework
- CTI training videos

### CF Implementation support
- SharePoint for CF Facilitators
  - Local CTIs
  - Training resources
  - Project management resources
  - Guidance on evaluation
  - Recommended outcome measures
  - Ongoing and completed projects
- Delegation training resources
- CF Website
- Published CTIs on the web
- Models of care funding

### MoC and Project Evaluation
- Guidance on project management and evaluation
- HP Research Fellows for evaluations
- HP Research Scheme Funding – target ESP

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State-wide Implementation – CTIs

- Standardised clinical task instruction (CTI) design
  - Common templates, standardised terms
- Training in CTI development
  - CF Facilitators coordinate CTI development, access templates
- Coordination and communication
  - CF Facilitator Network – check before develop CTIs
  - 3-step review process for state-wide validation before publishing:
    - Workforce validity (construction as a tool for delegation / skill sharing); clinical validity; educational validity
AHPOQ commissioned a state-wide evaluation of implementation and produced future recommendations.

“Outcomes associated with the Calderdale Framework Implementation in health services include decreases in client waitlist times, changes in occasions of service, reduced costs associated with client appointments, improved teamwork and greater staff satisfaction, as well as high client satisfaction. Furthermore, no significant difference in clinical outcome between skill sharing and conventional uni-professional Practice was found.”

AHPOQ commissioned state-wide evaluation of implementation and produced future recommendations

Conclusion: Key factors pertaining to state-wide workforce redesign include: providing coordinated and centralised systems to support staff, ensuring adequate training, prioritising the development of key local staff, and proactively managing local contextual factors.
Great Northern Northern Australia
Regional Training Network (GNARTN) project
Mapped and described the clinical tasks that are, or could potentially be, safely skill shared within multi-disciplinary teams.

State-wide Implementation - Outcomes

Facilitators
- 128 Facilitators trained
- Dozens of projects generated CTIs to support training and governance of skill sharing and delegation
- 150+ “local CTIs” generated (80% delegation)
- 54 CTIs have been published on the web (25 delegation, 29 SS)
- Few CTI ‘double-ups’ = coordination is working
- CTI quality improving
- A few CTIs are quite ‘niche’ to a clinical area

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State-wide Implementation - Outcomes

- Clinician satisfaction & clinical improvement
- Increased appreciation of AH disciplines
- Improved cross-discipline relationships
- More efficient & timely intervention
- Enhanced access to basic holistic Ax & Rx
- Clinical education pilot projects
### Key Ingredients – My thoughts

- Strategic coordinating body
- CF coordinator (Practitioner level)
- Standardisation
- Shared resources
- Network of CF Facilitators
CTI Learnings – My thoughts

What works well with a state-wide approach?

- High volume of products that are clinically relevant and grounded in ‘real world’ needs
- Engages the workforce, which supports uptake

What are the challenges?

- Coordination is resource intensive
- State-wide validation process is challenging
- Quality of products (CTIs) is improving
- (Dis)Incentives for local teams to ‘put up’ the CTI
- Limited ‘control’ over CTIs developed
- Reviewers are ‘dislocated’ from authoring service
Evaluation – My thoughts

Set up a process of monitoring outcomes of projects from the outset

Identify a common outcome measures dataset

Be clear about the methodology for impact evaluation of the program
“System-level” Opportunities

Meta-synthesis of service analysis outputs

To inform: scope of practice discussions, service and workforce planning, education and training

Pre-requisites: agreed language (standardised terms), commitment
Opportunities

Ministerial taskforce - Extended and expanded scope practice

AHPOQ MoC funding

Piloting the CF in the education of pre-entry students

Research – standardised outcome measures to support systematic reviews with meta-analyses

CTI training videos

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Assessing the implementation process and outcomes of newly introduced assistant roles: a qualitative study to examine the utility of the Calderdale Framework as an appraisal tool

The Queensland Health Ministerial Taskforce on health practitioners’ expanded scope of practice: consultation findings

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Skill sharing and delegation practice in two Queensland regional allied health cancer care services: a comparison of tasks

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Implementation of a new model of clinical education for regional occupational therapy student clinical placements

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Tilley Pain; Sarah Patterson; Pim Kuipers; Petrea Cornwell

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<table>
<thead>
<tr>
<th>Author(s)</th>
<th>Year</th>
<th>Title</th>
<th>Publication details</th>
</tr>
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<tbody>
<tr>
<td>Pighills, Alison C., Bradford, Michelle., Bell, Kirsty., Flynn, Laura J., Williams, Gary., Hornsby, Danielle., Torgerson, David J., Kaltner, Melissa</td>
<td>2015</td>
<td>Skill-sharing between allied health professionals in a community setting: A randomised controlled trial</td>
<td>International Journal of Therapy and Rehabilitation, 22(11), 524-534</td>
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<tr>
<td>Kaltner, M., Murtagh, D., Bennetts, M., Pighills, A., James, J., &amp; Scott, A</td>
<td>2017</td>
<td>Randomised controlled trial of a transprofessional healthcare role intervention in an acute medical setting</td>
<td>Journal of Interprofessional Care, 31(2), 190-198. doi:10.1080/13561820.2016.1248237</td>
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</tbody>
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AH Rural Generalist Pathway

Developing Rural Generalist (AHRG Training Position – Stage 1)
- Early career role (0-2 years)
- Workplace support / supervision
  - Co-located, profession-specific supervisor
  - Frequent, structured formal workplace support and supervision
- Education & training
  - Level 1 Rural Generalist Education Program
  - Minimum 4 hr/week development time
- Service
  - Demonstrates competent use in own practice and supports development of rural generalist service delivery strategies

Developing Rural Generalist (AHRG Training Position – Stage 2)
- > 2 years professional experience
- Workplace support / supervision
  - Profession-specific and inter-professional support
  - Onsite or ‘remote’ profession-specific supervision and inter-professional
- Education & training
  - Level 2 Rural Generalist Education Program
  - Minimum 4 hr/week development time
- Service
  - Increasing leadership and integration in own practice of rural generalist service delivery strategies

Proficient Rural Generalist
- Proficient rural generalist practice in own profession with local clinical leadership
- Workplace support / supervision
  - As relevant, mentoring / practice supervision for developing advanced capabilities in:
    - management and senior leadership,
    - extended scope (complex) practices
    - education and/or
    - research
  - Supervises rural generalist trainees
- Education & training
  - As relevant to role / setting, undertake formal education and work-based training to support development of advanced capabilities.
- Service
  - Leadership of rural generalist service development, planning and quality in relation to profession / practice area

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Queensland Government
Questions & Discussion
Creating an Allied Health Rural Generalist Model of Care by implementing the Calderdale Framework using Clinical Re-design Methodology

Alison Pighills
Associate Professor Health Practitioner research
Aim

To provide the required range of Allied Health clinical tasks to meet the needs of rural patients, by developing a clinically governed model of Allied Health service delivery for rural facilities.
Clinical Re-design Methodology

Planning
- Limited Allied Health services in the Hinterland due to:
  - Physical distances between sites
  - Tele-health underutilised
  - Fractional posts, recruitment and retention difficulties
  - Informal skill sharing with a lack of governance

Diagnostics
- Problem identification involved service analysis including:
  - Type and frequency of AH clinical tasks provided
  - Staffing levels and in/out-patient and Tele-health contacts
  - Qualitative interviews recorded and thematically analysed: patient (n=3), carer (n=1) and staff (n=17)

Solutions Design
- An AH Rural Generalist model of care was identified by staff as a solution to the issues and root causes identified.
- Calderdale Framework used to define the scope of AH Rural Generalist and AHA roles and determine which clinical tasks could be skill-shared or delegated

Implementation (current phase)
- Transferable Rural Generalist professional skill-sharing and delegation MoC implemented
- Strategic vision for AH services in the Hinterland
- Staffing structure and skill mix revised
- Supervision structures established and orientation materials created
- Tele-health built into the model

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1/3rd of AH clinical tasks that should have been provided in the Hinterland weren’t provided because some AH disciplines were not represented.

There was only one permanent AH employee in the Hinterland out of a total of 9 positions.
He’s got a bad back, he’s got all the discs and everything just all stuffed in his back. If we had a Physiotherapist that visited Dysart, maybe he could go to the Physiotherapy and get a bit of relief, as we are now, we’ve got nothing in Dysart … whereas, if you’ve got it in your home town it makes life so much easier and affordable, you know, it just makes life so much easier.

Historically I don’t know how it’s evolved, how they picked what disciplines are out there and they seem to have morphed over time... I don’t know the history as to how the disciplines that are there have been selected and on what scientific basis, and to be honest, probably there isn’t one... It would be more like there’s someone just moved into town that’s a Physio, let’s put them on, at least we’re getting some type of Allied Health service.

For me this is where an Allied Health assistant could really support us. By advocating and facilitating Tele-health. By being present to take notes and if required to do observations for the Specialist and / or clinic and to provide feedback from this end regarding treatment.

For an old person to drive 3 hours to Mackay, you know, for a 10 minute consult, goodness sake why can’t we do it by Tele-health?

So the silos, we have got to get out of the silos and start to look at it as one health system, one health service, not a Moranbah service or a Clermont.

But OT, I mean, how could you not have an OT in a whole hinterland? You know, not even one OT in the whole three different places, it’s just unbelievable.

Patients identify gaps in service provision
## Diagnostics – issues identification

<table>
<thead>
<tr>
<th>Issue</th>
<th>Votes</th>
<th>Rank</th>
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</thead>
<tbody>
<tr>
<td>Limited AH services in the Hinterland</td>
<td>11</td>
<td>1</td>
</tr>
<tr>
<td>Lack of strategic vision for the hinterland AH service</td>
<td>8</td>
<td>2</td>
</tr>
<tr>
<td>Lack of preventative / Health Promotion work</td>
<td>6</td>
<td>3</td>
</tr>
<tr>
<td>Temporary contracts</td>
<td>6</td>
<td>3</td>
</tr>
<tr>
<td>Tele-health underutilised</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Service silos</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Lack of supervision</td>
<td>4</td>
<td>5</td>
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# Solutions design

<table>
<thead>
<tr>
<th>ROOT CAUSE ANALYSIS</th>
<th>COUNTERMEASURE</th>
<th>L/T</th>
<th>COST</th>
<th>RISK</th>
<th>FEASIBILITY</th>
<th>O/all Priority</th>
</tr>
</thead>
<tbody>
<tr>
<td>Limited strategic vision for AH service provision across the whole of Hinterland</td>
<td>Develop a strategic vision for AH services in the Hinterland, revise the staffing structure and skill mix. Introduce a professional skill sharing and delegation model of care. Create an AH Rural Generalist role descriptor to enable all AH disciplines to apply for vacancies. Advertise vacancies for the Hinterland as a whole. Implement the HP3 to 4 pathway to provide career progression</td>
<td>Red</td>
<td>Yellow</td>
<td>Green</td>
<td>Yellow</td>
<td>2</td>
</tr>
<tr>
<td>Limited AH specific leadership and service planning. Inconsistent decision making</td>
<td>Secure grant funding to appoint a HP5 AH Team Leader for the Hinterland. Establish the reporting structure so that the HP5 T/L reports directly to the EDRS to ensure that an integrated Hinterland AH service is provided. All Hinterland AHPs to report to the TL for operational and clinical issues. Set clear KPIs for the TL to reflect the strategic vision</td>
<td>Red</td>
<td>Red</td>
<td>Green</td>
<td>Green</td>
<td>2</td>
</tr>
<tr>
<td>AHA posts do not exist, Nursing Assistants not available to AHPs</td>
<td>Review staffing structure and create AHA positions and/or apply for grant funding to provide AHAs</td>
<td>Red</td>
<td>Red</td>
<td>Green</td>
<td>Green</td>
<td>2</td>
</tr>
<tr>
<td>Resource constraints to purchase VC equipment limit the use of tele-health</td>
<td>Apply for grant funding to provide tablets / purchase tablets from existing equipment budget</td>
<td>Yellow</td>
<td>Yellow</td>
<td>Green</td>
<td>Green</td>
<td>1</td>
</tr>
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Implementation

Moranbah, Clermont and Dysart Current Allied Health Staffing Structure

Legend
- If an HP4 position is not filled, development of a HP3 Rural Development role will be considered (refer to HR Policy B66: HP3 to HP4 Rural Development Pathway http://qheps.health.qld.gov.au/ahwac/content/hp3_hp4_ruraldevpath.htm)

Notes:
- Representation required from OT; PT; SW or Psychology; SP
- Dietetics to be provided via telehealth from MBH

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The Calderdale Framework provided the structure to develop a Rural Generalist AH workforce, which operates in an expanded scope of practice (professional skill sharing) and delegation model of care.
Implementation

The Calderdale Framework

1. Awareness Raising
2. Service Analysis
3. Task Analysis
4. Competency Identification
5. Supporting Systems
6. Training
7. Sustaining

7 Stages to Successful Implementation
## Implementation

<table>
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<tr>
<th>Staff Group</th>
<th>Additional Tasks</th>
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<tbody>
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<td>Occupational Therapy</td>
<td>22</td>
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<tr>
<td>Podiatry</td>
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<td>Physiotherapy</td>
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<td>Speech Pathology</td>
<td>8</td>
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<tr>
<td>Social Work</td>
<td>12</td>
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<tr>
<td>AHA</td>
<td>24</td>
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Rural Allied Health Strategic Vision

**BUSINESS OBJECTIVES**

1. **Healthy Queenslanders**
   - Enable patients to take responsibility for their healthcare
   - Ensure that patients have access to the right clinician, providing the right care, at the right time, in the right place

2. **Accessible services**
   - Provide equitable access to services
   - Provide access to safe and sustainable care through the use of technology
   - Increase the range of Allied Health services available (public & private)

3. **Safe services**
   - Ensure that quality, safe, evidence-based care is provided by skilled clinicians
   - Ensure a positive patient experience

4. **Value for money**
   - Improve integration of healthcare
   - Improve continuity of care
   - Reduce patient travel

5. **Governance and innovation**
   - Ensure that information is timely and accurate
   - Ensure that the service is properly governed
   - Provide strong AH leadership
   - Introduce an professional skill sharing and delegation (expanded scope) practice model of care
   - Capitalise on innovation and research opportunities
   - Develop a strategic plan

6. **Partnerships and engagement**
   - Increase consumer engagement
   - Optimise use of local health partners
   - Expand professional relationships with other rural AH services and the AH Professions Office Qld (AHPOQ)
   - Research activities through partnerships with local, tertiary and private sector

**ALLIED HEALTH (AH) OBJECTIVES**

- Enable patients to take responsibility for their healthcare
- Ensure that patients have access to the right clinician, providing the right care, at the right time, in the right place
- Provide equitable access to services
- Provide access to safe and sustainable care through the use of technology
- Increase the range of Allied Health services available (public & private)
- Ensure that quality, safe, evidence-based care is provided by skilled clinicians
- Ensure a positive patient experience
- Improve integration of healthcare
- Improve continuity of care
- Reduce patient travel
- Ensure that information is timely and accurate
- Ensure that the service is properly governed
- Provide strong AH leadership
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- Capitalise on innovation and research opportunities
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- Increase consumer engagement
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- Research activities through partnerships with local, tertiary and private sector

**ALLIED HEALTH STRATEGIES**

- Improve partnerships with consumers and support them to become active agents in their health care
- Create prevention and health promotion opportunities
- Identify workforce requirements to meet consumer need through a skill mix review and implement the required rural AH organisational structure
- Streamline referral processes (internal and external) to improve access to rural AH services
- Improve recruitment and retention by appointing to permanent positions; providing a career progression structure and implementing a Rural Generalist HP3-4 pathway
- Introduce rotational HP3 posts to enhance recruitment
- Carry out succession and leave relief planning to ensure service delivery is sustainable
- Identify and leverage ICT opportunities
- Increase the use of telehealth to provide efficient and equitable services to rural patients
- Identify iemR opportunities
- Identify areas of duplication and service gaps through the Community Health Partnership Group
- Introduce a skill sharing and delegation model of care to improve efficiency and reduce duplication
- Increase the integration of rural Allied Health services through the Team Leader role
- Introduce Health Pathways and clinical task instructions to streamline and standardise practice and ensure continuity of care
- Capitalise on telehealth and VOIP opportunities to minimise patient travel
- Increase investment in ICT and iemR
- Increase accuracy of telehealth activity reporting
- Implement a clinical governance framework, through a skill sharing and delegation model of care, to expand and standardise practice, risk manage skill sharing and delegation and define roles and responsibilities
- Develop clinical task instructions (CTIs) to standardise clinical practice
- Create a rural Allied Health (AH) organisational structure to include a Team Leader, Discipline Directors, state wide networks and the Allied Health Professions Office Qld (to support implementation of the Ministerial Task Force recommendations)
- Foster innovation in service delivery and establish innovation and research projects
- Create a strategic direction roadmap with timeframes
- Improve partnerships with consumers and support them to become active agents in their health care
- Solicit consumer feedback
- Improve communication throughout rural AH services and between Mackay Base Hospital (MBH) and rural sites through the Team Leader role
- Maintain strong professional links between the Team Leader, Discipline Directors, state wide networks and the Allied Health Professions Office Qld (to support implementation of the Ministerial Task Force recommendations)
- Engage with Higher Education Institutions to maintain the academic rigor of research
Alison Pighills

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