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

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Abstract

Objective. Queensland Health established a Ministerial Taskforce to consult on and make recommendations for the expansion of the scope of practice of allied health roles. This paper describes the findings from the stakeholder consultation.

Methods. The Ministerial Taskforce was chaired by the Assistant Minister for Health and included high-level representation from allied health, nursing, medicine, unions, consumers and universities. Widespread engagement was undertaken with stakeholders representing staff from a wide cross-section of health service provision, training and unions. Participants also tendered evidence of models incorporating full-scope and extended scope tasks undertaken by allied health professionals.

Results. The consultation incorporated 444 written submissions and verbal feedback from over 200 participants. The findings suggest that full scope of practice is often restricted within the Queensland public health system, resulting in underuse of allied health capacity and workforce inefficiencies. However, numerous opportunities exist to enhance patient care by extending current roles, including prescribing and administering medications, requesting investigations, conducting procedures and reporting results. The support needed to realise these opportunities includes: designing patient-centred models of service delivery (including better hours of operation and delegation to support staff); leadership and culture change; funding incentives; appropriate education and training; and clarifying responsibility, accountability and liability for outcomes. The taskforce developed a series of recommendations and an implementation strategy to operationalise the changes.

Conclusions. The Ministerial Taskforce was an effective and efficient process for capturing broad-based engagement for workforce change while ensuring high-level support and involving potential adversaries in the decision-making processes.

What is known about the topic? Anecdotal evidence exists to suggest that allied health professionals do not work to their full scope of practice and there is potential to enhance health service efficiencies by ensuring practitioners are supported to work to their full scope of practice.

What does this paper add? This paper presents the findings from a large-scale consultation, endorsed by the highest level of state government, that reinforces the perceptions that allied health professionals do not work to full scope of practice, identifies several barriers to working to full scope and extended scope of practice, and opportunities for workforce efficiencies arising from expanding scope of practice. The top-down engagement process should expedite the implementation of workforce change.

What are the implications for practitioners? High-level engagement and support is an effective and efficient way to broker change and overcome intraprofessional barriers to workforce change policies. However, practitioners are often prevented from expanding their roles through an implied need to 'ask for permission', when, in fact, the only barriers to extending their role are culture and historical practice.

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Background

The 2005 Productivity Commission report, *Australia's Health Workforce*,[1] recognised that simply expanding the health workforce would not adequately address the increasing pressures within the Australian healthcare system.[2] The report noted the importance of improving the efficiency and effectiveness of health workforce arrangements. These included implementing a broader scope of practice for health disciplines and recognised a need for 'realignment of existing health workforce roles, or the creation of new roles, to make optimal use of skills and ensure best health outcomes' (p. XXI).[1] The expansion of the scope of practice of allied health roles was emphasised, as was the need to consider more effective division of work between allied health professions and relevant assistant roles.

The Queensland Health *Blueprint for Better Healthcare in Queensland*[3] emphasises that 'Clinicians need to work to their full scope of practice' (p. 27). However, culture, historical practice and a range of other variables have meant that this is not always the case for allied health professionals (AHPs) working in the Queensland public health system. Even so, in Queensland, across Australia and internationally, there are many examples of AHPs working in new ways that improve the quality, safety and efficiency of patient care through changes to the scope of practice.

Although the body of literature regarding new and expanded allied health roles is steadily growing, the level of evidence remains relatively low and reliance on grey literature is high.[4] Despite this situation, there is evidence of improvements in patient flow, waiting times, waiting lists and patient satisfaction without increased risks.[5,6]

A recent systematic review on workforce reform[7,8] identified a range of potential outcomes from new models of care, including:

- effective use of roles through practitioners working to their full scope of practice;
- sustainable models of care;
- career development opportunities;
- new service configurations;
- increased service efficiency through using a more appropriate provider;
- reduced service costs;
- increased service accessibility, including reduced waiting times and more access to appropriate services;
- patient satisfaction; and
- staff satisfaction.

Since 2008, Queensland Health has made a considerable investment in allied health workforce reform and redesign. The Allied Health Profession's Office of Queensland implemented a large-scale Models of Care project and an Allied Health Assistant project.[9] These bodies of work involved 59 demonstration projects examining new models of care incorporating advanced practitioner roles and allied health assistants across 14 allied health disciplines in a range of clinical contexts and geographic areas. Policies and tools were developed to support extended and advanced scope roles and delegation of tasks. Findings from a recent evaluation of this work synthesised three principles that, when attended to, optimise the success of workforce reform. These included the following:[7]

(1) Workforce change needs to be driven by perceived or potential benefits to patients, staff or services at a local level.
(2) The context for change must be supportive in all domains, including legislative, industrial and professional, and across all organisational levels.
(3) Mechanisms for change should include engagement of all stakeholders; resources to support implementation and performance of new roles; a facilitated change process; and appropriate governance and support structures.

The Queensland Health Ministerial Taskforce on health practitioner expanded scope of practice (the taskforce) was a commitment through an industrial agreement to look at advanced health practitioner roles and delegated tasks. The term 'health practitioner' is an industrial term used by Queensland Health to refer to a wide range of health professions (non-medical and nursing staff). The umbrella term 'expanded scope of practice' was used to refer to the introduction of any role or task that would increase the current scope of a profession's practice within a particular context in Queensland Health.[10] These roles and tasks included working to the full scope of practice where practitioners were previously prevented from doing so, undertaking advanced practice or extended scope tasks in appropriate contexts, and delegating relevant tasks to the support workforce.

The focus of the taskforce was specifically on the traditional allied health professions.

The objectives of the taskforce were to identify:

- opportunities for AHPs to work to their full scope of practice and extend scope in appropriate contexts;
- means to achieve effective delegation to the support workforce;
- an integrated education, training and clinical governance strategy to support practice changes; and
- the funding implications of implementing workforce changes.

The premise of the taskforce was that better outcomes could be delivered to the community, Queensland Health and the workforce if AHPs were enabled to work to the full extent of their professional scope and to extend their scope in appropriate contexts. Additionally, it was recognised that further improvements could be made if the support workforce was used effectively. Box 1 provides the definitions used by the taskforce for each of these three concepts.

This paper summarises the outcomes of the consultation process used to inform the Ministerial Taskforce.

Methods

A Ministerial Taskforce, including diverse stakeholder representation, was established to oversee the process. The taskforce was chaired by the Assistant Minister for Health. A consultation paper[11] provided the platform for consultation with internal and external stakeholders, including health professionals; health educators; health service managers and administrators; consumers; professional associations; specialist medical colleges; and unions. Statewide feedback was gathered through an e-survey (circulated via Queensland Department of Health networks); written submissions; consultation workshops; focus groups; interviews; and submission of evidence-based models incorporating the full scope and extended scope tasks undertaken by AHPs.

Box 1. Definitions used by the Taskforce

Full scope of practice

The full spectrum of roles, functions, responsibilities, activities and decision-making capacity that individuals within a profession are educated, competent and authorised to perform. The full scope of a profession is set by professional standards and, in some cases, legislation. Working to full scope means working to the full extent of the profession's recognised skill base and regulatory guidelines, acknowledging that some functions may be shared with other professions, individuals or groups.

Extended scope of practice

A discrete knowledge and skill base additional to the recognised scope of practice of a profession or regulatory context of a particular jurisdiction. The tasks involved are usually undertaken by other professions. Over time, what once constituted an extended scope of practice may become part of a profession's full scope of practice. Extending the scope of practice is relevant where it allows more efficient management and care of the patient, and decreases the number of visits or transactions in the patient journey. Legislative change may be required to legally enable extended scope of practice in some circumstances.

Delegation

Delegation occurs when practitioners authorise another healthcare worker to provide treatment or care on their behalf. In making the decision to delegate, practitioners make the judgment that the person to whom they are delegating tasks has the appropriate education, knowledge and skills to undertake the activity safely. The delegating practitioner remains responsible for the overall management of the client and for the decision to delegate. The person to whom responsibility has been delegated is accountable for their decisions and actions, not the delegating allied health professional.

The survey and face-to-face consultation gathered participant perspectives on:

- the principles that should guide decision-making regarding allied health scope of practice;
- opportunities for implementing the full scope of practice and extended scope of practice in appropriate contexts;
- opportunities for delegating to the support workforce;
- the barriers to expanding allied health scope of practice and strategies to respond to these; and
- models of care, roles and tasks.

An extensive process of awareness-raising was conducted through 19 awareness-raising sessions with in-scope allied health disciplines; two statewide video teleconferences within Queensland Health; one meeting with delegates and officers from Together Queensland; one meeting with delegates and officers from United Voice Queensland; one meeting with officers from the Queensland Nurses' Union; one breakfast forum with AHP associations; electronic newsletters including the monthly Allied Health Professions' Office of Queensland e-news; 'What's new' on the Queensland Health intranet; and regular emails to Queensland Health stakeholders to encourage contribution to the consultation process.

A total of 129 letters of invitation to contribute to the taskforce were distributed to identified internal and external stakeholders of the taskforce. To facilitate access to the consultation paper and other relevant information, the invitation included links to the publicly available taskforce page on the Queensland Health website. Stakeholders were invited to provide feedback through an online survey or by written submission.

A series of consultation workshops were held with internal and external stakeholders to gather additional perspectives on the concepts and issues presented in the consultation paper. One workshop for allied health practitioners was held in each of four locations (Bundaberg, Brisbane, Toowoomba and Cairns). Each workshop group was formed by sending an expression of interest to AHPs in each hospital and health service, specifically seeking the participation of professionals working in clinical roles. A total of 207 expressions of interest were received. Final participant lists were determined on the basis of gaining representation across allied health professions, levels of expertise and experience, clinical context and geographic location. Two single workshops were held with directors of allied health and with allied health discipline directors from across Queensland metropolitan and regional areas.

The full details of the taskforce, and relevant workforce reform initiatives and tools are publicly available on the Queensland Health website.

Results

Participant details

A total of 200 participants contributed to consultation workshops, focus groups and interviews. Participants included consumers; allied health clinicians, managers and academics; and health service managers and administrators. The four consultation workshops with allied health clinicians included 105 participants representing 16 disciplines from 14 of Queensland's 17 Hospital and Health Services.

Of the 444 respondents who commenced the survey or provided a written submission, 407 provided responses to key consultation questions and were included in the analysis. Of these 407 respondents, 280 responded to all questions (68.8%) and 127 (31.2%) completed one or more key consultation questions. Queensland Health employees represented 83.7% ($n = 341$) of all respondents. Table 1 describes the number and proportion of respondents from each of the organisational contexts represented.

Thirty-one different disciplines responded to the survey or provided a written response. AHPs represented 85% ($n = 296$) of respondents. Most responses were received from physiotherapists (16.6%; $n = 67$), followed by occupational therapists (10.4%; $n = 42$) and social workers (8.9%; $n = 36$). The medical workforce accounted for 3.4% ($n = 14$) of responses, including two from specialist medical colleges. Nurses represented 1.2% ($n = 5$) of the responses.

Table 1. Organisational context of survey respondents

Organisational context[A]	Number ($n = 407$)	Percentage
Queensland Health	341	83.7
Professional association – allied health[B]	39	9.6
Private practitioner – allied health	23	5.7
Education provider[C]	19	4.7
Other state or federal government department	14	3.4
Non-government or not-for-profit organisation	15	3.7
Private practitioner – other	5	1.2
Specialist medical college	2	0.5
Registration body	1	0.2
Professional association – medical	1	0.2
Other	14	3.4

[A]More than one response could be selected.
[B]Of the 39 responses indicating that the respondent worked for or represented a professional association, 24 were from individuals and 14 were formal submissions from an allied health professional association.
[C]Of the 19 responses indicating that the respondent worked for or represented an education provider, 17 were from individuals and two were formal submissions from a university faculty.

Participant responses

Respondents identified multiple factors that should inform decisions about the scope of practice by AHPs. These factors centred around four principles:

- delivering patient-centred care;
- ensuring quality and safety;
- providing cost-effective services; and
- providing collaborative care in a team environment.

AHPs consistently indicated that they are not working to the full scope of practice they are educated, competent and authorised to perform. Opportunities were identified to improve service efficiency and quality, health outcomes, patient satisfaction and demand on the public and private medical workforce through addressing this issue.

Numerous discipline-specific, full-scope tasks were identified that Queensland Health AHPs cannot consistently perform. These included but were not limited to: working as a first contact professional, making direct referrals to public medical specialists and AHPs, requesting investigations, prescribing equipment and consumables, documenting the findings of an investigation and criteria-led discharge.

Despite these findings, there were many misunderstandings across the health workforce regarding what constitutes the full scope of practice for allied health disciplines and the mechanisms that determine scope of practice.

Perspectives on AHPs undertaking extended scope tasks were widely divergent. The majority of AHPs and all AHP associations recognised opportunities for improved patient care and efficiency through AHPs undertaking extended scope tasks that are a natural extension of existing roles and would be implemented in appropriate contexts. Examples included but were not limited to: prescribing, administration of medications, requesting investigations, conducting procedures and producing the final report on an investigation.

These findings contrasted significantly with most medical officers, the responding specialist medical colleges and the Australian Medical Association Queensland. These respondents expressed concerns about patient safety, lack of evidence, the cost of training and clinical governance, and impacts on medical officer training. In contrast, one medical officer articulated the opportunities that extended scope of practice by AHPs could bring, but noted the barrier that current funding models present to this being achieved.

AHPs identified a multitude of tasks that could be appropriately delegated to the support workforce. Responses reflected the expectation that additional dedicated resources would need to be made available to establish the support workforce as a key component in models of care.

The consultation identified numerous models of care and a host of tasks incorporating full-scope and extended scope allied health roles across the field of allied health practice. The full details are provided in the taskforce report.[10]

Barriers to change

Participants identified a range of interconnected challenges that limit the capacity of AHPs to maximise their scope of practice within the Queensland public health system, including:

- an inadequate focus on patient-centred service design and delivery;
- cultural barriers and inadequate leadership;
- funding incentives and models;
- operational issues;
- education and training;
- concerns regarding liability;
- Accreditation standards;
- legislation and regulations; and
- restricted hours of operation of allied health services.

These are expanded below.

Patient-centred care

Although professionals stressed the importance of patient-centred practice driving decisions about scope of practice, consumers noted this is not the way services are typically designed or delivered. Consumers expressed frustration at existing gatekeeping mechanisms that delay and limit service access, and add to the burden of accessing services in terms of their time as well as their finances. With respect to facilitating change that achieves more patient-centred outcomes, consumers indicated a strong desire to participate actively in managing their own health and to contribute to decisions about service design and implementation.

Culture and leadership

Cultural barriers were the most frequently identified reasons for lack of systemic implementation of full-scope and extended scope tasks by AHPs. Concerns were expressed by allied health clinicians, allied health managers and consumers that a lack of managerial and clinical leadership would limit change. It was suggested this would result in persistence of the current variability in scope of practice of AHPs across Queensland. AHPs identified they needed to be given ‘permission to lead’ in

order to contribute to this change. It was not evident where this permission was sought from.

More specifically, hierarchies within a single allied health discipline, between allied health disciplines, and between allied health disciplines and other professions were identified as significant barriers to change.

Funding models

Multiple issues regarding funding models were reported to be impediments to maximising AHPs' scope of practice. Interestingly, some of these issues reflect genuine barriers and others suggest misunderstandings regarding how some elements of current funding models work. Specific examples include:

- a lack of systems-level resource allocation to achieve the most clinically appropriate and cost-effective mix of AHPs, medical officers, nurses and support workers;
- a lack of opportunity to invest budget savings from service redesign into the service that generated the savings;
- a lack of financial resources to design, implement and evaluate change;
- concern that the national funding agreement requires referrals to be directed to the medical specialist or speciality indicated on a referral rather than to the most appropriate health professional for the presenting condition;
- a belief that activity-based funding results in reduced funding to hospital and health services when a service is provided by an AHP rather than a medical officer;
- the threat to hospital and health service revenue raised through Medicare rebates if AHPs request investigations or undertake tasks typically carried out by a medical practitioner (this is a particular issue where AHPs request diagnostic imaging and pathology);
- limited allied health access to Medicare item numbers and the requirement for medical referrals, care plans and practitioner credentials to access some of the available rebates; and
- the ineligibility of AHP services for Medicare rebates when these are provided in most public health facilities.

Operational issues

Operational concerns expressed regarding the consequences of implementing full-scope and extended scope tasks included the following:

- demand management: higher conversion rates to surgery from medical consultations, insufficient work for the medical workforce and excessive demand for allied health services if self-referral is implemented;
- accountability and responsibility: questions from medical practitioners and some AHPs regarding who would be accountable when AHPs undertake tasks they have not previously been responsible for; and
- authorising for services and resources: where access to services and resources requires referral or authorisation from a specified allied health discipline, there are limitations to the full benefits of allied health disciplines extending their scope through the skill-sharing of tasks (e.g. assessment for home modifications by professionals other than occupational therapists).

Education and training

Education and training was raised as an enabler to maximising the scope of practice for AHPs and was emphasised as necessary for change to occur. AHPs noted the importance of updating their skills to re-establish competence and confidence in full-scope tasks they may not have practised recently. Respondents also stressed the importance of appropriate training, credentialing and clinical supervision for extended scope tasks.

Liability

Medical practitioners and a small number of AHPs repeatedly raised concerns regarding liability and indemnity as a barrier to changing AHPs' scope of practice. This was particularly the case in relation to AHPs working as first-contact professionals and undertaking extended scope tasks.

Legislation and regulations

Respondents indicated that although the scope of practice of allied health disciplines has being undergoing significant change at a national level, Queensland legislation does not always enable reformed practices to be implemented. Specific Queensland legislation and regulations identified as impacting on AHPs implementing contemporary models of care, included:

- *Radiation Safety Act 1999—Radiation Safety Regulation 2010*;
- *Health Act 1937—Health* (*Drugs and Poisons*) *Regulation 1996*; and
- *Mental Health Act 2000.*

Some respondents suggested that registration acts as a barrier to specific disciplines undertaking particular clinical tasks. This reflects a misunderstanding of the *Health Practitioner Regulation National Law Act 2009 (Cth)*, which places minimal restriction on the scope of practice. The law operates on the protection of title rather than scope of practice and the intention is that registered practitioners are able to practice to the full extent of their competence.

Accreditation standards

Educators and academics supported the need for Queensland Health to work closely with accreditation bodies. They noted that the scope of practice reflected in accreditation standards must be responsive to current and emerging community needs and clinical practice.

Hours of operation

The fact that the current hours of allied health services in most hospital and health services do not always best meet the needs of the community and patients was raised repeatedly through the taskforce. Increasing the availability of AHP services across 7 days and for a greater number of hours in a day was highlighted as an important means for improving patient flow.

Discussion

Facilitating change towards AHPs working to full scope and undertaking extended scope tasks relies on reorienting services to being more patient-centred, redefining policies and processes,

reviewing team roles and functions, providing appropriate education and training, and supporting changes in team culture.

The taskforce recommendations and implementation plan provide direction to guide changes to AHPs' scope of practice and service delivery models within the Queensland public health system in the coming years. The recommendations focus on facilitating change that is systemic and statewide, rather than change that is piecemeal and dependent upon specific individuals. The recommendations have been developed into key performance indicators to support their implementation by Hospital and Health Services in Queensland.

Effective change is dependent upon strong leadership across the health workforce, including health service administrators, as well as clinical leaders within allied health, medicine and nursing. Importantly, every allied health clinician has a leadership role to play in advancing optimal models of care that facilitate the most effective use of available resources.

This taskforce was relatively unusual in that it was chaired at the highest level, ensuring Ministerial engagement with the processes. This was informed by feedback from all levels and sectors of health care delivery. The taskforce members were key stakeholders with the power to endorse and ultimately facilitate the taskforce recommendations; conversely, they were also in positions that could prevent the implementation of the taskforce recommendations. The high-level engagement facilitated discussions that diffused several of the potential barriers to implementing workforce change. This resulted in an expedited process of high-level support for what might have been a controversial innovation in health workforce redesign. A limitation of the consultation process was the potential for response bias, where those with a strong opinion or a particular vested interest may have had a greater incentive to engage with the process.

The intended outcomes of the taskforce are yet to be realised. Even so, successes to this point include the value of Ministerial endorsement of aspirations for change, alignment of the taskforce consultation and recommendations with current government priorities, and the contribution the taskforce process itself has made to challenging current boundaries as well as to providing some initial steps in allied health clinicians being given 'permission to lead'.

Conclusion

The taskforce findings demonstrate that most Queensland Health AHPs perceive that they do not work to the full scope of practice of their discipline. There was strong support from taskforce respondents for this situation to be changed. AHPs, their professional associations, consumers and nurses were also supportive of AHPs undertaking extended scope tasks in appropriate contexts. This same support for extended scope tasks was not evident from medical officers. A wide range of discipline and context-specific full-scope and extended scope tasks were identified that could improve patient satisfaction, health outcomes, service quality and efficiency. Even so, a complex mix of connected issues were identified that will impact on the capacity for such achievements to be realised. The Ministerial Taskforce approach is a highly effective way to overcome several of the potential intra-professional barriers likely to limit the effectiveness of workforce change.

Competing interests

None declared.

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